Program Safeguard Systems Assessment

INTERNAL

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Sri Lanka: Strengthening Integrated Health Care and Governance for Universal Health Coverage Program

PROGRAM SAFEGUARD SYSTEMS ASSESSMENT

1. **The results-based lending (RBL) program.** The Government of Sri Lanka, through the Ministry of Health (MOH), has realigned its health sector priorities to align with the global universal health coverage agenda and the Sri Lanka National Health Policy (SLNHP). The National Strategic Framework for the Development of Health Services (NSFDHS) 2016–2025 has been developed under the guidance of the SLNHP. It represents a comprehensive strategy aimed at enhancing efficiency and ensuring widespread access to health services across the country. The NSFDHS outlines strategies and actions to integrate and strengthen preventive care, curative care, and rehabilitation services. It also focuses on reforming health sector management, supply chains, human resources, and health financing to create a responsive, people-centered health system that is evidence-based and provides a comprehensive package of services. This framework aims to ensure continuity of care and adequate financial risk protection for users. The health system encompasses both curative and preventive programs, which are administered by the government. However, the structure of the health sector can be somewhat confusing. According to the 13th Amendment to the Constitution of the country, health is a devolved subject. The MOH at national level (central government) is dedicated to planning and stewardship, overseeing the procurement of pharmaceuticals and medical supplies, and managing national and teaching hospitals. The 9 provincial councils[1] are responsible for delivering services and managing public hospitals at provincial level. The MOH also provides technical guidance and directives to the regional directors of health services and all technical staff across various levels. Despite this structure, doctors at provincial hospitals are direct employees of the central government, yet they remain accountable to the provincial councils for managing health services within their respective provinces.

2. The proposed RBL program aligns with the NSFDHS and supports the government's health initiatives. It focuses on: (i) institutionalizing the provision of quality, efficient, and accessible integrated patient-centered curative care and management services for high burden diseases across all level of hospitals; (ii) supporting the integration of health and non-health services for addressing risk factors of diseases, including those that are gender differentiated, and improve service accessibility with special attention to elderly and vulnerable populations; and (iii) supporting reforms on improving the efficiency and governance of the health system. [2]

3. **Program scope.** The RBL program aims to foster a healthier nation, contributing to the economic, social, mental, and spiritual development of Sri Lanka. This goal aligns with the vision of the SLNHP, the NSFDHS, their supporting policies, and the 2023 reform recommendations. The program outcome seeks to improve the efficiency and quality of secondary health services as first referral care. The outcome will be measured by two disbursement-linked indicators (DLIs)[3] (i) The average waiting time of patients for three elective surgeries (cataract, hernia by sex, and hysterectomy) at first referral hospitals (base hospitals type A and B) reduced by 30% from baseline (DLI 1), and (ii) The IV cannula and surgical site hospital-acquired infections per 10,000 admissions (disaggregated by sex) at first referral hospitals (base hospitals type A and B) reduced by 40% (DLI 2). The RBL program consists of three outputs as follows: (i) Output 1: First referral care services enhanced; (ii) Output 2: Pandemic prevention, preparedness, and response enhanced; and (iii) Output 3: Health sector technical capacity and pharmaceutical supply chain

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[2] Asian Development Bank (ADB). 2024. *Concept Note: Proposed Results-Based Loan and Administration of Grant and Technical Assistance Grant to the Democratic Socialist Republic of Sri Lanka for Strengthening Integrated Health Care and Governance for Universal Health Coverage Program.*

[3] Disbursement-Linked Indicators, Verification Protocols, and Disbursement Schedule (Annex 1).

management improved. Each output encompasses various hardware and software activities aimed at strengthening and expanding health service development.

A. Program Environmental and Social Impacts and Risks

1. Environmental Risks

4. Out of the activities planned under the proposed RBL program namely, (i) improvement of healthcare infrastructure of secondary hospitals-base hospitals types A and B (DLI 4), (ii) introducing climate resilient measures for base hospitals types A and B in climate moderate or high risk areas[4] (DLI 4), (iii) construction of new Centre for Diseases Control (CDC) at National Institute of Infectious Diseases (NIID), Angoda (DLI 6), and (v) Medical Research Institute (MRI) building renovation and air quality improvement[5] (DLI 6) are expected to trigger environmental risks. However, these impacts are expected to be not significant and are reversible, short term, site specific, and are easily mitigable (scale shall not be of category A). The impacts are short term except the issues like healthcare waste (HCW) due to increased number of patients to first referral hospitals during operation but could be managed through existing HCW management procedures. Therefore, the overall environmental risk is rated as *moderate*.

5. The construction of new facilities and renovation works will involve construction activities such as clearing and grubbing, existing building demolishing, land formation, piling, excavation, building construction (substructures and superstructures), finishing, painting, mechanical, electrical and plumbing works, transportation, installation and commissioning of medical equipment, etc. During construction, impacts due to disposal of demolition and construction waste (likely including asbestos cement waste mainly from roofing sheets), disposal of accumulated clinical waste (likely), construction vibration and noise (mainly at CDC), dust generation, supply of construction material, machinery and equipment transportation, drainage issues, soil erosion, disturbances to existing amenities such as water, sewerage, electricity and telecommunication, etc., occupational safety risks and temporary access issues can be anticipated. Such impacts can be avoided and/or minimized through proper planning and construction site management including noise and dust barriers, protection fencing, proper traffic management during construction material movements, avoiding interference and interruptions of utilities during construction. Solid waste will be managed with the assistance of respective local authorities. Hazardous components will not be mixed with other wastes and will be collected and disposed as per the Guidelines for the Management of Scheduled Waste in Sri Lanka in accordance with the National Environmental (Protection & Quality) Regulation No. 01 of 2008. All the contractors (and subcontractors) will plan and implement environmental and social management plan, site

[4] Climate resilience is defined as - if any 5 or more of the following 9 aspects are addressed in selected base hospitals (i) reducing greenhouse gas emissions; (ii) improving water management; (iii) sourcing food locally and reducing food waste; (iv) improving water, sanitation and hygiene (WASH) measures; (v) improving energy efficiency by purchasing energy efficient appliances and lighting systems, utilizing renewable energy sources like solar power, conducting energy audits to identify inefficiencies, and investing in building renovations to enhance insulation and ventilation; (vi) building stronger infrastructure to withstand extreme weather; (vii) relocating infrastructure from vulnerable areas are considered; (viii) availability of a Disaster Response Plan for activating during a climate related disaster situation affecting the hospital; and (ix) promoting behavioral changes among staff. (Source: Revised Disbursement-Linked Indicators, Version March 18, 2025).

[5] The MRI building renovation and air quality improvement needs to include with replacement of flooring, roof, ceilings, power transformers and electric wiring systems, fire safety measures, decontamination facilities, access control mechanisms, and laboratory fittings to provide a non-hazardous, safe environment and to replace and upgrade the MRI air quality system with High Efficiency Particulate Air (HEPA) filters, animal health center and virology laboratories required air pressures, to ensure a high-level of biosafety in the laboratory and to ensure it can carry out its routine day-to-day operations (Source: Revised Disbursement-Linked Indicators, Version January 17, 2025: footnote 12).

safety management plan, complaints handling and information disclosure, etc. A summary of environmental and social impacts and risks and mitigating strategy is given in the table below.

Table 1: Summary of Environmental and Social Impacts and Risks and Mitigating Strategy

Environmental and Social Impacts / Risks	Mitigating Strategy
Impacts due to disposal of demolition and construction waste (likely including asbestos cement waste)	Demolition waste shall either be used for filling of prior identified land under approval of relevant authorities or disposed of to a designated disposal site. Disposal of asbestos waste (mainly from roofing sheets) if any, shall be done according to Guidelines for the Management of Scheduled Waste in Sri Lanka with the consultation of the Central Environment Authority (CEA).
Disposal of accumulated healthcare waste (likely)	Accumulated healthcare waste will not be mixed with other wastes and will be collected and disposed as per the Guidelines for the Management of Scheduled Waste in Sri Lanka with the assistance of registered hazardous (scheduled) waste management service provider.
Construction noise and vibration	Noise shall be kept within the applicable standards (National Environmental (Noise Control) Regulations No.1 1996 published in the Gazette (Extraordinary) No. 924/12 dated 23 May 1996) in order to prevent any inconvenience. The equipment used on site shall be in good service condition. Noise barriers should be installed where applicable. The pile driving activities could result in high vibration levels causing damage to nearby buildings as well as causing inconvenience to the public. The number of piles driving machines used at tandem (if required) will be managed to avoid generating vibration levels over the acceptable limits (Proposed Interim Standards for Air-Blast Over Pressure (ABOP) and Ground Vibration Control published by the Pollution Control Division of CEA on 4 December 2008). A property condition survey shall be conducted, and regular monitoring shall be done during piling operations to manage the vibration levels.
Dust generation	Materials such as gravel and soil shall be covered during transportation. Dust generating surfaces shall be kept dampened and covered to minimize the emission of dust. Dust screens will be installed where applicable. Water shall be sprayed on exposed areas and access roads at a suitable frequency.
Drainage issues and soil erosion	No drain paths will be obstructed in any way during construction activities. In order to prevent soil being washed away, materials will be stored to minimize erosion. Silt traps shall be placed where appropriate to minimize sedimentation of nearby waterways. A stormwater drainage management plan shall be prepared and implemented.
Supply of construction material	Construction material such as sand, soil, metal and rubble shall be sourced from licensed sites. Timber shall be sourced from agencies that have obtained the required licenses.
Machinery and equipment transportation	Machinery and equipment shall be transported with the relevant approvals and with the implementation of a traffic management plan.
Disturbances to existing amenities	Alternative access will be provided if relocating affected amenities such as water, sewerage, electricity, and telecommunications is not possible.
Increased solid waste	Proper waste bins shall be placed at construction sites and labor camps. The contractor shall prepare and implement a waste recycling plan to minimize waste. Construction sites will be cleaned and cleared regularly through designated cleaning days. Workers' knowledge of good housekeeping practices will be enhanced through frequent awareness sessions.
Occupational safety risks	During construction, a Safety Management Plan will be implemented. Safety measures against fire, lightning, etc., will be enforced. Contractors will follow safety regulations to minimize risks. Necessary barriers, warnings, and signs marking unsafe areas will be installed according to standard construction practices. Safety nets will be used to cover sites and prevent injuries to patients, staff members, and visitors.
Temporary access issues	In case of regular access paths are interrupted, temporary access shall be prepared with proper safety arrangements.

