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

Appraisal Stage | Date Prepared/Updated: 13-Jan-2020 | Report No: PIDISDSA27316

BASIC INFORMATION

A. Basic Project Data

Country	Project ID	Project Name	Parent Project ID (if any)
Ukraine	P170740	Additional Financing to Serving People, Improving Health Project	P144893
Parent Project Name	**Region**	**Estimated Appraisal Date**	**Estimated Board Date**
Serving People, Improving Health Project	EUROPE AND CENTRAL ASIA	27-Jan-2020	19-Mar-2020
Practice Area (Lead)	**Financing Instrument**	**Borrower(s)**	**Implementing Agency**
Health, Nutrition & Population	Investment Project Financing	Ministry of Finance of Ukraine	Ministry of Health

Proposed Development Objective(s) Parent

The proposed “Serving People, Improving Health” Project seeks to improve the quality of health services in selected Oblasts, with special focus on primary and secondary prevention of cardiovascular diseases and cancer, and to enhance efficiency of the health caresystem.

Proposed Development Objective(s) Additional Financing

To improve efficiency and quality of health services, particularly for non-communicable diseases, in line with the health sector reforms

Components

Improving Service Delivery at the Local Level
Supporting Selected Priority Areas of Health Reform
Project Implementation Support and Monitoring and Evaluation
Commission 0.25%

PROJECT FINANCING DATA (US$, Millions)

SUMMARY

Total Project Cost	100.00
Total Financing	100.00
of which IBRD/IDA	100.00
Financing Gap	0.00

DETAILS

World Bank Group Financing

International Bank for Reconstruction and Development (IBRD)	100.00

Environmental Assessment Category

B-Partial Assessment

Decision

The review did authorize the team to appraise and negotiate

Other Decision (as needed)

B. Introduction and Context

Country Context

Ukraine is a large lower-middle-income country with a gross domestic product (GDP) per capita of US$3,056 in 2018. Between 2014-16, Ukraine experienced acute political, security and economic challenges, which led to the *Euromaidan* uprising, the armed conflict in eastern Ukraine, extensive financial exposure to a deteriorating global economic environment, and a large cumulative contraction of the economy by 16 percent.

Ukraine's economy has largely stabilized since the 2014-15 crisis, though economic growth remains weak. Over the last five years, Ukraine has taken positive steps to recover from these shocks which have helped to stabilize the economy: economic growth has since recovered to 2.4 percent in 2016-17 and 3.3 percent in 2018[1] and 3.5 percent in the first half of 2019. Public discontent with corruption, living standards and the demand for improved public services have led to the recent election of the President, renewed Parliament with a dominating President's party, and the formation of a new government in September 2019.

Despite the recovery, Ukraine's economic transformation remains incomplete and growth is anemic: at the growth rate of recent years, it will take Ukraine more than 50 years to reach income levels of today's Poland.[2] In terms of per capita income and labor productivity, Ukraine remains among the lowest in the Europe & Central region. Poverty incidence increased from 3.5 percent in 2014 to 7.8 percent in 2015 and while it has come down slightly since 2015, in 2018 it remained above pre-crisis levels.[3] Shared prosperity has also become more challenging over the last decade, and consumption of the bottom 40 percent contracted in the period between 2011-2016, emphasizing the need for faster economic growth.

[1] World Bank Special Focus Note on Tapping Ukraine's Growth Potential
[2] World Bank Ukraine Growth Report and Special Focus Note on Tapping Ukraine's Growth Potential
[3] World Bank (2019). Poverty & Equity Brief for Ukraine.

Health outcomes are suboptimal. Ukraine has not managed to transform its obsolete health care system, which contributes to poor health outcomes, since its independence in 1991. The life expectancy at birth in Ukraine is 71 years,[4] more than 10 years less than the average in the European Union (EU). The adult mortality rate is higher than the average for the European region of the World Health Organization (WHO), especially for men, whose mortality rate is 65 percent higher (295 per 1,000 in Ukraine compared to 178 per in the WHO European region). Non-communicable diseases (NCDs) are the main cause of morbidity and mortality:[5] cardio-vascular diseases and cancer were causing about 81 percent of all deaths in 2018. Over one quarter of the adult Ukrainian population, 18 to 65 years of age, has a chronic disease or condition; around 7 percent have multiple (three or more) chronic diseases or conditions.

