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Environmental and Social Systems Assessment (ESSA)

Colombia: Improving Quality of Healthcare Services and Efficiency In Colombia (P169866)

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World Bank

Abbreviations

CONPES	National Council of Economic and Social Policy *(Consejo Nacional de Política Económica y Social)*
COTSA	Territorial Councils of Environmental Health *(Consejos Territoriales de Salud Ambiental)*
DANE	National Administrative Department of Statistics *(Departamento Administrativo Nacional de Estadística)*
DNP	National Planning Department *(Departamento Nacional de Planeación)*
EAPB	Administrators of Benefit Plans *(Entidades Administradoras de Planes de Beneficios)*
EPS	Health Insurance Company *(Entidad Promotora de Salud)*
EPSI	Indigenous Health Insurer *(Entidad Promotora de la Salud Indigena)*
ESE	State Social Companies *(Empresas Sociales del Estado)*
ESSA	Environmental and Social Systems Assessment (*Evaluación de los Sistemas Sociales y Ambientales*)
GoC	Government of Colombia *(Gobierno de Colombia)*
HCW	Health Care Waste *(Residuos de Establecimientos de Salud)*
IDEAM	Institute of Hydrology, Meteorology and Environmental Studies
IETS	Health Technology Assessment Institute *(Instituto de Evaluación Tecnológica en Salud)*
INVIMA	National Institute for Food and Drug Surveillance
IPS	Health Care Provider *(Instituto Prestador de Salud)*
MADS	Ministry of Environment and Sustainable Development (*Ministerio de Ambiente y Desarrollo Sostenible*)
MSPS	Ministry of Health and Social Protection (*Ministerio de Salud y Protección Social*)
PAHO	Pan American Health Organization (*Organización Panamericana de la Salud*)
PBS	Health Benefits Package *(Plan de Beneficios en Salud)*
PEP	Special Residence Permit
PforR	Program for Results (*Programa por Resultados*)
PGIRHS	Comprehensive Management Plan for Hospital and Similar Waste *(Plan de Gestión Integral de Residuos Hospitalarios y Similares)*
PND	National Development Plan *(Plan Nacional de Desarrollo)*
POT	Land Management Plans *(Planes de Ordenamiento Territorial)*
PPSS	Social Participation in Health Policy (*Politica de Participacion Social en Salud*)
PQRSD	Mechanism for Petitions, Claims, Requests and Complaints *(Peticiones, Quejas, Reclamos, Sugerencias y Denuncias)*
RESPEL	Registry of Generators of Waste or Hazardous Waste (*Registro de generadores de residuos o desechos peligrosos*)
SGSSS	General System of Social Security in Health *(Sistema General de Seguridad Social en Salud)*
SISBEN	System of Identification of Potential Beneficiaries of Social Programs *(Sistema de Identificación de Potenciales Beneficiarios de Programas Sociales)*
SISPI	Indigenous System of Own Intercultural Health (*Sistema Indígena de Salud Propia Intercultural*)
SIVIGE	Integrated Information System on Gender Violence
TMF	Border Mobility Card
WEEE	Waste Electrical and Electronic Equipment (*Residuos de Aparatos Eléctricos y Electrónicos*)

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EXECUTIVE SUMMARY

The World Bank (WB), according to the World Bank's Operating Policy 9.00, carried out an Environmental and Social Systems Assessment (ESSA) of the Country's health system that apply to the "Improving Quality of Health Care Services and Efficiency in Colombian" (the Program) under a Program for Results (PforR) financing operating scheme[1]. The scope of the ESSA was to assess the systems that promote environmental and social sustainability, which allow: avoiding, minimizing or mitigating the potential adverse impacts associated with the Program on natural habitats and physical cultural resources; protecting patients and patient's companions, and worker safety; considering issues related to indigenous peoples, ethnic groups, vulnerable people and migrants; and avoiding social conflict. It additionally identified the necessary actions to improve/strengthen national systems and mitigate potential environmental and social risks.

ESSA specific objectives include: (a) identify the possible benefits, risks and environmental and social impacts applicable to the interventions of the Program; (b) review the policy and legal framework related to the management of the environmental and social impacts of Program interventions; (c) assess the institutional capability regarding environmental and social management systems within the Program system; (d) assess the performance of the Program system with respect to the basic principles of the PforR instrument and identify gaps, if any; and (e) submit recommendations and Program Action Plans (PAP) to address gaps and improve performance during the program's implementation.