CEA = Central Environment Authority.
Source: Asian Development Bank.

6. As the new and expanded healthcare facilities become operational, they will be able to accommodate and treat more patients. This increase in patient numbers will naturally lead to generations of higher volume of HCW. However, no significant risk is anticipated due to this as the HCW management capacity will be enhanced through the support of the RBL program. The HCW will be handled and disposed through established standard practices and mechanisms according to the Guidelines for the Management of Scheduled Waste in Sri Lanka with the assistance of registered hazardous (scheduled) waste management service provider/s. Nonclinical solid waste and sewage will be disposed via existing systems with the assistance of relevant local authorities.

7. The proposed land for the CDC building is located within the respective NIID hospital premises at Angoda. Buildings earmarked for renovation in MRI are located within the premises of MRI. All renovations and repairs proposed under the program for base hospital types A and B will be located within the respective existing health care facility premises. None of these sites are located within any environmentally sensitive area.

2. Risks Associated with Involuntary Resettlement

8. The proposed RBL program is expected to implement the following civil construction activities: DLI 4: improvement of healthcare infrastructure of secondary hospitals (base hospitals types A and B), introducing climate resilient measures for base hospitals types A and B in climate moderate or high risk areas, DLI 6: construction of new CDC at NIID, Angoda and MRI building renovation and air quality improvement (DLI 6).

9. Preliminary consultations with MOH officials confirmed that all these sites (for the new CDC building and MRI buildings) are located on MOH-owned land and within the hospital premises. Therefore, no acquisition of private land is required. All other hospital lands (base hospitals type A and B) are free from encroachments and commercial activities. There will be no land use restrictions. Therefore, the proposed activities shall not trigger any involuntary resettlement impacts of Category A or B nature.

3. Risks Associated with Indigenous Peoples

10. The MOH confirmed that there are no adverse impacts on Indigenous Peoples (IPs) or any other ethnic minority groups, as all proposed RBL activities are concentrated within hospital premises across all regions. Additionally, the proposed development will take place in urban or semi-urban areas where IPs are not present. Therefore, the program scope will not trigger the safeguard requirements for IPs or ethnic minorities as they are not located within the program areas. However, all populations, including ethnic group communities living in these areas, will equally benefit from the program results.

B. Safeguard Policy Principles Triggered

11. An analysis of local system and Asian Development Bank's (ADB) Safeguard Policy Statement (SPS) environmental safeguard principles triggered, and assessment of implementation capacity is given in table below.

Table 2: Safeguard Policy Principles Triggered

ADB Safeguard Policy Principle	Description	
	Congruence between Local System and SPS Environmental Safeguard Requirements	**Assessment of Implementation Capacity**
Environmental		
PP1. Use a screening process for each proposed project, as early as possible, to determine the appropriate extent and type of environmental assessment so that appropriate studies are undertaken commensurate with the significance of potential impacts and risks.	For each proposed activity under the program, screening and categorization will be undertaken using Rapid Environmental Assessment (REA) checklist and categorization forms. The ESMF will provide the necessary guidelines for the screening.[6] Under the National Environment Act (NEA), No. 47 of 1980 and its subsequent amendments and regulations, for the prescribed projects shall be undergo through project approval process and conduct an EIA or IEE if the activity is listed as a prescribed project. The process is initiated through the submission of a filled Basic Information Questionnaire (BIQ).	The screening and categorization using the REA checklist, filling the BIQ and submission to ADB and Central Environmental Authority (CEA) will be performed by MOH and nine provincial health authorities. In general, the technical committees appointed at national level are capable of carrying out the screening and categorization process based on their experience with international donor-funded projects. However, there may be lapses at the provincial level, resulting in inconsistent application of these procedures. Therefore, training and capacity-building efforts are necessary for MOH and engineering department staff at provincial level at the beginning of the program.
PP2. Conduct an environmental assessment for each proposed project to identify potential direct, indirect, cumulative, and induced impacts and risks to physical, biological, socioeconomic (including impacts on livelihood through environmental media, health and safety, vulnerable groups, and gender issues), and physical cultural resources in the context of the project's area of influence. Assess potential transboundary and global impacts, including climate change. Use strategic environmental assessment where appropriate.	Under the ADB SPS, as a category B project, the activities proposed under the program will have to prepare environmental assessments as identified and guidance provided in ESMF. Under the NEA, there may be prescribed activities which require to undergo the project approval process (EIA/IEE process) as described above. Hence, there may be requirements for IEE for some activities.	Healthcare staff do not specialize in environmental assessments and conducting them in-house is not advisable. Preparation of IEE and ESMPs shall be carried out by hired consultants through MOH or relevant Provincial Health Authority. However, it would be beneficial for the program to provide training on the EIA/IEE process under the NEA and ADB Safeguard Policy Statement (SPS, 2009) for healthcare staff, as they serve as the primary focal points for the initial review of reports and represent the project developer before the CEA throughout the approval process. Further awareness on occupational health and safety and medical waste management would be beneficial to respective healthcare staff.
PP4. Avoid, and where avoidance is not possible, minimize, mitigate, and/or offset adverse impacts and enhance positive impacts by means of environmental planning and management. Prepare an environmental management plan (EMP) that includes the proposed mitigation measures, environmental monitoring and	For each activity with environmental impacts, an ESMP will be prepared. This will be carried out by MOH and provincial health authorities prior to the procurement process of respective contracts. The ESMF will provide comprehensive guidance in this regard. There are no ESMP requirements for non-prescribed projects under the national	Since healthcare staff lack specialized expertise in developing ESMPs, it is not recommended to prepare them in-house. Instead, the preparation of ESMPs should be outsourced to qualified consultants through the MOH or the respective Provincial Health Authority. Furthermore, training on ESMP preparation shall be incorporated into the said EIA/IEE training programs, as outlined in Item No. 2, to

[6] Each sub activity under the program will be screened using ADB's rapid environmental assessment checklist Categorization forms. Based on the screening, the MOH/Provincial Health Authority will propose the environmental categorization for each subproject and submit for ADB Sri Lanka Resident Mission (SLRM) review and approval. Category A activities will be excluded from ADB financing. Category B activities will require the preparation of an IEE including an EMP while Category C activities will require an EMP.

reporting requirements, related institutional or organizational arrangements, capacity development and training measures, implementation schedule, cost estimates, and performance indicators. Key considerations for EMP preparation include mitigation of potential adverse impacts to the level of no significant harm to third parties, and the polluter pays principle.	environmental laws and regulations.	ensure a comprehensive understanding of environmental safeguards and compliance.
PP5. Carry out meaningful consultation with affected people and facilitate their informed participation. Ensure women's participation in consultation. Involve stakeholders, including affected people and concerned nongovernment organizations, early in the project preparation process and ensure that their views and concerns are made known to and understood by decision makers and taken into account. Continue consultations with stakeholders throughout project implementation as necessary to address issues related to environmental assessment. Establish a grievance redress mechanism to receive and facilitate resolution of the affected people's concerns and grievances regarding the project's environmental performance.	Consultations with stakeholder will be continued throughout the program implementation as necessary to address issues specially related to those that are identified by ESMF and subsequent environmental assessments. A grievance redress mechanism will be established to receive and facilitate resolution of the affected people's concerns and grievances regarding the project's environmental performance. There is no mandatory requirement under the national environmental laws or any other local regulation.	There is no established institutional mechanism within MOH or provincial health authorities for these type of projects to facilitate stakeholder consultation. Therefore, developing such a stakeholder consultation framework should be prioritized as part of capacity-building efforts at early stages of the program. Further the consultation framework should ensure that the meaningful consultation is gender responsive.
PP6. Disclose a draft environmental assessment (including the EMP) in a timely manner, before project appraisal, in an accessible place and in a form and language(s) understandable to affected people and other stakeholders. Disclose the final environmental assessment, and its updates if any, to affected people and other stakeholders.	All environmental assessment and monitoring reports, once approved, will be published on the ADB website, MOH website, Provincial Council's website and the program's website (if any), and. However, this is not a mandatory requirement nor a common practice under the local regulatory framework.	This is standard practice for international donor-funded projects, and healthcare staff at the national and provincial levels are familiar with and capable of meeting this requirement, with no additional training needed. Improved coordination is essential between the personnel managing the MOH website, project staff, and website administrators at the provincial level to ensure seamless implementation.
PP7. Implement the EMP and monitor its effectiveness. Document monitoring results, including the development and implementation of corrective actions, and disclose monitoring reports.	The ESMP for each activity under the program will be incorporated into the relevant construction works contracts. The Engineering Division of the MOH will supervise the construction works of National hospitals, while the Provincial Engineering Department/Unit will oversee construction at the provincial-level base hospitals. The contractor will be responsible for implementing the ESMP, while the	The construction works will be supervised by the Engineering Division of the MOH for the construction of the CDC and MRI renovations, while the Provincial Engineering Department/Unit will oversee renovations, and repair works at provincial-level base hospitals. Accordingly, site-level supervision of the ESMP implementation will also be the responsibility of these institutions, with healthcare staff having the capacity to oversee the process. Therefore, training on environmental and social