Sectoral and Institutional Context

Ukraine has reached a critical point in its efforts to transform the health system. The Government launched a comprehensive health reform in November 2016 that aimed at modernizing the obsolete and inefficient health system in order to achieve better health outcomes. Key reform measures included: (a) transformation of health care financing through the establishment of a national purchasing entity – the National Health Service of Ukraine (NHSU)); (b) modernization of primary health care (PHC); (c) enhancement of the public health system; (d) addressing NCDs; and (e) improving access to pharmaceuticals. The World Bank (WB), together with other development partners, actively participated in the design of the reform. The implementation of the health reform officially commenced following the adoption of the laws on Health Financing Guarantees in December 2017. The NHSU was established in 2018, and the first phase of the reform, the transformation of the PHC, officially launched in July 2018 and is under implementation and progressing well. It is envisaged that the second phase of the reform will focus on the hospital sector and will start in April 2020. The reform will require substantial financial and technical assistance in order to optimize the hospital network, modernize priority hospitals, define the benefits package, establish systems for quality monitoring, and introduce output-based payment methods. The reform at the PHC level and the health financing reform implemented by the Ministry of Health (MoH) and the NHSU needs to be further strengthened, and the difficult, yet critical, hospital sector reform.

The country has implemented some reforms in health service delivery to better address NCDs. Among the key successes of the past three years was the expansion of the medical reimbursement of drugs for patients with hypertension, diabetes, and asthma within the “Dostupni Liky” program. Another key success is the significant improvement of cardiac care for patients with heart attacks, which is one of the priorities of the ongoing ‘Serving People, Improving Health (SPIH)’ Project. During the last three years, access to reperfusion therapy has dramatically increased, and stenting for patients with ST-Elevation

[4] The World Bank, Data (2016). *Life expectancy at birth, total (years)*. Retrieved from https://data.worldbank.org/indicator/SP.DYN.LE00.IN?locations=UA

[5] State Statistical Services of Ukraine. *Total number of deaths from five NCDs groups (ICD-10 codes included C00-D48, E10-E14, F00-F99, I00-I99, J40-J47) divided by total number of deaths in 2017 in percentage.* Retrieved from http://database.ukrcensus.gov.ua/MULT/Dialog/statfile_c.asp). Note: ICD stands for international classification of diseases

Myocardial Infarction increased from 22 percent of total heart attacks registered in 2015 to 41 percent in 2018.

The next stage of the health reform will require a focus on the optimization of the hospital network. Ukraine has an oversized hospital sector with almost twice as many hospitals as comparator countries of the WHO European Region (e.g., 4.2 hospitals per 100,000 population in Ukraine, 2.3 in Estonia, 2.8 in Poland and 2.9 in the United Kingdom). The hospital care system in Ukraine comprises mono-profile and general (multi-profile) hospitals providing care at the secondary and tertiary levels. Hospital care providers absorb the majority of the health budget and consist of outdated facilities with insufficient technological capacities to provide acute care in the case of emergencies or onset of NCDs. Of the total number of hospitals, about seven percent are psychiatry/narcology mono-profile hospitals; seven percent are recreational sanatoriums; and six percent are tuberculosis mono-profile hospitals. Such hospitals are almost non-existent in countries with more developed economies since many of their services can be provided in a PHC setting. At the same time, only a few facilities provide long-term, rehabilitative, or palliative care. To improve the efficiency of the system and ensure quality of care, many of the existing hospitals will need to be merged or reprofiled to provide non-acute services.