Regarding the environmental component, the World Health Organization (WHO) points out that the waste generated by the activities of health facilities, from contaminated needles, sharps, chemical, cytotoxic and radioactive waste, has a higher potential risk of producing wounds and infections than any other type of waste and its improper handling can cause serious public health consequences and considerable impact on the environment. The main environmental risks and impacts of the Program, as well as the ESSA approach, focus on the management of health-care waste (HCW) generated in Health Care Provider *(Instituto Prestador de Salud, IPS)*.

From the Social point of view, the ESSA assesses management capacity linked to distributive equity, affordability and cultural or gender limitations to access or participation in the Program. Furthermore, the assessment is made on the structure of the agencies involved, disclosure measures, consultation mechanisms, jurisdictional or geographical diversity, cultural, financial or physical barriers that hinder the participation of socially marginalized or disadvantaged groups (for example, the poor, the disabled, children, the elderly, indigenous peoples or religious or ethnic minorities). The risks of creating or exacerbating a social conflict are also considered, especially in fragile states or situations e.g. migrants, ethnic groups and remote or isolated populations.

This Program does not consider variations in property regimes, including resources in jointly owned property, including common property resources, customary or traditional rights to land or use of resources, and the rights of indigenous peoples.

The ESSA results confirm that the current systems of the Government of Colombia (GoC) to manage the environmental and social aspects of the Program to improve the quality of healthcare services and efficiency on the Colombian health system have a solid basis in a robust legal framework to provide equitable and inclusive access to health insurance companies (EPSs) and IPS services; and in a

[1] This innovative financing instrument for the Bank's client countries links disbursements of funds directly with the achievement of defined outcomes.

decentralized management system, with autonomy of its territorial, democratic, participatory and pluralistic entities established at the constitutional level. There are also long-standing institutional mechanisms based on the National Development Plan (PND) and the documents of the National Council of Economic and Social Policy (CONPES) so that several stakeholders have participation spaces regarding the Health System, including procedures for Petitions, Complaints, Claims, Suggestions and Whistleblowing at the national and local level.

This Program is expected to generate fundamental social benefits, particularly through its efforts to improve the General System of Social Security in Health (SGSSS).

The social risk was cataloged as "***low***" because there is a diagnosis based on participatory consensus and mechanisms to service health-related social demands. The Program additionally has a low probability of any negative social impact given that it includes the inclusion of indigenous peoples, ethnic minorities and other vulnerable communities linked to dispersed rural populations, the victims of the armed conflict and returning Venezuelan and Colombian migrants. As no construction is planned, no expropriations or resettlements will be carried out.

There is leadership from the Ministry of Health and Social Protection (MSPS) in the formulation of the Social Participation in Health Policy (PPSS), which aims to guarantee the right of citizens to be engaged in the decision making of the sector that affects or interests them on the part of the members of the SGSSS, in order to comply with the Statutory Health Law. Vulnerable populations have specific frameworks to reduce inequities. Ethnic groups and native peoples, as well as other vulnerable groups have spaces for consultation such as “Workgroups” and “Pathways” for a socio-cultural adaptation and inclusion of the intercultural approach, where they agree and establish standards of care that respect their ethnic and cultural identity, forms of social organization and linguistic characteristics. However, it is still in the process of resolution, the Intercultural Indigenous Health System (SISPI), and the guidelines with directives and guidance for a socio-cultural adaptation and inclusion of the intercultural approach for indigenous, Afro-Colombian, *Raizales, Palenquero* and the Rom peoples’ communities.

Indigenous peoples have less favorable indicators in terms of morbidity and mortality than the rest of the population. The infant mortality rate in all ethnic groups (mainly Rom and Palenqueros) is higher than in the national total and in the rest of the population, with rates equal to more than three times the national rate. For its part, in the case of maternal mortality, the indicator for indigenous, black and Afro-Colombian groups is equal to more than three times the indicator for the national total and about four times higher in relation to the rest of the population.

There are also two specific cases in Colombia, one related to the psychosocial impacts and damage to the physical and mental health of the victims caused by or in relation to the country's internal armed conflict. The other specific case is related to the migration of Venezuelans residing in or in transit through their territory (due to the difficult economic, political and social situation of their country), and returning Colombians who had emigrated due to the armed conflict.

Colombia has suffered for decades an internal armed conflict, which in addition to the direct consequences in its territories and to its inhabitants, has been the origin of an exodus of citizens to other countries. For the past six years the GoC has established the Psychosocial care and integral health for victims’ program (PAPSIVI), providing coverage through insurance in the health system, although without achieving full coverage in its first stage.