	implementing agency will be responsible for supervising and monitoring ESMP implementation. Under the local system, specific ESMPs are not typically included as part of construction contracts. However, contracts generally cover relevant areas in a non-site-specific manner, including health and safety, insurance, compensation, waste management, facilities for staff, lighting, security, and other related aspects. For submitted BIQs, in case the projects are not prescribed, the CEA issues environmental recommendations, which include essential requirements under the NEA for compliance during construction.	safeguards, pollution control, waste handling, health and safety, regulatory requirements, and approval conditions will be crucial for the Engineering Division of the MOH, the Provincial Engineering Department/Unit, and relevant healthcare staff.
PP9. Apply pollution prevention and control technologies and practices consistent with international good practices as reflected in internationally recognized standards such as the World Bank Group's Environmental, Health and Safety Guidelines. Adopt cleaner production processes and good energy efficiency practices. Avoid pollution, or, when avoidance is not possible, minimize or control the intensity or load of pollutant emissions and discharges, including direct and indirect greenhouse gases emissions, waste generation, and release of hazardous materials from their production, transportation, handling, and storage. Avoid the use of hazardous materials subject to international bans or phaseouts. Purchase, use, and manage pesticides based on integrated pest management approaches and reduce reliance on synthetic chemical pesticides.	The executing / implementation agencies will apply pollution prevention and control measures throughout the program's construction and operation stages. NEA provides sufficient regulations on this regard. The regulations and guidelines related to pollution control include water quality, air quality, noise, vibrations, waste management including scheduled (hazardous) waste management etc. International guidelines such as WHO, World Bank Group's Environmental, Health and Safety Guidelines and US-EPA will be used where applicable. The ESMF will provide further elaboration on this matter.	Healthcare Waste (HCW) will be handled according to Sri Lanka's Guidelines for Scheduled Waste Management, with registered hazardous waste management service providers. Non-clinical solid waste and sewage will be managed through existing systems with local authorities. The deputy director general, environment and occupational health (E&OH) and Director E&OH coordinate HCW management with hospital directors under the central government. Environmental and HCW management issues are coordinated with stakeholders such as the CEA and local authorities. All base hospitals fall under the RDHS, with the Director E&OH coordinating HCW management at that level. It is recommended The general recommendation for increased training and capacity-building for all involved stakeholders is also applicable to this item and ensure regular monitoring of collection and disposal of hazardous waste.
PP10. Provide workers with safe and healthy working conditions and prevent accidents, injuries, and disease. Establish preventive and emergency preparedness and response measures to avoid, and where avoidance is not possible, to minimize adverse impacts and risks to the health and safety of local communities.	Health and safety clauses will be incorporated into works contracts. Using Personal Protection Equipment (PPEs) is mandatory at sites and required PPEs will be provided to the workers. Emergency-response systems (fire, accidental spillages and other natural disasters) will be established in accordance with national /international requirements during operation and construction.	Health and safety clauses are included in works contracts under the local system, though some gaps still exist. However, it is essential to provide training on health and safety for the Engineering Division of the MOH and the Provincial Engineering Authority.

	This practice is also followed under the local system, although there are some gaps.	
PP11. Conserve physical cultural resources and avoid destroying or damaging them by using field-based surveys that employ qualified and experienced experts during environmental assessment. Provide for the use of "chance find" procedures that include a pre-approved management and conservation approach for materials that may be discovered during project implementation.	There are structures in some hospitals which are more than 100 years old. Excavations and trenching can uncover and/or damage archaeological and historical resources. Obtaining prior approval from the Department of Archaeology will require in case renovation/repair works are involved in hospital buildings which are more than 100 years old.	All the staff and laborers of the contractor should be informed about the possible items of historical or archaeological value, which include old stone foundations, tools, clayware, etc. If something of this nature is uncovered, the Department of Archaeology shall be contacted, and work shall be stopped immediately. The chance finds procedure of archaeological and cultural artefacts should be established. it is essential to provide training on relevant local regulations and ADB safeguards requirement and chance find procedure etc.
Involuntary Resettlement		
PP1. Screen the project early on to identify past, present, and future involuntary resettlement impacts and risks. Determine the scope of resettlement planning through a survey and/or census of displaced persons, including a gender analysis, specifically related to resettlement impacts and risks.	The National Involuntary Resettlement Policy Framework (NIRP) in the country and ADB's Safeguard Policy Statement (SPS) are aligned and compatible	The MOH's Environment Unit and PDHS have the necessary capacity to screen and assess the impact of involuntary resettlement (IR) on the proposed activities. If land acquisition is required, the Divisional Secretary (DS) is the authorized person to acquire or recover the possession of land.
PP2. Carry out meaningful consultations with affected persons, host communities, and concerned non-government organizations. Inform all displaced persons of their entitlements and resettlement options. Ensure their participation in planning, implementation, and monitoring and evaluation of resettlement programs. Pay particular attention to the needs of vulnerable groups, especially those below the poverty line, the landless, the elderly, women and children, and Indigenous Peoples, and those without legal title to land, and ensure their participation in consultations. Establish a grievance redress mechanism to receive and facilitate resolution of the affected persons' concerns. Support the social and cultural institutions of displaced persons and their host population. Where involuntary resettlement impacts and risks are highly complex and sensitive, compensation and resettlement decisions should be preceded by a social preparation phase.	The National Involuntary Resettlement Policy Framework (NIRP) in the country and ADB's Safeguard Policy Statement (SPS, 2009) are aligned and compatible.	MOH's Environment Unit and PDHS have the necessary capacity to conduct meaningful consultation with stakeholders including affected persons (if any as identified during screening and categorization).
Indigenous Peoples		

PP1. Screen early on to determine (i) whether Indigenous Peoples (IP) are present in, or have collective attachment to, the project area; and (ii) whether project impacts on Indigenous Peoples are likely	The rights of Indigenous Peoples (specifically the Veddha community) are safeguarded under existing legal protections, similar to those of other communities. However, certain, rights which are sometimes politically motivated, are introduced from time to time. These policies, though well-intentioned, are limited in scope, effectiveness, and implementation. Over time, the recognition of their inherent rights has been undermined due to the small size of the population and their gradual integration into the mainstream society, particularly in areas like education, employment, and marriage It is important to note that the marginalized population (MPs), particularly Indian-origin Tamils working in the plantations, is much larger than the Indigenous Peoples (IPs) in the country. The majority of them live in line rooms, which expose them to significant health risks due to their living conditions and habits. Additionally, many plantation workers live in large plantations, where they are unable to speak in Sinhala, further distancing them from the mainstream population and access to service.	IPs often face significant barriers to accessing healthcare services. These barriers are rooted in a variety of factors, including geographic isolation, limited awareness of available health services, cultural differences, and systemic neglect. Addressing these issues requires tailored approaches, such as orientation and training for healthcare staff to ensure better care delivery to Indigenous communities and marginalized communities.

Source: Asian Development Bank.

C. Diagnostic Assessment

1. Assessment Methodology and Resources

12. This program safeguard systems assessment (PSSA) is based on (i) comprehensive review of the policy and regulatory framework relevant to the environmental, involuntary resettlement and indigenous people safeguards; (ii) desk review of secondary data and information; (iii) field visits and observations on environmental and social aspects; (iv) discussions with relevant stakeholders; (v) collection of provincial level safeguard system information through a questionnaire; and (vi) review comments from ADB staff (safeguards experts and RBL program team).

13. Field inspections were made at the identified construction sites, including the new CDC facility at the NIID in Angoda (*formerly known as the Infectious Diseases Hospital, IDH*), and the existing MRI where laboratory's capacity expansion is proposed. These visits were accompanied by the Additional Secretary (Engineering Services) of the MOH. During the visits, key officers from the respective hospitals, such as the Deputy Director General (DDG) of National Hospital of Sri Lanka, the Deputy Director and Planning Director of MRI, the DDG of Public Health Services (Disease Control), the Director of NIID and the Technical Design Team of the National Buildings

Department, who will provide technical assistance for the CDC building were met. Administrative officers and technical staff from the relevant hospitals also participated in the visits. Provincial-level information related to environmental and social safeguard systems were collected through a questionnaire designed to capture the current practices and capacity in approvals procedures, environmental and social management, institutional capacity, health and safety, complaint handling and waste management, etc. Appendix 1 gives the summary assessment on safeguards based on the provincial data collection through questionnaire and meetings with MOH and provincial officers during September 2024 to March 2025.