To improve the capacities of hospitals in the capable network plan, the Government will focus on establishing emergency departments. Current emergency departments mostly function as admission departments (i.e., examining patients, filtering out patients who do not require acute care, and initiating paper work needed for patient hospitalization). Access to diagnostic technologies is often not provided in these departments, and access to emergency services varies greatly across regions. Even in hospitals that are specifically designated to receive patients in emergency conditions, the concept of an emergency department is often not applied. The MoH has expressed a need for updating standards for equipping, staffing, and organizing emergency departments in level one and two intensive care hospitals. Compliance with these standards will be one of the key requirements for such hospitals to receive funding from the NHSU. Hospitals with such capabilities will be included in the planning of hospital districts. Additionally, current national construction standards for hospitals must be changed to allow for the creation of emergency departments.

Another important area for improvement of hospital care is the delivery of quality stroke care. Ukraine has one of the highest burdens of stroke in the world,[6] and it is projected to grow. One-month case-fatality rates reach 30 percent, and a large proportion of stroke patients remain with limited mobility and require external assistance because of non-available diagnostic and treatment technologies, or non-adherence to good practices of managing patients with strokes. According to a MoH study, about 500 hospitals in Ukraine are providing stroke care, but only about 20 of them are properly equipped to diagnose ischemic strokes and provide necessary treatment for stroke patients. A better management of acute stroke cases can save thousands of lives in Ukraine.

Both investment financing and results-based financing (RBF) will be employed in a complimentary manor across components to address the Government's health reform priorities and investment needs. **.** RBF is recognized as an effective tool to streamline the use of WB resources and better align them with

[6]According to the Global Burden of Disease estimates, there were 203,018 strokes, 85,383 deaths, and 3,918 disability adjusted life years (DALYs) per 100,000 lost due to strokes in Ukraine in 2016 (GBD 2016 Stroke Collaborators).

the country priorities and has already proved effective under the ongoing project. The RBF component in the parent SPIH Project was introduced during restructuring, and five out of six DLI targets have already been reported as achieved. This additional financing (AF) will continue using RBF to help advance the important hospital restructuring agenda, will provide assistance for service improvement at the regional level, and will support the modernization of strategic hospitals in line with Government plans.

C. Proposed Development Objective(s)

Original PDO

The proposed "Serving People, Improving Health" Project seeks to improve the quality of health services in selected Oblasts, with special focus on primary and secondary prevention of cardiovascular diseases and cancer, and to enhance efficiency of the health caresystem.

Current PDO

To improve efficiency and quality of health services, particularly for non-communicable diseases, in line with the health sector reforms.

Key Results

The Project will measure success in achieving the Project Development Objectives (PDOs) using three indicators:

1. Number of hospitals reprofiled or merged (*new*);
2. Improved quality management (prevention, early diagnosis and treatment) measured as:
   a) Reduction of hypertension-related hospitalization (*continued from the parent project*);
   b) Percentage of health care providers implementing improved patient care pathways for emergency, stroke care and day surgeries (*new*); and
   c) Number of acute care hospitals included in the capable network providing quality emergency and stroke care (*new*).
3. Average in-patient length of stay in hospitals (*continued from the parent project)*.

D. Project Description

The Project will incorporate a results-based approach to supporting the Government's health reform agenda. Component 1 of the AF will support procurement for the upgrade of hospital emergency departments, stroke units, and outpatient facilities to provide select day surgeries and procedures. In addition to the indicators which will be used to track achievement of the PDO, the AF will apply a results-based approach under Component 2 with select disbursement-linked indicators (DLIs). These DLIs will cover the necessary preconditions for successfully achieving the PDO and sector-wide outcomes over the long-term.

Component 1: Improving Service Delivery at the Local Level (additional allocation of US$45 million). This component will support upgrades of service delivery in select hospitals and outpatient facilities based on the capable network plan. The Project will support procurement of the necessary equipment for the emergency departments, surgical departments to provide conditions for day surgery interventions, and stroke units in the selected hospitals of the capable network. The selection of the hospitals will be completed before the effectiveness of the AF. As a precondition to receive the procured equipment, these

hospitals will need to complete the refurbishment and reconstruction works financed by the state program foreseen for the upgrade of the hospitals and local co-financing funds. The budget allocated in 2020 for the upgrade of the emergency departments could cover between 30-50 hospitals. In addition, to support the reduction of unnecessary hospitalizations, this component will also support the procurement of equipment for outpatient facilities to strengthen the capacities to provide outpatient procedures.