For migrants (approximately 1.4 million Venezuelans), different strategies address their care, depending on whether their status is linked to the Special Residence Permit (PEP), or Border Mobility Card (TMF), among other mechanisms which include vaccination systems for children, birth care, initial emergency care, etc. However, there are still difficulties caused by the migrants' own irregularities (illegal entry, stays beyond time allowed), as well as by not being able to enroll in the subsidized health regime for not complying with the requirements set forth in the Potential Beneficiaries of Social Programs Identification System (SISBEN).

The Program has a low probability of any negative social impact and will mitigate several of these risks, based on six pillars that support health sector quality improvement: (1) certification of medical care providers; (2) accreditation of medical care providers; (3) mandatory quality indicators; (4) quality improvement plans for medical care providers; (5) healthcare human resources, and (6) citizen participation.

No land acquisition is anticipated, since the Program is not compatible with any construction, so there will be no expropriations or resettlements as a result of the project. The results areas focus on the quality and efficiency of medical care throughout the country and are expected to contribute, in the long term, to better health outcomes and to the financial sustainability of the health system.

To maximize the benefits of the Program, ESSA recommends that: (1) Continue with the mechanisms of broad participation of actors and social representatives of the sector, so that the SGSSS has the required legitimacy; (2) Proactively continue the development of the inclusion tables and routes provided in the CONPES for ethnic groups to conclude the guidelines, directives and guidance for the socio-cultural adaptation and inclusion of the intercultural approach that considers their standards of care that respect their ethnic and cultural identity, forms of social organization and linguistic characteristics for each ethnic group; (3) Move forward for the purpose of completing the SISPI, especially to complete Stage II (Preparation of the Base Document, and validation of the 5th component) and Stage III (administrative act of the MSPS and submission to the Permanent Coordination Workgroup), a documented record of the participation of stakeholders shall be established, which will include a description of the stakeholders consulted, a summary of the opinions received and a brief explanation of how the opinions were taken into account, or the reasons why this didn't happen, and (4) Establish mechanisms to identify migrants that allow the implementation of insurance mechanisms, to contribute to the particular health of migrants and to the protection of Colombian public health. This is made effective by means of a census list or equivalent instrument coordinated by the Directorate for Regulation of the Operation of Health Insurance, Occupational Risks and Pensions.

Environmental risk was considered "***Low***" because of the high percentage of citizens enrolled will not generate a significant increase in medical waste compared to the current situation, as the amount of IPS is not increased, nor is a substantial increase expected in the number of enrollees given its already high number. However, the possible (minor) increases in the generation of HCW may be due to improvements in the quality of benefits, and early diagnosis and treatment of diseases such as cancer or diabetes, during early stages (until such medical practices are usual in the universe of benefits). The operational phase may exhibit certain risks and impacts associated with the management of medical waste and other solid and liquid waste within health facilities (segregation or selective collection by category, packaging and temporary storage), the transportation, treatment and final disposal of solid medical waste, with special attention to hazardous waste. If not managed well, these activities will pose a threat to the environment, public health and safety at work. The institutional configuration has

the potential to develop the capacity required to deal with the potential environmental risks and challenges. Dispersed populations have disadvantages for the final treatment of HCW and Waste Electrical and Electronic Equipment (WEEEs), related to the lack of economic attractiveness of providers of said service linked to the low volumes generated.

The ESSA confirms that the current system for managing the environmental aspects of the Program is reasonably covered by the regulations and institutional capabilities, where the MSPS establishes the policies and the decentralized authorities carry out the actions of inspection, oversight and sanitary control (IVCS). The management of HCW has two instances, one within the health facilities (intramural) under the monitoring of the MSPS, and another outside the IPS (extramural) under the supervision of the Ministry of Environment and Sustainable Development (MADS). Decree 351 of 2014[2] regulates from an environmental and health standpoint the integral management of waste generated in healthcare and other activities. At the sub-national levels, the Departmental, District and Local Health Directorates are responsible for the IVC for the management of intramural RES. At an extramural level, the external management of the HCW is under the purview of the Regional Environmental Authorities (Regional Autonomous Corporations, Corporations for Sustainable Development, and Urban Environmental Authorities) in accordance with the legal provisions and policies of the MADS. The provisions in the existing environmental legal and regulatory framework are adequate and require an enabling institutional and technical capability to comply with these. Law 1672 of 2013 and Decree 284 of 2018 establish the Public Policy for the integral management of WEEEs. The destinations considered for the WEEEs are: (1) a post-consumption program with eight streams lacking economic costs (recovery), and (2) delivery to an authorized [waste] manager.