14. The program's likely positive and negative environmental impacts and risks are assessed. The PSSA also assesses the programmatic, institutional, and contextual risks that could affect the government's ability to implement the environmental safeguards for the RBL program effectively, the government's requisite capacity, implementation track record, and commitment to manage risks, information disclosure mechanisms and meaningful consultations with stakeholders, and grievance redress procedures.

2. Environment

15. **Regulatory framework for environment safeguards.** The following sections describe the National Environmental Legislation and existing HCW management framework in the country.

16. **National environmental legislation.** The National Environment Act, No. 47 of 1980 (NEA) is the primary national legislation for environmental protection and with its amendments the Act provides a framework for sustainable development with the management of natural resources such as water, air, soil, forests, flora, and fauna in Sri Lanka. The Central Environmental Authority (CEA) is the key regulatory body, established under the NEA. The NEA includes key regulatory provisions implemented by the CEA to assess, mitigate, and manage the environmental impacts of development activities. Those that relevant to the RBL program are, (i) The Environmental Impact Assessment (EIA) procedure for major development projects; (ii) The Environmental Protection License (EPL) procedure for the control of pollution; (iii) Scheduled Waste Management License (SWML) procedure for the management and control of hazardous waste disposal; (iv) Other regulations related to pollution control enacted under the provisions of the NEA. Apart from the regulatory provisions of the NEA, there are other relevant legislation and/or regulatory provisions for pollution control, environmental perseverance, and protection, which are enacted by state-sector entities.

17. **Environmental impact assessment.** The Government of Sri Lanka recognizes EIA as an effective tool for integrating environmental considerations with development planning. The application of this technique is considered as a means of ensuring the likely effects of development projects on the environment are fully understood and considered at an early stage of the project and throughout the project cycle.

18. Regulations pertaining to EIA process are published in Government Gazette Extraordinary No.772/22 dated 24 June 1993 and in several subsequent amendments. According to Section 23AA (1) under Part IV C (Approval of projects) of the NEA all "Prescribed Projects" that are being undertaken in Sri Lanka by any government department, corporation, statutory board, local authority, company, firm or an individual will be required to obtain approval under this Act for the implementation of such prescribed projects. The prescribed projects are set out in the Schedule of the Order under Section 23Z published in the Gazette (Extraordinary) No.772/22 of 24 June 1993 and in subsequent amendments in 1995. The procedure stipulated in the Act for the approval of projects provides for the submission of two types of reports (i) EIA, and Initial Environmental

Examination (IEE) report. The EIA process is implemented through designated Project Approving Agencies (PAA) as set out in the Schedule of the Order under Section 23Y published in the Gazette (Extraordinary) No. 859/14 of 23 February 1995 and in subsequent amendment in 2004. PAA's are those organizations that are directly connected with such a prescribed project. At present, 23 state agencies have been recognized as PAAs. A project proponent should submit preliminary information to the CEA regarding the nature, location, and impacts of a proposed project to determine whether the project and/or activity requires an EIA and/or IEE. The CEA has developed a Basic Information Questionnaire (BIQ)[7] for submission of preliminary information. (The BIQ may also be obtained from the EIA Unit of the CEA headquarters or the provincial and/or district offices of the CEA). The best time for a project proponent to submit the preliminary information on a proposed project and/or activity is immediately after it's concept is finalized for a given location is decided. The need for an environmental assessment and the level of analysis required (EIA or IEE) for a proposed activity is screened by the CEA based on the submitted BIQ by the project proponent. There are two possible screening outcomes. (i) Categorical Exclusion: the activity does not fall under the prescribed category or located in a sensitive area as defined in the regulations, and it is clear that the project will have no significant environmental impacts. Environmental Clearance is granted (with or without conditions – in the form of environmental recommendations) and the project may proceed; (ii) EIA/IEE required: the activity falls under the prescribed category, has potentially serious environmental impacts and/or is in a sensitive area. With the screening decision, the CEA establishes a scoping committee to decide on the level of study (IEE or EIA) and prepare terms of reference. Alternatively, if the project falls within the jurisdiction of a government authority which is an appointed project approving authority the CEA will then determine which will be the appropriate PAA for administering the EIA process. Upon submission of the EIA/IEE report, a Technical Review Committee appointed by CEA/PAA reviews the completed IEE or EIA report and recommends whether environmental clearance should be granted; the final decision is made by CEA.

19. **Environmental protection license.** The environmental protection license (EPL) is a regulatory and/or legal tool under the provisions of the NEA that has been introduced to (i) prevent or minimize the release of discharges and emissions in compliance with national discharge and emission standards; (ii) provide guidance on pollution control for polluting processes; and (iii) encourage the use of pollution abatement technology such as cleaner production, waste minimization, etc. The "prescribed activities" for which EPL is required are stipulated in the Gazette (Extraordinary) No. 2264/18 dated 27 January 2022. The specified categories of 'prescribed projects' need to comply with the regulations and discharge and emission standards depending on the type of activity as well as the receiving environment are stipulated in the Gazette (Extraordinary) No. 2264/17 dated 27 January 2022. The EPL regulation classifies activities into four categories, namely, A, B, C and D based on the polluting potential of the relevant activity discharging and/or emitting waste into the environment. While EPL for A and B categories are directly administered by the CEA, issuing EPL for category C and D are delegated to the local authorities. CEA has published standards for various parameters such as effluent quality, air quality, noise, and interim standards for vibration.

20. **Disposal of scheduled waste.** As stipulated through National Environmental (Protection & Quality) Regulations as published in Gazette Notification No. 1534/18 (dated 25.01.2008), which deals with hazardous waste from specific and nonspecific sources and these wastes are called scheduled waste. Handling of scheduled waste (generate, collect, transport, store, recover or recycle and disposal of waste or establish any site or facility for the disposal) should conform to the said regulations. Part II of the regulation deals with the issue of license for the management

[7] Central Environment Authority. 2023. *Basic Information Questionnaire.*

of scheduled waste, which is commonly called as SWML and Part III on general matters including definitions of terms, etc. Four schedules under the regulation include the application forms for scheduled waste management and operating a facility for scheduled waste management (Schedule IV), format for maintaining records (Schedule V) format for the reporting of details of waste disposal operations and environmental surveillance (Schedule VI), format for reporting accidents (Schedule VII) and categorization of non-specific and specific scheduled waste (Schedule VIII).

21. **Applicability of the NEA to the proposed program activities.** The improvement of healthcare infrastructure of secondary hospitals (base hospitals type A and B), interventions related to climate resilience of secondary hospitals and MRI building renovation and air quality improvement activities envisaged under the program are not likely to fall within prescribed categories of the NEA for environmental impact assessment and as such IEE/EIA is not required. However, the requirement to undergo the EIA/IEE process, especially for the construction of new CDC at NIID, Angoda, shall be confirmed by CEA through the Basic Information Questionnaire, as soon as the preliminary information about the proposed components becomes available. Further, any improvements to the waste management systems in the selected hospitals shall be referred to in the EPL process.

Table 3: Most Common Environmental Regulations that are Applicable to the Proposed Program Activities

Environmental Component	Relevant Regulations	Compliance Requirement	Regulatory Agency
Ambient water quality	National Environmental (Ambient Water Quality) Regulations No. 1 of 2019 published in Gazette (Extraordinary) No. 2148/20 dated 05 November 2019	EPL; Compliance	CEA
Discharge of wastewater / effluents	National Environmental (Protection and Quality) Regulations, No. 1 of 2008 published in Gazette (Extraordinary) No. 2264/18 dated 27 January 2022	EPL; Compliance	CEA
Discharge of HCW (Scheduled waste)	National Environmental (Protection and Quality) Regulations No.1 of 2008, published in Gazette No. 1534/18 dated.01 February 2008	SWML; Compliance (Details are given below,)	CEA
Ambient air quality	National Environmental (Ambient Air Quality) Regulations, 1994, published in Gazette (Extraordinary), No. 850/4 of December 1994 and amendment gazette (Extraordinary) No. 1562/22 of 2008	EPL; Compliance	CEA
Air emissions	National Environmental (Stationary Sources Emission Control) Regulations, No. 01 of 2019 under the Gazette (Extraordinary) No. 2126/36 dated 05 June.2019	EPL; Compliance	CEA
Noise	National Environmental (Noise Control) Regulations No.1 1996 published in the Gazette (Extraordinary) No. 924/12 dated 23 May1996	EPL; Compliance	CEA
Vibration	Proposed Interim Air-Blast Over Pressure and Ground Vibration Standards for Sri Lanka, Pollution Control Division, CEA dated 04 December 2008	EPL; Compliance	CEA

CEA = Central Environment Authority, EPL = environment protection license, SWML = Scheduled Waste Management License.
Source: Asian Development Bank.