A proper organization of the emergency departments in select hospitals will be supported by providing the necessary oversight and training envisioned in Component 3. After the development of the capable network of hospitals, and based on the survey of needs and conditions of the emergency departments, select hospitals will need to upgrade their emergency departments. The MoH will prepare the requirements and propose the type of projects for the organization of these departments, including staffing and equipment suggestions. The financing and supervision of their reconstruction, where needed, will be organized by the MoH team. Upon meeting the stated requirements, the emergency departments will receive the needed equipment from the Project. The Project activities will help to reorganize patient pathways and improve triage and response time to patients with acute conditions in such hospitals.

The Project will contribute to improving the quality of stroke care in select hospitals. The Project will support the establishment and equipping of stroke units and stroke centers, in line with the organization of the capable network hospitals and prioritization of hospitals that will provide the most effective coverage of stroke patients. The overall approach would be to develop one comprehensive stroke center (24/7) for 1.5 million population, with three to four stroke units per comprehensive stroke center, depending on population density, geographic location and transport routes between centers. Activities under Component 3 will include support for the necessary training and development of updated care pathways that will cover emergency and stroke care delivery for better health outcomes.

The Project will support centralized procurements of the equipment and its distribution to the pre-selected hospitals and outpatient facilities. It is expected that the procurements will be organized separately for the equipment needed for emergency departments, surgical, stroke units, and outpatient facilities. Since the supply and installation of the equipment for the emergency departments and stroke units may need additional refurbishment and reconstruction works from the receiving hospitals, these procurements will be organized in the second and third year of the AF. Based on the good practice of the SPIH Project, the use of International Competitive Bidding will be the main procurement method for such procurement.

Component 2: Supporting Selected Priority Areas of Health Reform (additional allocation of US$50 million). This component will finance the priority actions within the health reform. The component will be providing RBF upon achievement of the defined DLIs to drive policy changes and incentivize a focus on results. The main implementing agent for Component 2 will be the NHSU, which will need to gradually strengthen its capacity as a strategic purchasing agency and receive adequate support and authorization from the Government to implement contracting of hospitals and outpatient facilities and design the appropriate incentives for the rightsizing of hospitals and improving efficiency in health service delivery.

The main focus of the activities under Component 2 will be to provide support for the reorganization of the hospitals. The DLIs have been designed to support important decisions on: (a) hospital right-sizing, reduction in unnecessary hospitalizations; (b) implementation of the guaranteed benefits package; and (c) extension of the payment reform. The activities of Component 2 are interlinked with the support envisioned in Component 1. The rightsizing of the hospitals will need to demonstrate the improvements on the delivery side in the remaining hospitals. There are high expectations for the improved quality of services in the modernized emergency departments of hospitals and stroke units in prioritized hospitals. It is important that the hospital modernization be selective in covering a subset of the existing hospital infrastructure, focusing on multi-specialty hospitals.

13. **The DLIs will support the course of the health reforms and hospital restructuring agenda.** The proposed DLIs will need to be linked to the Eligible Expenditure Program and can include the following targets:

> ***Global DLI: Government maintains in effect the Law on Medical Guarantees and the capable network plan;***
> ***DLI 1: Number of hospitals from the capable network that have been contracted by NHSU using case-based payments;***
> ***DLI 2: Number of hospitals that have been reprofiled or merged;***
> ***DLI 3: Number of contracted providers that have been monitored by NHSU, including the review of records from hospitals and outpatient facilities;***
> ***DLI 4: Percentage of stroke patients that have received appropriate treatment; and***
> ***DLI 5: Percentage of outpatient-based procedures and day surgeries that have been undertaken by health care providers contracted by the NHSU.***