The findings of the ESSA identified a general level of implementation and satisfactory compliance with current standards for the handling of medical waste, being further able to verify the structure and content of reports from the Registry of Generators of Waste or Hazardous Waste[3] (RESPEL). The RESPEL becomes in a management instrument for the Deputy Directorate of Environmental Health of the MSPS, the MADS, and the Institute of Hydrology, Meteorology and Environmental Studies (IDEAM) from the records generated at the IPS level. The information collected in the RESPEL (annual) report is prepared for the year ended, a situation that conditions timely decision-making if changes in the patterns of generation of HCW (quantities, types) occur. In this manner, the information for a modification of policies, needs for inputs and resources, could be late in the face of trends in general increases in the HCW or of a particular waste stream that would demand a timely or specific treatment.

An adequate forecast of patients to for service in the EPS / IPS, the types of diagnoses and medical practices to be carried out and the timely information about volumes and streams of HCW generated, allow estimating the material, human and budgetary resources necessary for the adequate handling and final disposal of RES, reducing risks and environmental impacts.

To maximize the benefits of the Program, the ESSA recommends: (1) Maintain continuous training efforts in the handling of RES, in addition to the inclusion of modules on HCW management in the training of human talent; (2) Monitor the result of the IVCS actions under the purview of local authorities. At present, the reporting level is annual for the year ended, which makes it difficult to make informed decisions for the preparation of public policies (that anticipate and avoid risks and HCW impacts, and when it is not possible to avoid them, they can minimize them or reduce them to

[2] Compiled in Decree 780 of 2016 - Single Regulatory Decree of the Health Sector.

[3] It is integrated from standardized, homogeneous and systematic information on the generation and handling of waste and hazardous waste originating from the country's various productive and sector activities.

acceptable levels). Recommend moving towards a more limited time report, or partial reports which the Deputy Directorate of Environmental Health can access; (3) Promote access to information on HCW flows that allow the display of disaggregated data making it available to the Deputy Directorate of Environmental Health for the sub-categories: Y1.1 (pathological waste), Y1.2 (bio sanitary waste), Y1.3 (sharps waste); and Y1.4 (animal waste) in timely fashion; and (4) Continue with the implementation of the national and regional dissemination and awareness-building plan for WEEEs that is provided in Decree 284 of 2018.

The "Guidelines for the Formulation of Plans for Adaptation to Climate Change, from the Environmental Health Component" were proposed by the Deputy Directorate of Environmental Health of the MSPS in 2016.

The main health impacts expected as a result of Climate Change are linked to the fact that 85 percent of the Colombian territory has ecological, climatic and epidemiological characteristics conducive to the transmission of malaria. A two-degree increase in temperature (from 24 ° C to 26 ° C) more than double the number of infectious mosquitoes, which links temperature and precipitation variations with an increase in the incidence of diseases transmitted by malaria and dengue fever vectors. The increase in the minimum nighttime temperatures in the foothills of the Andes and with changes in the hydrological cycle induced by the phenomenon of the *El Niño*-Southern Oscillation (ENSO) favor the development of vectors.

1 BACKGROUND

1.1 The context

1.1.1 Country Context

1. **Colombia's economic growth has begun recovering gradually since mid-2017, supported by sound fiscal and monetary policies.** A robust macroeconomic policy framework has enabled orderly fiscal and external adjustments to the significant external shocks experienced over the mid-2014-2015 period. Growth had fallen to 1.4% in 2017, before accelerating gradually to 2.6% in 2018. Lower inflation and a slightly accommodative monetary stance supported a recovery in consumer confidence and private consumption. Economic growth is expected to accelerate gradually to 3.3% this year, and further to 3.6% in 2020.

2. **While the authorities remain committed to a fiscal adjustment path consistent with Colombia's fiscal rule, tax reforms approved over the past years have not yet generated a much-needed structural increase in revenues.** Colombia has a fiscal rule, which mandates a reduction of 1.5 percentage points of GDP in the central Government fiscal deficit between 2018 and 2022, which is equivalent to cutting the structural deficit of the central Government to 1 percent of GDP by 2022. The Fiscal Rule Consultative Committee allowed an additional space of 0.5 percent of GDP to accommodate migration-related spending. This additional spending would decline gradually over time as a share of GDP. Thus, the fiscal deficit allowed under the fiscal rule is 2.7 percent in 2019. However, the government is targeting a deficit of 2.4 percent of GDP, to be achieved primarily through spending cuts. Additional fiscal consolidation measures may be needed in 2020.