22. However, discharge of HCW during operation falls within the prescribed category for pollution control, and as such, is required to obtain an SWML. The HCW types applicable for the proposed activities are specified in the schedule VIII the National Environmental (Protection and Quality) Regulations No.1 of 2008, (Gazette No. 1534/18, 2008.02.01).

Table 4: Scheduled Waste Classifications Applicable for the Program

Waste Code	Scheduled Waste
PART I - Scheduled Wastes from Non-Specific Sources	
26.	Pathogenic and clinical wastes and quarantined materials
N 261	Pathogenic and clinical wastes and quarantined materials
28.	Mixtures of scheduled wastes
N 282	A mixture of scheduled and non-scheduled wastes
PART II - Scheduled Wastes from Specific Sources	
4.	Clinker, slag and ashes from scheduled wastes incinerator
S 041	Clinker, slag and ashes from scheduled wastes incinerator
28.	Bio Medical and Health Care Waste from Health Care Institutions including Medical Laboratories and Research Centres
S 281	Infectious health care waste including laboratory cultures; waste from isolation wards; tissues (swabs), materials or equipment that have been in contact with infected patients; Human tissues or fluids
S 282	Sharps including needles and scalpels
S 283	Biological and Anatomical waste including tissues, organs, body parts, human fetuses and animal carcasses, blood, and body fluids
S 284	Outdated and discarded drugs including cytotoxic drugs and chemical reagents
S 285	Materials and containers contaminated with the above specified waste

Source: Schedule VIII the National Environmental (Protection and Quality) Regulations No.1 of 2008.

23. **Draft national policy on healthcare waste management.** In 2001, the Government of Sri Lanka drafted a comprehensive national policy on HCW management. It has three main sections covering: (i) general considerations on HCW management and the institutional mechanism for policy implementation that should be set up at national level; (ii) provisions for the safe management of HCW in medical institutions, including regulations and HCW management plans, and (iii) provisions for the implementation of and the monitoring of HCW management plans at national and provincial levels including legislation, provision of human and financial resources, training and awareness, and participation of the private sector. The institutional mechanism for implementing the national policy was envisaged under three levels of management such as: at the central level, at the provincial level and at the local level. The national policy on HCW management to this date remains a draft as all attempts for its formal adoption in the past have not been successful.

24. **National guidelines on healthcare waste management.** In 2001, the government drafted national guidelines for healthcare waste management with the aim of (i) providing a better understanding of the fundamentals of HCW planning management, and (ii) directing health care facilities (HCFs) in setting necessary procedures and standards to comply with policy and legislative requirements. These have been drafted in a form that provides all fundamental elements that should be integrated into future legislation specific to HCW. Although guidelines were reviewed by the National Committee on Clinical Waste Management as well as the MOH, it did not receive formal endorsement by the government.

25. The draft national guidelines contain both practical and conceptual information on HCW management covering four main sections: (i) definition and categorization of HCW, including potential harmful effects that can result from its improper management; (ii) procedures for segregation, packaging, labelling, collection, storage, transportation, and disposal (including the

selection of appropriate treatment and disposal technologies for HCW that should be applied and followed by all HCFs in the country; (iii) instructions for the implementation of healthcare waste management plans, including detailed description of duties and responsibilities of healthcare provider at various levels, and; (iv) instruction for personnel of Central and Provincial Health Services who oversee HCW management to ensure smooth implementation of the guidelines and to set up regular monitoring mechanisms.

26. In 2007, concise guidelines for HCW management were prepared under the hospital efficiency and quality component of the Sri Lanka Health Sector Development Project based on the detailed draft guidelines prepared in 2001. The concise guidelines which mainly contain sections in waste categorization and healthcare waste management procedures have been formally adopted and incorporated into the Handbook of Infection Control.

27. **Categorization for environment safeguards.** With respect to the RBL program, ADB's environment safeguards are triggered for the activities namely, DLI 4: improvement of healthcare infrastructure of secondary hospitals (base hospitals type A and B), introducing climate resilience measures for base hospitals type A and B in climate moderate or high-risk areas, DLI 6: construction of new CDC at NIID, Angoda, and MRI building renovation and air quality improvement. The overall environmental risk is *moderate.* The program will exclude any Category A activities on environment from the financing. The potential environmental impacts due to the program's interventions are less severe, manageable and site-specific. All the program activities will be located within the respective existing healthcare facility premises and are not located within an environmentally sensitive area. Program activities are well known, and manageable with existing processes and/or procedures. The impacts are reversible, and mitigation and management measures are more predictable and readily available. Program interventions are expected to provide positive long-term health benefits to beneficiaries. The RBL program will help increase access to primary healthcare and maintain high levels of service quality covering environmental and safety provisions. No investment supported through the program will have adverse impacts on natural habitats, physical cultural property, natural resources, or people's livelihoods. Therefore, as a result of the above, the proposed RBL program is categorized as category *B* for environmental safeguards.

28. **Likely programmatic risks.** Considering the nature of the activities proposed, existing capacities of the executing agency, i.e., the MOH and 9 provincial health authorities in implementing environmental safeguards requirements, programmatic risks are not expected to be significant. With respect to the program scope, the major gap between the national environmental policy and ADB SPS environmental requirements is that the level of assessments applicable. Under the National Environment Act, No. 47 of 1980 and its subsequent amendments and regulations, most of the proposed activities under the program are not likely to be prescribed activities that require following the project approval process (EIA/IEE process). However, the requirement to undergo the EIA/IEE process, for the construction of new CDC at NIID, Angoda, shall be confirmed by CEA through the Basic Information Questionnaire (BIQ), as soon as the preliminary information about the proposed components becomes available. The healthcare facilities will be required to obtain environmental protection licenses and scheduled waste management licenses and proposed new facilities may require obtaining them or integrating into existing licenses.

29. With knowledge and experience with safeguard requirements of multilateral development bank (MDB) projects including ADB, the executing and/or implementing agencies are expected to manage the safeguard requirements. Further, the MOH has immense experience in managing

emergency situations such as working under the coronavirus disease pandemic situation and during country's economic crisis.

30. **Institutional risks.** The MOH and provincial councils will ultimately be responsible for managing environment related matters with support from Central Environmental Authority under NEA, No. 47 of 1980 and Provincial Environmental Authority in case of activities planned in Northwestern Province. The MOH and program's provincial focal point liaise with the district environmental officers attached to the district offices of environmental authority as applicable. The MOH has been implementing several projects with support from MDBs as listed above. However, the in-house staff and capacity to manage the environmental requirements, especially for the activities involved in construction activities, could be further enhanced. The safeguards program actions were identified and specified the training requirements to enhance the capacity of MOH staff. The Directorate of Environmental Health, Occupational Health and Food Safety is the key unit established within MOH that oversees the environmental compliance related to operations of country's health care facilities. This unit has a separate budget line under the MOH. The directorate has sufficient staff strength and capacity for occupational health and safety, food and drug safety, health care waste management, etc. It is evident that the directorate has facilitated many EPLs/SWMLs for major hospitals in all nine provinces so far through the provision of training, evaluation and follow up support.

31. With the implementation of the 13th Amendment to the Sri Lankan Constitution, since 1990s, the ownership and administration of public health institutions was split between MOH and the provincial councils and their provincial MOHs. The MOH has the sole responsibility for formulating national health policies and strategies according to the Constitution and can provide operational guidelines for policy implementation. Although provinces can set their own policies and draft their own legislation, these must conform to national policy and related guidelines. In practice, most operational guidelines that apply to hospitals are produced by MOH, and MOH retains substantial control even at provincial hospitals. In contrast, even though the subject of environment is a devolved subject (while the central government also has controlling powers since the subject is a concurrent subject), and by the amendment, each provincial council had the authority to enact and implement any statute related to their responsibilities, only the North Western Provincial (NWP) Council passed its own environmental statute and created its own Environmental Authority, the Provincial Environmental Authority of the North Western Province (PEA-NWP). Except for the Northwestern Province, there are no separate environmental statutes for other provinces. Therefore, provincial environmental activities are also regulated under the NEA No.47 of 1980 and its subsequent amendments.

32. **Likely contextual risks**. None of the RBL program activities are planned within any environmentally sensitive areas. All the activities will be located within respective existing health care facility premises. The initial assessment revealed that there are no legacy or significant unresolved issues that can affect the performance of the program. This program is not expected to have any chance to result in any reputational risks.

3. Involuntary Resettlement

33. **Involuntary resettlement legal framework and implementation practice.** The primary legal framework governing land acquisition and involuntary resettlement for public development consists of the Land Acquisition Act of 1950, the National Involuntary Resettlement Policy of 2001, and relevant donor policies on resettlement. For ADB-funded projects, the applicable policy is RBL policy (August 2019) on Safeguard Systems (paras. 72–81), which provides the policy guidance on safeguard delivery process for RBL program. RBL policy follows the policy principles

of the Safeguard Policy Statement (SPS, 2009) on Involuntary Resettlement Safeguards. However, since this RBL program will not involve land acquisition (including land use restrictions) or involuntary resettlement risks and impacts, IR safeguards will not be triggered.