Global DLI: Government maintains in effect the Law on Medical Guarantees and the capable network plan. This DLI is a necessary condition for all disbursements, and, as such, constitutes a "global DLI". No funding is linked to this DLI. The disbursements of other DLIs will only take place if this DLI is met. The following are considered key elements of the reform for the purposes of the global DLI: (1) health financing reform: (1a) ensuring financial protection by financing, through the State Budget of Ukraine, a program of medical guarantees for the provision of health care services (medical services) and medications of proper quality necessary for patients, as stipulated by the Law of Ukraine on Public Financial Guarantees of Health Care Services (the Law on Medical Guarantees); and (1b) maintaining the scope of responsibilities of the NHSU as the strategic purchaser for services provided under the program of medical guarantees, as the Authorized Agency stipulated under the Law on Medical Guarantees and the Cabinet of Ministers Resolution No. 1101; and (2) Hospital reform: (2a) implementing a capable network plan acceptable to the WB, which includes inter alia identification of seven or eight levels one and two intensive care hospitals in each oblast that will be modernized with funds from the state and local budgets.

DLI 1: Number of hospitals from the capable network contracted by NHSU using case-based payments. The NHSU is planning to launch contracting of acute hospitals in 2020 using a combination of global budget and case-based payments (planned date is April 2, 2020). This will mark an important shift from line-item budgeting to output-based payment. The introduction of case-based payments will be based on the experience from the piloting of case-based payments in hospitals in Poltava oblast and results of the pilot implementation of the Australian version of diagnosis-related groups supported under the SPIH Project. It is expected that at least 300 hospitals from the capable network will be contracted in 2020 using a combination of case-mix and global budget payments.

DLI 2: Number of hospitals that have been reprofiled or merged. The NHSU has established requirements for hospital contracting. According to these requirements, to provide acute care the hospitals need to meet certain standards. Only the larger general-profile hospitals that will be included in the capable network will meet the requirements. The requirements also include a regulation that for select vertical specialties (e.g. tuberculosis, psychiatry, etc.) the NHSU will provide only one contract for all such facilities per region. This will necessitate small hospitals and mono-specialty hospitals to merge with other hospitals or reprofile. To support this process, the MoH is preparing regulations to allow the provision of psychiatric care in general care hospitals and other relevant regulations. The target for this indicator will be that at least 100 hospitals will merge with general profile hospitals or reprofile.

DLI 3: Number of contracted providers that have been monitored by NHSU, including the review of records from hospitals and outpatient facilities. The NHSU has contracted primary care providers and pharmacies within the drugs reimbursement program “Dostupny Liky” in 2018-2019, and it is launching the contracting of hospital and outpatient care providers in 2020. To enact its strategic purchasing role, the NHSU needs to strengthen the capacity of its monitoring department to detect anomalies in coding and claims management, both retrospectively and in real time. The implementation and expansion of the diagnosis-based grouping of hospital cases, along with fee-for-service arrangement for diagnostic services and procedures at the outpatient levels provides an opportunity to use big data and operational monitoring for the prevention of fraud and abuse at the provider level. The proposed DLI will help improve the capacity of the NHSU and put in place routine analytical procedures to prevent, detect and address fraud and reduce waste.

DLI 4: Percentage of stroke patients that have received appropriate treatment. Improvement of stroke care will require better access to qualified care providers, upgrade of diagnostic capacity, and training of medical personnel. It will also require better access to thrombolytic therapy and new standards to immediately administer thrombolytics to patients with confirmed ischemic stroke. For year one of the AF implementation, the target will be to admit at least 70 percent of patients with stroke to stroke-prequalified hospitals contracted by NHSU, and for the next two years access to thrombolytic therapy or mechanical removal of thrombus in the first hours after admission is expected to increase to at least 40 percent from the current baseline of less than one percent.