3. **The on-going process of peace consolidation and the large migration inflow from Venezuela generate significant additional fiscal pressures.** Post-conflict spending commitments – which according to Government estimates may cost approximately 0.7% of the GDP per year – and spending related to the migration flows from Venezuela, together with the need to ensure enough public investment to support medium-term growth, put pressure on Colombia's tight fiscal space. As of June 30, 2019, there were 1.4 million Venezuelans in Colombia, including about 742 thousand regular migrants. Many of these migrants are not only income poor but also come to Colombia with acute health care needs, as a result of the collapse of the Venezuelan health system. It is estimated that, in 2018 alone (when migration numbers were still lower), between 0.26% and 0.41% of GDP would have been required to provide access to services to the returnees and eligible migrants at a level similar to that provided to the local population. This implies that additional fiscal consolidation measures over the 2020-2022 period will be necessary, including targeted expenditure containment and rationalization, as well as efficiency-enhancing measures.

4. **The Government of Colombia (GoC) concluded the formulation and approval of the 2018-2022 National Development Plan (Plan Nacional de Desarrollo, PND).** With a projected investment of approximately COP$550 trillion (around US$180 billion) for the next four years – 50% of the Government's pluriannual investment plan for the period – the PND seeks to increase capital formation and multifactor productivity, which are expected to increase the country's potential growth. The PND aims to: a) reduce monetary poverty by 2.9 million people (thus reducing the monetary poverty rate from the current 27% to 21% in 2022); b) reduce the population in extreme poverty by 1.5 million people (from 7.4% currently to 4.4% in 2022); c) reduce the population in multidimensional poverty by 2.5 million people (from 17% to 11.9% in 2022); and d) create 1.6 million additional jobs during the four-year period of its implementation.

5. **Colombia is a decentralized unitary Republic, with autonomy of its territorial, democratic, participatory and pluralistic entities (National Constitution of 1991).** It implements administrative decentralization as part of the development policies carried out by the national government, through which a large part of the State administration is shared between the administrative entities at the central and territorial level. These entities, organized hierarchically, are the departments, municipalities and districts. Other special divisions are indigenous territorial entities and collective territories. The Departments are headed by a governor in charge of the autonomous administration of the resources granted by the State. They have autonomy in handling matters related to their jurisdiction and function as coordinating entities between the nation and municipalities. In Colombia there are 32 departmental units, and a Capital District (Bogotá). The Municipalities (1,123) are administratively and legally organized territorial entities and are headed by a mayor. The Districts are territorial entities with a special administration. Because of their national importance, in Colombia the cities of Bogotá, Cartagena, Barranquilla, Santa Marta and Buenaventura hold this distinction. Indigenous Territorial Entities are indigenous local governments that occupy some part of a department or municipality. For their part, Collective Territories have been awarded to the Afro-Colombian population predominantly in the Pacific zone, allowing it to organize around community-based and business schemes.

1.1.2 Sectoral and Institutional Context

Results

6. The Colombian SGSSS provides almost universal insurance coverage and a significant level of financial protection to its beneficiaries. The increase in health insurance coverage achieved after the approval of the 1993 health reform (Law 100), from 23.5% in 1993 to around 94-96% since 2010, had a particularly large impact on the poor: during the period 1997 to 2016, health insurance coverage for those in the lower income quintile increased from 42% to approximately 93% and from almost 48% to 93.5% for those in the second quintile. Nevertheless, insurance coverage among migrants remains low. Although registered migrants are eligible to the SGSSS, only 25% of those eligible are currently affiliated and only 35.8% of those are enrolled in the subsidized regime.

7. Some of Colombia's main health outcomes show important progress in recent years, but due to the demographic and epidemiological transitions, the country is simultaneously experiencing a rapid increase in the prevalence of non-communicable diseases (NCDs), which contribute to the growing concern regarding the financial sustainability of the SGSSS.