34. **Involuntary resettlement categorization**. ADB's Involuntary Resettlement Safeguards are triggered by involuntary physical and economic displacement. Principles 1 and 2 of ADB's Safeguard Policy Statement (SPS) and para. 77 of the RBL policy apply to this RBL program. According to the RBL policy, activities are eligible for financing under the program unless they are assessed as likely to cause significant adverse impacts that are sensitive, diverse, or unprecedented on the environment and/or affected people. Based on the preliminary screening of proposed RBL program activities outlined in paras. 3–7 of the PSSA, they will be implemented within the existing premises of provincial hospitals and on land owned by the MOH. Land acquisition (including land use restrictions) or involuntary resettlement shall not be required. Therefore, these activities under the RBL program are classified as category *C* for social safeguards.

35. **Likely programmatic risks.** The programmatic risks related to involuntary resettlement are not expected due to the nature of the RBL program actions proposed. There is no land acquisition and involuntary resettlement impacts involving the proposed RBL actions. The civil works and renovation activities are to be carried out on lands owned by the MOH, within existing facilities and within the provincial hospital premises.

36. **Institutional risks.** The MOH consists of medical and Sri Lanka administrative service professionals. While the medical professionals do not possess the required skills to address E&S safeguard implementation, administrative officers of the MOH have been trained in land acquisition and social safeguard policies during initial job training. Similarly, the administrative officials at the provincial council are knowledgeable on matters related to land acquisition.

37. The institutional setup in the health service is complex. After health became a devolved subject, the secondary hospitals, which are the first referrals of patients by primary care physicians, are managed by the provincial councils. In contrast, doctors in the tertiary, secondary, and primary healthcare pathways and provincial health units are employees of the central government. Hence, practically the total control of health sector activities is vested with the MOH. Since land acquisition and resettlements are not involved under the RBL program, this complex institutional setup will not have an adverse impact on the effectively implementing E&S safeguards/risks. A focal point at the MOH needs to be established to coordinate the RBL program including the E&S safeguard issues.

38. **Likely contextual risks.** No contextual risks related to involuntary resettlement are expected due to the nature of the proposed RBL program actions. There are no resettlement or land acquisition issues associated with these development initiatives at any location in the country.

39. Currently there are no social conflict or likelihood of social conflict in any part of Sri Lanka. The majority of the three ethnic groups understand the potential consequences of social conflicts due to awareness campaigns conducted by civil society and the Government of Sri Lanka.

4. Indigenous Peoples

40. ADB's Indigenous Peoples (IP) safeguards are triggered if a project directly or indirectly affects the dignity, human rights, livelihood systems, or culture of Indigenous Peoples or affects

the territories or natural or cultural resources that Indigenous Peoples own, use, occupy, or claim as an ancestral domain or asset. The scope of the RBL program, as outlined in para. 3, does not trigger IP safeguard requirements. Although Indigenous Peoples such as the *Veddhas* have a long history in Sri Lanka and currently live in scattered settlements across the island, they represent less than 1% of the population. Some have integrated with Tamil and Sinhalese communities, while others maintain traditional lifestyles. Sri Lanka lacks legal protections for Indigenous Peoples, and government policies often limit their access to ancestral lands. A 2017 UN review underscored their ongoing marginalization and the need for stronger rights protection.

41. The Indian community in Sri Lanka, brought by the British in the late 18th and early 19th centuries for plantation work, remains one of the country's most marginalized groups. Primarily residing in tea plantations across Nuwara Eliya, Badulla, and Kandy, many are landless and live in basic line rooms, though some have benefited from housing programs. While not classified as Indigenous Peoples, the community shares similar characteristics, including long-term residence, distinct cultural practices, self-identification, and a history of marginalization and discrimination.

42. **Regulatory framework for Indigenous Peoples.** There is no specific IP law in Sri Lanka may be due to the size of the indigenous population and the integration with the other main communities in the country. However, considering the residence of plantation workers in Sri Lanka over the past 150 years, the “Persons of Indian Origin Act No 35 of 2003” was enacted to grant Sri Lankan citizenship to persons of Indian origin and their descendants. Since then, they have been recognized as the ethnic group that has access to the same level of services as other Sri Lankans; providing them, to some extent, with rights to lands, leaving the plantation and employing outside the tea productions; and providing them with social welfare and social empowerment.

43. **Indigenous Peoples categorization.** The RBL program is categorized as *C* for IP safeguards. There will be no land acquisition, involuntary resettlement impacts, neither physical displacement nor economic displacement. The program is not expected to negatively affect the livelihood systems of any IPs/ethnic minority groups. The RBL program will not discriminate against any group or individual.

44. **Contextual risks.** IPs and other ethnic minorities do not reside within the construction sites (locations are within the hospital premises or MOH/PC-owned bare lands) or their vicinity as the locations are all within hospital premises.

45. Overall, the RBL program is expected to enhance access to higher-quality medical services for all users at all levels (primary, referral, and higher levels, including poor, Indigenous, and marginalized people in remote locations such as tea plantations without any discrimination. The RBL program will be implemented across Sri Lanka and reform the health services. Given the geographical scope, indigenous peoples will be program recipients or beneficiaries. Some program locations (e.g., Eastern Province and Central Province) may have a higher representation of marginalized groups, minorities, and indigenous communities. The program will make the environment for Indigenous and marginalized peoples access to efficient medical services, especially from referral hospitals, modern medical equipment, and better-trained health sector human resources at all levels. In addition, these segments of society receive better awareness of preventive healthcare services, primary healthcare services, etc. through medical officers of Health in these areas. However, the remaining socio-cultural barriers (e.g., social, religious, and/or cultural norms; language barriers; discrimination and social stigmatization or physical and mental disabilities) and economic barriers related to affordability remain significant

challenges. Concerns about securing funds for medical treatment and the distance to health facilities continue to be prominent issues.

46. Indigenous and marginalized groups are also not enrolled in any health insurance coverage (some poor and remote rural populations are not covered by the national health insurance scheme as it is confined to the government servants). Many rural people including indigenous groups and plantation workers live under poor economic conditions and without adequate access to livelihoods, job opportunities, and services, including medical services. These issues reflect Sri Lanka's overall economic and health care development challenges. The RBL program contributes to addressing some of these contextual risks.

47. Currently, there is no social conflict or likelihood of social conflict in any part of Sri Lanka. The majority of the three ethnic groups understand the potential consequences of social conflicts due to awareness campaigns conducted by civil society and the Government of Sri Lanka. This program will support the government's initiatives to improve, organize, and expand health facilities in the country and is not expected to result in any reputational risks.

48. The initial assessment revealed that there are no legacy or significant unresolved issues related to IP that can affect the performance of the program.

49. **Likely programmatic risks.** No significant or moderate programmatic risks are expected on IPs and any other ethnic minority as they do not reside in the construction locations (locations are within the hospital premises) or their vicinity. The program's impacts on IPs are beneficial.

50. **Institutional risks.** The MOH has been implementing several projects with support from MDBs (e.g. health sector enhancement project assisted by ADB). However, the in-house staff and capacity to manage the environmental and social safeguard requirements, especially for the activities involved in construction activities, could be further enhanced.

51. The RBL program will strengthen the capacity of medical personnel at all levels of health service to consider environmental and social matters and/or engage with IPs in preventive health promotional activities. In some instances, capacity building will affect the employment status of health sector staff recruited from the indigenous/marginalized peoples. Conducting a needs assessment for MOH staff and health workers on poor/marginalized and IP issues, especially in areas with plantation workers and IP populations is needed before a capacity-building program is designed.

52. Although MOH has managed development projects previously, they may require awareness of recording and managing complaints related to E&S. A Grievance Redress Mechanism (GRM) is required to address E&S issues encountered throughout project implementation. A timely resolution of grievances based on their nature will prevent adverse E&S issues. A safeguard monitoring system will be established to facilitate proper coordination and communication with concerned agencies. An internal monitor will be engaged to conduct monitoring of the compliance of the E&S safeguard measures. Information disclosure and community consultation are essential components of transparent RBL development objectives and their success. These include providing stakeholders with project plans, objectives, benefits, potential impacts, mitigation measures, and timelines. By disclosing information, stakeholders, including affected communities, government agencies, NGOs, and the general public, can better understand the project's purpose, potential benefits, and associated E&S risks.

53. Further, the preliminary assessment indicates several key gaps between ADB requirements and national standards: (i) inadequate documentation of consultation and information disclosure activities, as well as grievances received and resolutions; (ii) insufficient culturally appropriate and gender-sensitive social impact assessments; and (iii) inadequate monitoring and evaluation processes. However, none of the anticipated gaps are expected to impede the borrower's capacity to effectively implement the E&S safeguard measures related to the RBL program. The implementation will be monitored to ensure compliance and address any issues.