DLI 5: Percentage of outpatient-based procedures and day surgeries that have been undertaken by health care providers contracted by the NHSU. Hospital restructuring will require continued strengthening of public health and primary care services, intensification of hospital care, and moving select cases to an outpatient basis. Introduction of case-based payments may create incentives to admit more patients to hospitals. The suggested indicators under DLI 5 will help to control and incentivize gradual shifts of diagnostic procedures, elective and less invasive surgeries to an outpatient setting. The baseline will be established once the NHSU begins to contract with facilities for inpatient and specialized outpatient services in April 2020 and collects utilization data.[7] During the implementation of the AF, the share is expected to increase by 30 percent from the baseline.

Component 3: Project Implementation Support and Monitoring and Evaluation (additional allocation of US$5 million). This component will support the day-to-day management, monitoring and evaluation, and audits of the Project. These activities will be conducted by a single national PIU which will be responsible for the entirety of Project activities (including support to decentralized level). Therefore, its capacity needs to be significantly strengthened in order to manage the Project effectively. For example, in addition to the consultant that is responsible for social safeguards and citizen engagement, an environmental safeguards consultant would need to be hired. It will also finance necessary assessments and surveys required to inform and evaluate Project activities, as well as assessing the achievement of DLIs.

Component 3 will have two sub-components. Subcomponent 3.1 will include all technical assistance activities needed for the implementation of the AF. Subcomponent 3.1 will include:

(a) **Consultancy for engineering advice and technical oversight to upgrade select hospitals.** Although the works necessary for the modernization of emergency departments and stroke units will be financed from Government resources, the MoH will require guidance, appropriate advice and oversight to ensure adherence to good construction practices, as well as environmental and social requirements of the WB. Based on the good experience of engaging a supervision engineering consultant for the construction of the hospitals in Vinnytsia under the SPIH Project, the selection method will be by Quality and Cost Based Selection and may cost approximately US$1 or 1.5 million to adequately support Project implementation.

(b) **Training and capacity building activities linked to the improvement of hospital management and provision of acute, emergency, and stroke care.** The MoH will use a combined approach of streamlining access to knowledge and training materials at the national level and cascading training in regions. The training plan will include training for the hospital management on good practices of organizing emergency departments and stroke units, trainings for clinicians (doctors and nurses) in the hospitals, and emergency medicine services, etc.

(c) **Contract with the WHO for implementation of hospital care improvements.** The WHO was contracted in the SPIH Project and contributed to the achievement of significant progress in the public health agenda. In the AF, WHO will provide assistance to strengthen the capacity of the care

[7] NHSU plans to purchase 1,556,000 day surgeries and 3,000,000 priority outpatient examinations in 2020. However, the number of day surgeries will need to be recalculated as the historical data are not reliable and since the project will focus on select surgical procedures that are recommended for day surgery care.

providers and support implementation of standard operating procedures, provide materials, and train trainers for cascading the training activities under this Component.

Subcomponent 3.2 will combine all activities related to the project management and implementation of monitoring and evaluation activities in the AF. It will cover costs of the consultants in the project consultancy support unit (PCSU), studies, operating costs and project audit.

E. Implementation

Institutional and Implementation Arrangements

Institutional and Implementation Arrangements. Overall, institutional and implementation arrangements for the AF-supported Project activities will remain largely unchanged, with a few important adjustments. Specifically, the MoH will continue to have overall responsibility for implementing the AF-supported activities, with a Deputy Minister of Health appointed as a Project Coordinator and focal point for the WB and other stakeholders for Project-related matters. The PCSU will also continue to provide support to the MoH on technical aspects and day-to-day Project management, including ensuring compliance with the WB requirements for procurement, program/financial reporting, auditing, safeguards, and monitoring and evaluation of the Project. However, given the broadened Project focus, such support will be provided solely by the national PCSU, which will be responsible for the entirety of Project activities (including support to decentralized levels).