8. According to the data of the Observatory of Human Talent in Health, (OTHS) of the MSPS, the estimated number of health professionals for 2017 was 323,039. The number of assistants was 311,984, of professional technicians 668, and of registered technologists 30,921. The estimated density of health workers is 11.5 per 1,000 inhabitants throughout the country and there are approximately 2.1 doctors per 1,000 inhabitants (Health Situation Analysis -ASIS- 2018), below the rates of the OECD of more than 3 doctors per 1,000 inhabitants. Only Bogotá has levels comparable to European countries with higher densities. Departments such as Guainía, Vichada, Guaviare and the San Andres Archipelago, among others, have densities equal to or less than one doctor per 1,000 inhabitants (ASIS 2018). The public system has 931 public hospitals. According to 2018 data from the Registry of Health Service Providers (REPS) there are approximately 66,000 health service provider sites. Colombia has 15 hospital beds for every 10,000 people.

9. The GoC has made efforts to strengthen provision of health services, which is reflected as better results in many areas. The coverage of prenatal care, at least one visit 97.2%, share of deliveries attended by qualified health personnel 95.9%, lost healthy years is 10.7%. Chronic malnutrition,

teenage pregnancy and vaccination coverage have shown improvements. Chronic malnutrition decreased from 13.2% to 10.8% between 2010 and 2015. In 2015, teenage pregnancies returned to their lowest level since 1990 (17.4%), after reaching 19.5% in 2010. Pentavalent vaccine coverage which prevents diphtheria, whooping cough, tetanus, hepatitis B and influenza B reached 91%, while coverage of the triple viral vaccine (measles, mumps and rubella) reached 92%. Colombia greatly expanded its vaccination program and now has one of the most complete immunization programs in Latin America.

10. The National Administrative Department of Statistics (DANE) reported for the year 2018 that the main cause of death was ischemic heart disease 16.5%, homicides 8.7% and deaths from cerebrovascular disease 5.7%. This was followed by acute respiratory infections, hypertensive diseases, road injuries, urinary system diseases, diabetes mellitus.

11. Mortality from communicable diseases has been on a downward trend. Acute respiratory diseases constitute the first cause of death within the group, between 2005 and 2017 they produced 51.8% (94,096) of deaths. In turn, HIV (AIDS) was attributed to 17.20% (31,280) of deaths from communicable diseases and is the second most frequent cause of death. The frequency of sub-cause of mortality in this group is similar between genders[4].

12. Neoplasms are the third cause of death in Colombia. Between 2005 and 2017, malignant tumors of the digestive organs and peritoneum, except stomach and colon, were the top cause of mortality in men and women (4.6% of deaths). Prostate cancer is the second cause of mortality in men. Breast cancer mortality in women increased 23.62% from 10.15 to 12.55 deaths per 100,000 women[5]. Women with early diagnosis (stages I and II), accounted for 44% of breast cancer cases detected in the contributory regime and for only 29% in the subsidized regime or in the uninsured population.

13. Indigenous peoples have less favorable indicators in terms of morbidity and mortality than the rest of the population. In all ethnic groups there is a higher infant mortality rate than in the national total and in the rest of the population. The highest infant mortality rate (by ethnicity) is exhibited by the Rom people, while the Palenquero and indigenous groups occupy the second and third place respectively, with rates equal to more than three times the national rate. For its part, in the case of maternal mortality, the indicator for indigenous, black and Afro-Colombian groups is equal to more than three times the indicator for the national total and about four times higher in relation to the rest of the population.

14. The access to comprehensive care of children belonging to ethnic groups is conditioned by the limited availability of services with a differentiated ethnic approach. Households with ethnicity identity face deprivation in early childhood care, which includes simultaneous access to health, adequate nutrition and initial education 1.45 times higher than the general population. Within the framework of comprehensive care in 2017, only 26% of children aged 0 to 5 belonging to ethnic groups had access to comprehensive priority care to early childhood care.

15. For the year 2017, the unified victim's registry of the conflict (Victims Unit, 2017) found that 13.8% of the total victims corresponded to minors from ethnic communities.

16. Colombia has made progress in terms of coverage and social protection, but still faces challenges in terms of financial sustainability, access and quality of care.

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[4] Health Situation Analysis (ASIS) Colombia, 2018 Directorate of Epidemiology and Demography, MSPS.

Access

17. Colombia's National Political Constitution enshrines life as a fundamental right of Colombians, with health as a right the State is the guarantor for the population. Article 49 of the Constitution determines that health services shall be organized in a decentralized manner, by levels of care and with the participation of the community. On the basis of Law 100 of 1993, the **SGSSS**, from which the **Health Benefits Plan** (**PBS**), where individual services are organized according to the logic of an insurance market, whose objective is to provide health care to the population of the national territory. In this scheme, the **EPSs** are the insurers that engage the population to the health system, to guarantee the provision of the PBS through the **IPS**. Law 1751 of 2015, called the Statutory Health Law, enshrines health as a fundamental autonomous right, guarantees its provision, regulates it and establishes its protection mechanisms. Public expenditure on health is on the order of 5.3% of GDP, and in 2017, public expenditure per capita on health was 336 dollars per inhabitant. By 2018, 94.44% of the country's population was enrolled in the SGSSS.