54. Although fully equipped referral hospitals are established in provinces, there is a shortage of subject-specialized doctors and other medical personnel such as nurses, medical laboratory technicians, etc. in the country. Production of an adequate number of doctors as per the population and an unprecedented number of doctors leaving the country will harm the objectives of the RBL program (due to the economic crisis of Sri Lanka around 1,700 doctors and other healthcare professionals left the country in 2022–2023, A health ministry report, also shared exclusively with the Thomson Reuters Foundation showed that 4,284 doctors obtained "Good Standing" certificates considered mandatory to verify an individual's professional status to foreign regulators from the Medical Council between June 2022 and July 2023, indicating that they to leaving.[8] The inadequate number of medical officers at the medical officer of Health units at the divisional level and the capacity of other health workers to deliver enhanced primary healthcare and health education programs to rural communities including Indigenous peoples and marginalized plantation workers in a culturally appropriate manner is limited. Hence, the commitment of medical officers of Health and the relevant staff in preventive care and health education is a crucial factor in achieving RBL goals, apart from skill training attitudinal development among health human resources (including general doctors, specialists, nurses, and paramedical staff).

55. The institutional commitment towards Indigenous and marginalized people under the safeguards program action should be enhanced. It would be beneficial to raise awareness among medical staff about the importance of addressing the needs of Indigenous Peoples and marginalized groups. This includes understanding their social challenges such as historical marginalization, exclusion, and social stigma, and ensuring that these people have equal access to health services. This action promotes social inclusion and ensures that Indigenous and marginalized groups are fully utilizing the health services available to them.

56. Other than the above-discussed matters, institutional barriers that might hinder the borrower from implementing the RBL program are not anticipated.

5. Grievance Redress Mechanism

57. The MOH and provincial health authorities have experience in grievance redress through their involvement in both completed and ongoing health sector infrastructure projects funded by donor agencies such as the World Bank, ADB, and JICA, all of which require structured complaint-handling mechanisms. It was noted that grievances reported in previous projects were documented and forwarded to the appropriate sections or individuals at relevant levels, including the site/hospital level, Regional Director of Health Services (RDHS) and Provincial Director of Health Services (PDHS) levels, and, in some cases, the provincial CEA level for resolution.

[8] *The Economic Times*. 2024. Sri Lankan health crisis could worsen as doctors seek world abroad. 19 February.

58. To ensure transparency and accountability in the implementation of the project, a GRM will be established to address concerns and complaints from affected stakeholders, including affected persons. The MOH should review the existing grievance redress mechanisms used in other projects implemented by the MOH and develop a structured approach with effective procedures for addressing grievances. This approach should be based on the ground situation and consultations, with a clear process for receiving and resolving complaints and concerns from affected persons and interested parties.

59. Grievances can be submitted directly to the MOH, PDHS/provincial level, local grievance redress committees at the site level, or through designated representatives. A grievance form will be available to facilitate submissions, though verbal or electronic submissions will also be accepted. All grievances should be acknowledged and recorded in a logbook, which will include details of the complainant, the nature of the grievance, and the resolution status. Grievances submitted confidentially shall also be resolved through the process.

60. The guiding principles for the GRM will include convenience for affected parties, accessibility, transparency, mutual understanding, dialogue, and consensus-building, aimed at resolving issues quickly and in a culturally appropriate manner, ideally at the site level. Other tiers of the mechanism will operate at the provincial and MOH levels. The executing agency will be required to obtain government approval for the proposed mechanism. Information about the GRM will be widely disseminated to affected parties through consultations, brochures, and electronic media.

6. Monitoring and Reporting

61. Given the MOH extensive experience in managing numerous health sector infrastructure development projects, the skills available within the MOH and provincial health authorities for monitoring RBL programs are sufficient. They regularly track the financial and physical progress of infrastructure projects and take appropriate actions to ensure both align with the agreed upon work plan. In addition to routine site-level monitoring, environmental and social aspects are typically reviewed during weekly or monthly progress meetings and site visits.

62. A comprehensive monitoring plan for RBL implementation is essential to track the progress of the RBL program. The MOH will take overall responsibility for monitoring and evaluating the project implementation at the national level, in collaboration with the PDHS. The Chief Secretary of the provinces will monitor the progress of the RBL program together with the PDHS, the Deputy Chief Secretary (Technical), and other relevant line ministries of the Provincial Council.

63. Progress reporting formats to be developed in alignment with the current Management Information System (MIS) used by the MOH. The data and information will be fed into the MIS, which will provide real-time reports to enable the MOH to make informed decisions regarding the physical and financial progress of the project implementation.

D. Safeguard Program Actions

64. Detailed assessments of environment, involuntary resettlement, and Indigenous People's safeguards were carried out as part of PSSA preparation. Based on the assessment findings, the actions listed in the Detailed Safeguards Program Actions are deemed necessary to ensure compliance with SPS principles, or to otherwise address identified performance gaps with respect to environmental and social issues. The safeguards program actions further strengthen the

capacity of the MOH in managing the environmental and social aspects of the RBL program and in enhancing its capacities to address safeguards related issues and complaints. Key actions are listed in the table below.

Table 5: Safeguards Program Actions

Gap / Issue	Proposed Action	Indicator	Responsibility	Timing
Screening and categorization				
Screening and categorization (ADB standards)	MOH / PDHS to submit screening and categorization checklists to ADB for all civil works to be financed by the RBL (one checklist per Base Hospital, CDC, MRI, NMRA, MSD, and RMSD)	Activity REA checklists accepted, and categorization confirmed by ADB. No category A projects approved.	MOH / PDHS	Continuous from Q3 2025
Confirmation for the requirement of EIA/IEE under NEA;	Submit the duly filled BIQ to the relevant District office of CEA	Requirement / nonrequirement of EIA/IEE under NEA confirmed. CEA environmental recommendations obtained.	MOH / PDHS	Continuous from Q3 2025
Preparation of EIA / IEE (in case of required by the CEA under NEA for an activity)	Submit EIA/IEE reports according to the TOR issued by the CEA	EIA/IEE submitted to CEA. Comments made by CEA/TEC. Approval for the Activity is issued.	MOH / PDHS	Continuous from Q3 2025
Capacity building				
Limited capacity of the MOH to coordinate the E&S of the program	Nominate focal points within the MOH and PDHS on E&S safeguards	Focal points nominated	MOH / PDHS	Continuous from Q2 2025
	Training of program staff of the MOH, PDHS and Provincial Technical Committee with E&S responsibilities and HCW management	Number of training sessions held Number of participants	PCO, ADB	Continuous from Q3 2025
E&S Safeguards implementation				
Civil and E&M work contractors not complying with E&S requirements.	The ESMP shall form part of the civil / E&M works contract documents	All Civil and E&M work contract documents include the ESMP	MOH / PDHS	Continuous from Q3 2025
Monitoring and reporting	Establish a safeguard monitoring system, Prepare semi-annual E&S monitoring report, and disclosure	Safeguard monitoring system established. Reports accepted by ADB. Safeguard documents (including PSSA, ESMF, IEE and monitoring reports) disclosed on ADB website and MOH / Provincial Council websites.	MOH / PDHS / ADB	Continuous from Q3 2025

GRM	Establish a robust, public-friendly, accessible and functional GRM.	Availability of grievance register Display public notice at the construction sites regarding the GRM and contact numbers to submit any grievances.	MOH / PDHS	Continuous from Q2 2025

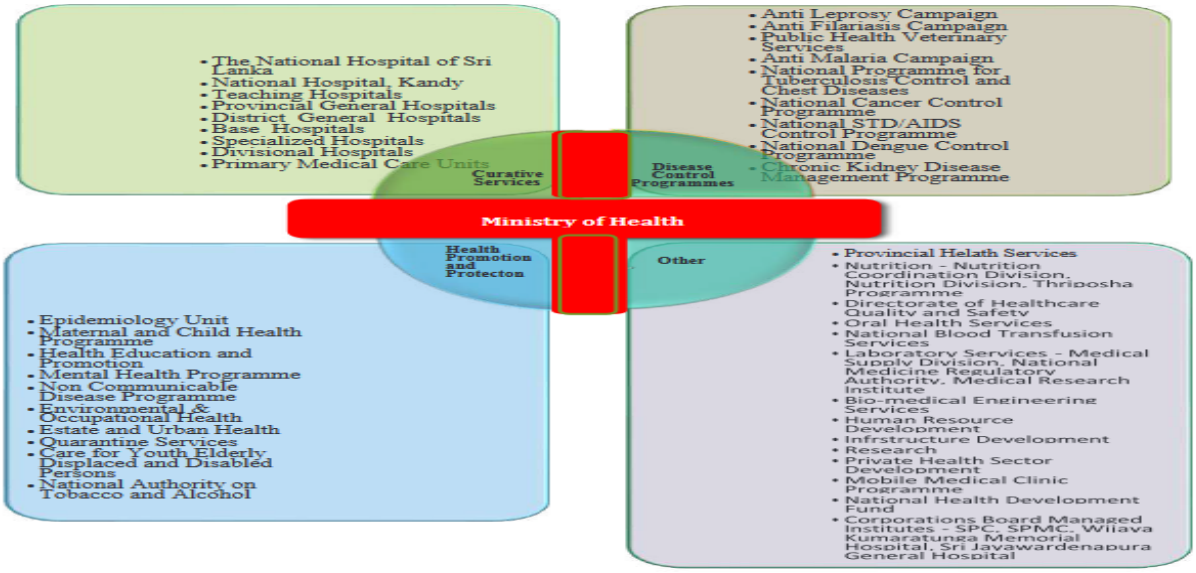
Source:

E. Institutional Arrangement

65. RBL program implementation will take place through the existing governance structure of the health sector. No special arrangements are envisaged to be put in place for the RBL program. The executing agency of the RBL program will be the MOH, and the implementing agencies will be the MOH and all 9 provincial councils. The RBL program will be steered by a program steering committee chaired by the Secretary of Health and co-chaired by the Secretary of Finance Commission. The steering committee will have Chief Secretaries of all 9 provinces, representatives of Ministry of Finance and Ministry of Local Government and provincial council as its members.