For Component 1, the major change under the AF relates to centralization of Project management. The current eight regional project implementation units (PIUs) will be phased out once the SPIH regional sub-projects are completed. Project management support will be provided by the project coordination unit (PCU); the PCU comprising heads of all relevant MoH units and subordinated agencies (e.g., Informatics Centre for e-Health activities) will provide technical guidance and be responsible for strategic decision-making. In addition, the PCU would be in charge of the fiduciary oversight role, including monitoring and reviewing the budgeting process, reporting, and audit arrangements. The Deputy Minister/Project Coordinator will chair the PCU, and the manager/head of MoH Department in charge of health system reforms will serve as deputy chair. Handling of procurement processes for medical equipment under Component 1 may be delegated/outsourced to the new "Central Procurement Agency (CPA)[8] for the health sector "Medical Procurement of Ukraine." Since its establishment, the CPA has conducted many small-value procurement procedures (with a total cost estimate of UAH100 million, or around US$4 million). Suitability of having the CPA be responsible for such a role will be subject to findings of a WB Procurement Capacity Assessment. If CPA capacity is found appropriate, the details of CPA involvement in implementing AF-supported procurement processes will be reflected in the Project Procurement Strategy for Development and other Project documents as necessary.

Component 1 of the parent Project will be restructured, including an extension of the closing date by 12 to 18 months, to secure additional time for the regional sub-projects in select Project regions (Vinnytsia, Dnipro, Rivne and Volyn) to complete the agreed activities using the SPIH resource allocation and implementation arrangements. The extension is needed to finalize the construction/reconstruction that have experienced major delays at the start of the Project. Implementation of selected regional proposals/projects that will be extended will remain the responsibility of the Oblast State Administrations (OSAs), with the Health Departments in OSAs leading the technical execution and the central PCSU providing Project management and coordination support. For oblast-level coordination, each participating oblast will retain its Subproject Management Unit chaired by the deputy head of respective OSA or by the manager of the Health Department within the OSA.

For Component 2, the responsibility for the implementation of the activities to achieve DLI targets will stay with the MoH and the NHSU. The WB will receive quarterly reports on the progress towards achievement of the DLIs. The achievement of the targets will be reported by the MoH to the WB. The MoH should notify the WB of any amendments to the Law on Medical Guarantees or the capable network plan.

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

The parent project is being implemented in 8 oblasts of Ukraine (Poltava, Dnipropetrovsk, Vinnytsia, Volyn, Rivne, Lviv, Zakarpattya, Zaporizhzhia). Potential negative impacts of the project are predictable, small-scale and manageable. These potential impacts are associated with rehabilitation and reconstruction of existing premises of hospitals, polyclinics, and primary care centers in select regions under Component 1. A sub-project involving a new building as a way to optimize the network of emergency cardiac services is Environmental Category B (Vinnytsia Oblast). Any activities that may cause any permanent or temporary physical or economic displacement will be excluded from the project. Therefore the Involuntary Resettlement Policy OP4.12 is not triggered.

G. Environmental and Social Safeguards Specialists on the Team

Arcadii Capcelea, Environmental Specialist
Mariia Nikitova, Social Specialist
Oksana Rakovych, Environmental Specialist

SAFEGUARD POLICIES THAT MIGHT APPLY

Safeguard Policies	Triggered?	Explanation (Optional)
Environmental Assessment OP/BP 4.01	Yes	
Performance Standards for Private Sector Activities OP/BP 4.03	No	
Natural Habitats OP/BP 4.04	No	
Forests OP/BP 4.36	No	
Pest Management OP 4.09	No	
Physical Cultural Resources OP/BP 4.11	No	
Indigenous Peoples OP/BP 4.10	No	
Involuntary Resettlement OP/BP 4.12	No	
Safety of Dams OP/BP 4.37	No	

[8] The CPA was established in late 2018 as a state-owned enterprise with the objectives of providing professional procurement services and ensuring efficient/effective procurement of drugs and devices from the state budget and economies of scale in decentralized procurements.