18. The EPSs are the insurers that engage the population with the health system and are responsible for registering enrollees and collecting their contributions. Their basic function is to organize and guarantee, directly or indirectly, the provision of the mandatory health plan for members (Law 100, 1993). Any person after their enrolment in an EPS must be assigned to one of the IPSs, according to their choice, for outpatient care through the provider network set up by the EPS.

19. The Health Benefits Plan (formerly Mandatory Health Plan) contains a set of health services that all EPSs, without exception, must provide to all persons who are enrolled in the Social Security Health System by the Contributory or Subsidized Regime (Ministry of Social Protection, 2004).

20. Through the SGSSS the conditions of access to a Health Benefits Plan for all the inhabitants of the national territory are created. This plan should allow the integral protection of families to maternity and general illness, in the phases of promotion and health promotion for the prevention, diagnosis, treatment and rehabilitation of all pathologies, according to the intensity of use and the levels of care and complexity. that are defined (Law 100, 1993).

21. The ***Contributory Regime*** is a set of rules that govern the enrollment of individuals and families in the SGSSS, through the payment of an individual and family contribution, or a prior economic contribution financed directly by the enrollee or together between the latter and their employer (Law 100, 1993). The ***Subsidized Regime*** corresponds to a set of rules that govern the enrollment of individuals in the SGSSS, through the payment of a totally or partially subsidized contribution, with fiscal or solidarity resources (Law 100, 1993).

1.2 Description of the borrower's past experience with the World Bank in the health sector.

22. The experience of MADS in projects with the World Bank is scarce. A previous project financed by the Bank (Solid Waste Management Program Project CO-P101279) created capability in the MADS regarding knowledge of the Bank's operational policies and their relationship with the Colombian regulatory framework. There are no recent records of the MSPS in projects with the Bank where HCW will be managed.

23. Since then, the GoC regulatory frameworks have evolved by developing complementary standards that clearly establish the roles and responsibilities of each of the actors in the sequence of HCW generation. Additionally, decentralization of management entails the responsibilities of compliance with public policies in the territory, for which the GoC has established responsibilities at each level of intervention.

2. THE PROGRAM

2.1. Program Scope

24. **The program to be supported by this PforR is part of the Government's 2018-2022 PND.** The main objective of the health sector program is to simultaneously improve the health status of the population, guaranteeing high standards of quality and satisfaction on the part of the users, as well as the optimal use of available resources. In order to achieve this triple aim, the Government program proposes the construction of a pact that allows all the agents of the health system and civil society, in a concerted manner and through clear commitments, to ensure that the health system is effectively leveraged as one of the priority accelerators for social mobility and equity. The Government's health sector program connects six broad objectives: (i) strengthen the stewardship and governance of the health system; (ii) define public health priorities and interventions; (iii) organize all health sector actors around the promotion of quality services; (iv) invest in infrastructure and allocate resources to ensure access and foster quality; (v) develop, strengthen and properly recognize the value of human resources for health; and (vi) reach efficiency in spending through the optimal use of the resources available and the addition of new resources from all stakeholders. The PND allocates COP$119 trillion (US$ 35,000 million) for the period 2019 – 2022 of public resources to the health program.

25. **Program Scope.** The PforR will support specific results under objectives I, III, V and VI of the health program of the PND, and objective II of the Pact for Women of the PND, that are related to improving quality and efficiency in the SGSSS. The Program will focus its support in the health sector stewardship and managerial functions of the MSPS and will support the development of policies and regulations required to achieve its expected results during the three-year (2020-2022) implementation period. Focusing the PforR resources on these quality and efficiency related interventions will ultimately contribute to the financial sustainability of the health system and to improvements in population health, especially in women's health.

The proposed PforR will be structured around two results areas:

(a) Results area 1: improve the quality of healthcare services; and
(b) Results area 2: improve efficiency in the delivery of healthcare services.

2.2. Geographical scope of the Program. The Program will be implemented nationwide.

Exclusions: No land acquisitions are planned in the Program and no construction is planned either.

2.3. Program Objectives

26. **The Development Objective of the Program** is to support improvements in the quality of health care services and in the efficiency of the health system.