66. **Ministry of Health.** The MOH as the executing agency for the RBL program has overall program oversight and program steering responsibility. The implementation of the RBL program will be coordinated by the MOH through the Directorate General of Health and the PDHS in 9 provinces. Figure D.1 shows the institutional structure of the MOH.

Figure D.1: Institutional Structure of the Ministry of Health



Source: Ministry of Health - Performance and Progress Report, 2023.

67. **MOH's environmental and occupational health unit.** In late 2000, MOH established the Deputy Director General Environmental and Occupational Health (DDG/E&OH) post and identified it as the focal point of the MOH for the management of clinical waste. Director E&OH and a few consultant community physicians were appointed for this purpose under the DDC. Their responsibilities included preparing policies, guidelines, training, monitoring, supervision, and supporting financial allocation. Inter-sectoral coordination is one of the most important activities

of the above unit. So far, the team has performed well and conducted all the tasks but under several resource limitations and constraints.

68. DDG/E&OH and Director E&OH coordinate all issues on HCW management directly with the directors of hospitals that come under the central government. In hospitals where a microbiologist is available, she/he supervises the infection control unit and HCW management. In addition to the microbiologist, medical officer public health PHI/MO infection control is also available for HCW management.

69. With regard to environment-related matters and HCW management, all relevant stakeholders such as the Central Environment Authority and local authorities are coordinated with the MOH in parallel levels using formal and informal communication. All Base Hospitals come under the RDHS and the Director of E&OH coordinates with the RDHS regarding HCW management.

70. With the devolution of power in 1987, health was stated as an entity of provincial councils. However, with the objection of trade unions, medical officers were included in the central government and recognized as an all-island service. The administrative setup was changed with 9 provincial directors for each province and twenty-five regional directors for each district. The Medical Officer of Health is a grassroot-level officer who comes under the RDHS and PHI is the field-level officer who looks after the environmental problem of HCW management. Almost all the base hospitals and provincial general hospitals come under the provincial administration. All institutes that come under provincial administration are headed by the Medical Superintendent or Medical Officer in charge while preventive health institutions are headed by the medical officer of health. MO public health and Infection Control Nursing Officer are the grassroots level officers in those hospitals responsible for HCW management.

71. A Program Coordination Office (PCO) shall be established under the DGHS (the Program Director of the RBL program) to support overall coordination, consolidation of program implementation progress, and financial and DLI results reporting. The PCO will consist of a program manager, a program coordinator, and two to three program assistants in safeguards, finance, and monitoring. These staff members will facilitate coordination with the Finance Commission and through them with the 9 Provincial Councils and Directorates within the MOH, and the Ministry of Finance (MOF). A technical committee for the RBL program's planning and implementation will be established at each PDHS level: (i) to lead the development of the 5-year and annual costed plans in collaboration with the MOH and other provincial-level stakeholders, and (ii) to oversee the implementation of the approved plans. The construction of approved civil works will be managed and supervised with the assistance of the respective Provincial Engineering Department, ensuring compliance with environmental and social safeguard measures, as outlined in the IEEs/ESMPs.

72. The institutional arrangements for program implementation and monitoring outlined above are considered adequate to manage the RBL program's environmental and social risks. As discussed above, the available accreditation framework is considered the key measure to overcome environmental and social safeguards capacity and commitment constraints and will be monitored through DLI. The MOH will monitor and periodically re-confirm the capacities and performance of the independent monitoring agency.

F. Conclusion and Recommendations

73. In conclusion, the RBL program is dedicated to enhancing the capacity of health services across the nation by investing in vital infrastructure, acquiring necessary equipment, and developing the skills of health personnel. This initiative includes the construction of new CDC at the NIID in Angoda, as well as the rehabilitation and modernization of existing facilities in base hospitals type A and B in 9 provinces, introducing climate resilient measures for above selected-base hospitals in climate moderate or high-risk areas and MRI building renovation and air quality improvement. All planned activities will proceed without requiring land acquisition, involuntary resettlement, or causing adverse environmental impacts. Also, none of the program activities are planned within any environmentally sensitive areas.

74. The overall rating of the proposed RBL would be *moderate* considering the environmental risks/ impacts related to its activities and the proposed program is categorized as categorized as category *B* for environmental safeguards. The program activities are well known, and manageable with existing processes/procedures. The program activities are not within environmentally or socially sensitive areas. The risk management measures are more predictable and readily available and the borrower/implementing agencies have a proven track record in managing risks (although not perfect) and limited capacity building/training measures are needed. This PSSA confirms that the RBL program poses no significant social risks and reaffirms its categorization as Category *C* concerning involuntary resettlement, and Indigenous peoples, in alignment with ADB's Safeguard Policy Statement (SPS, 2009).

75. With the new and expanded healthcare facilities becoming operational, this increase in patient numbers will naturally lead to generate higher volume of HCW. However, no significant risk is anticipated, as HCW management capacity will be strengthened through the RBL program. HCW will be handled according to Sri Lanka's Guidelines for Scheduled Waste Management, with registered hazardous waste service providers. Non-clinical solid waste and sewage will be managed through existing systems with local authorities. The DDG/E&OH and Director E&OH coordinate HCW management with hospital directors under the central government. In hospitals with microbiologists, they oversee infection control and HCW management, supported by public health and infection control officers. Environmental and HCW management issues are coordinated with stakeholders such as the Central Environment Authority and local authorities through formal and informal communication. All base hospitals fall under the RDHS, with the Director E&OH coordinating HCW management at that level.

76. The institutional framework overseeing the RBL program, particularly in terms of environmental and social management, is robust, with qualified personnel at the MOH addressing health and environmental safety concerns. However, there is a need for targeted training for provincial health staff and who may lack expertise in these areas. Strengthening capacities related to environmental and social management, as well as addressing the needs of IPs and marginalized groups, should be integrated into the program action plan.

77. Establishing efficient and effective operation and maintenance (O&M) procedures for health service improvement facilities under the RBL program is essential for its success. Currently, a significant gap exists in trained personnel, as evidenced by the situation at MRI, where only one individual is responsible for maintaining all facilities, equipment, and buildings. To address this critical issue, it is recommended that a loan covenant be included in the RBL program, mandating the recruitment of adequate and qualified maintenance staff at national and first referral hospitals across all provinces. This will ensure the sustainability of services and align with the objectives of the RBL program, ultimately enhancing the overall effectiveness of health service delivery.

SUMMARY ASSESSMENT ON SAFEGUARDS

Consultations were conducted with the Ministry of Health (MOH) and Provincial Health Authorities, including the Deputy Director General (DDG) of National Hospital of Sri Lanka (NHSL), the Deputy Director and Planning Director of Medical Research Institute (MRI), the DDG of Public Health Services (Disease Control), the Director of National Institute of Infectious Diseases (NIID), Additional Secretary (Engineering Services) and the Technical Design Team of the National Buildings Department, who will provide technical assistance for the CDC building. Discussions also included MOH Provincial Engineers from the Northern and Eastern Provinces.

In addition, a structured questionnaire was circulated among the 9 Provincial Health Authorities to collect relevant data and insights. The consultation and assessment process focused on the following key areas:

Objectives of the Assessment:

1. To gain an understanding of the experience of the MOH, Provincial Health Authorities, and Provincial Engineering Divisions in the implementation of donor-funded projects.
2. To assess the institutional capacity of the MOH and Provincial Directorates of Health Services (PDHS) in ensuring compliance with environmental and social safeguard principles during RBL project implementation.
3. To evaluate the coordination mechanisms and relationship between the MOH and Provincial Health Authorities in carrying out their responsibilities during RBL project implementation.

Key Findings:

- The MOH and PDHS have adequate experience in the implementation of donor-funded projects and demonstrate compliance with environmental and social (E&S) safeguards during project execution.
- Provincial Engineering Sections possess the technical capability to manage and monitor project activities. However, capacity is needed specially on screening, categorization and preparation of Environmental and Social Management Plan (ESMP).
- Environmental inputs and guidance from the Central Environmental Authority (CEA) are incorporated into project planning and implementation to ensure proper environmental management and issue mitigation. However, it is observed that there is a delay in obtaining Environmental Protection License (EPL).
- Administrative officers in the provinces understands the policy and regulatory frameworks relevant to environmental protection, involuntary resettlement, and indigenous peoples' safeguards. However, awareness building is required.
- Both the MOH and PDHS recognize the importance of establishing a Grievance Redress Mechanism (GRM) to ensure smooth project implementation. In most cases grievances are addressed case by case. Further, it was noted that GRMs are typically established only when required by donors.
- There is a need to further strengthen the commitment of the MOH and Provincial Health Authorities to E&S safeguard actions and ensure full compliance with the National laws and Asian Development Bank's Safeguard Policies.