Projects on International Waterways OP/BP 7.50	No
Projects in Disputed Areas OP/BP 7.60	No

KEY SAFEGUARD POLICY ISSUES AND THEIR MANAGEMENT

A. Summary of Key Safeguard Issues

1. Describe any safeguard issues and impacts associated with the proposed project. Identify and describe any potential large scale, significant and/or irreversible impacts:

There are no potential large-scale, significant and/or irreversible impacts expected as a result of project activities. The original SPIH project was subject to the World Bank Safeguards Policies and Procedures. As long as the AF remains focused on scaling up activities under the original Project, the existing Safeguard Policies and Procedures will continue to apply. Similarly, the original project classification as category B will remain unchanged as long as no new safeguards policies are triggered, and no new types of activities are envisaged.

The parent project has demonstrated consistent and sound approach to ES management throughout the project implementation. However, some issues with OHS requirements compliance were recorded during last supervision missions, thus overall ES performance rating stands on Moderately Satisfactory. Additionally, the PIU was instructed to pay more attention to issues of construction waste management, as well as OHS training for workers. These issues will be under close focus for AF implementation.

The AF project will support modernization and upgrade of the intensive care hospitals from the capable network. The project will help acquire necessary equipment, improve care pathways, and provide training to the medical personnel to provide care to patients in emergency cases and to improve outpatient care. In some facilities an upgrade of the emergency departments and/or stroke care units during the project will be required. Such upgrade will be done within current footprint of the health facility and no new land acquisition will be required. The potential subproject eligible for the upgrade will undergo environmental and social screening to assure compliance with project safeguards requirements. The possible reconstruction and refurbishment of the premises will be conducted at the expense of the government financing. The scope of such works will not exceed the scope of the reconstruction works implemented in the parent project. The MoH will hire an engineering supervision consultancy firm to ensure adherence to the environmental and social safeguards requirement during the preparation and implementation of the upgrades as necessary.

Following the World Bank Safeguards Policies and Procedures, the original Environmental Management Framework that was prepared and approved in 2014 will continue to be used, with the necessary revisions made to (i) cover social impact assessment and update template ESMP with social mitigation measures; (ii) reflect the AF-supported activities (including associated activities); (iii) address safeguards issues during AF implementation; (iv) address changes in management arrangements and necessary capacity building within PCSU; (v) detail requirements of the new law “On Environmental Impact Assessment” adopted on December 18, 2018; (vi) reflect reporting requirements under Environmental and Social Incident Reporting Tool; (vii) provide guidelines on GRM-handling procedures for subprojects’ implementing parties.

2. Describe any potential indirect and/or long term impacts due to anticipated future activities in the project area:
No potential indirect and/or long term impacts are expected due to anticipated future activities in the project area.

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

4. Describe measures taken by the borrower to address safeguard policy issues. Provide an assessment of borrower capacity to plan and implement the measures described.
The Ministry of Health has established the PIU and hired a designated safeguards specialist with good experience in social assessment and public consultations, who also serves as GRM Focal Point. For this AF, the PIU will need to be strengthened with capacity on environmental assessment (including health and safety issues) and supervision. Additionally, the MoH will hire an engineering supervision consultancy firm to ensure adherence to the environmental and social safeguards requirements during the preparation and implementation of AF as necessary.

5. Identify the key stakeholders and describe the mechanisms for consultation and disclosure on safeguard policies, with an emphasis on potentially affected people.
Health care institutions and general population in their service area are key stakeholders of this project. The Environmental Management Framework (EMF) was prepared by the client in 2014 and has been updated accordingly.

B. Disclosure Requirements (N.B. The sections below appear only if corresponding safeguard policy is triggered)

Environmental Assessment/Audit/Management Plan/Other

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

"In country" Disclosure

C. Compliance Monitoring Indicators at the Corporate Level (to be filled in when the ISDS is finalized by the project decision meeting) (N.B. The sections below appear only if corresponding safeguard policy is triggered)

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APPROVAL

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Approved By

Safeguards Advisor:	Nina Chee	13-Jan-2020
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