27. **The higher-level objective of the Program** is to contribute to the longer-term goals of strengthening the financial sustainability of the health system and improving health outcomes.

28. **Three PDO indicators have been selected to measure progress in achieving the two results areas of the Program.** The three PDO indicators proposed are also indicators of the PND endorsed by the Colombian parliament, for which the Government has committed the achievement of specific results by the end of calendar year 2022:

(a) Percentage of women with breast cancer detected in early stages, up to stage IIA, at the time of diagnosis;
(b) Performance index for public hospitals (composite performance index of 17 performance indicators); and
(c) Efficiency gains achieved over the period 2020-2022 with new regulations in the pharmaceutical market.

3. DESCRIPTION OF THE SOCIAL AND ENVIRONMENTAL SYSTEMS APPLICABLE TO THE PROGRAM

3.1. Key Program implementation agencies and partners

29. The implementation of the Program will be executed and supervised at national level using the regulations and capabilities of the existing substantive areas, corresponding to the MSPS.

30. The MSPS within the framework of its powers, formulates, adopts, directs, coordinates, executes and assesses public policy in the field of health, public health, and social promotion in health, and participates in the formulation of pension policies, periodic economic benefits and professional risks. Furthermore, it directs, guides, coordinates and assesses the SGSSS and the General Professional Risks System, under its powers, additionally formulates, establishes and defines the guidelines related to the Social Protection information systems.

31. The MSPS is comprised of two deputy ministries: the Deputy Ministry of Social Protection and the Deputy Ministry of Public Health and Service Provision, and by the Office of the Minister with specific functions in Formulation, implementation and monitoring of policies with specific offices equipped with specific working groups on Assistance and Management (Assistance and Reparations Group for Victims of Armed Conflict; Ethnic Affairs Group; Disability Management Group; Integral Social Promotion Management Group; Health Disaster Risk Management Group, Management and Promotion of Social Participation in Health Group, among others).

3.1.1. The key areas and partners in Social participation

32. The key areas and partners in Social Participation in the Colombian Health System are engaged in the Policies, Plans and Programs that are based on an important regulatory framework, in the 2018-2022 PND and in the CONPES documents. The MSPS through Resolution 2063 of 2017 adopts the PPSS for the purpose of fulfilling the responsibility of strengthening the citizenry in health processes, developing actions that allow the State to guarantee the right to social participation in health policy generating conditions for the active and effective participation of citizens. Additionally, the "Office of Territorial Management Emergencies and Disasters", through the "Management and promotion of social participation in health" Group under the Office of the Minister tracks, monitors and assesses the implementation of the PPSS, articulates with society through various mechanisms of social participation in health, such as the Territorial Councils for Social Security in Health (CTSSS); the Community Attention Department (SAC); the User Attention System (SIAU); Community Participation Committees (COPACO); Users Association; Hospital Ethics Committee; and Citizens' Health Inspectorships. The Office of Social Promotion (attached to the Minister's Office), through the Ethnic Affairs Group, interacts with these minorities as described below.

33. Law 10 of 1990 gives the community the opportunity to participate in health organization councils and, Decree 1416 of 1990, incorporates the head of the Directorate of Departmental and Municipal Health in structuring the National Councils of Social Security in Health (COPACOS). Article No. 175 of Law 100 of 1993 states that "The territorial entities at the sectional, district and local levels may create a Territorial Council for Social Security in Health that advises the Health Directorates of the respective jurisdiction, on the formulation of health plans, strategies, programs and projects and in the guidance of the Territorial Social Security in Health Systems, which carry out the policies defined by the National Council of Social Security in Health. Decree 1216 of 1989 that creates the COPACOS. Law 1751 (Statutory Health Law) in chapter II "Guarantee and mechanisms of protection of the fundamental right to health", Article 12. Participation in the decisions of the health system. It sets forth that: "The fundamental right to health includes the right of individuals to participate in decisions taken by health system agents that affect or are of interest to them."

34. The Integral Territorial Action Model (MAITE) seeks to strengthen local authorities and engage the community in joint work to develop plans that improve the health of the population. To this end, the health needs of each territory shall be identified to direct the assistance provided by the MSPS. The MAITE has just been designed to replace the Comprehensive Healthcare Model (MIAS) and is the new operational approach of the Comprehensive Healthcare Policy (PAIS). It will be carried out through eight lines of action: Insurance, Public Health, Provision of services, Human Talent in Health, Financing, Differential approach, Intersector articulation and Governance. MAITE is the management instrument used to improve the health conditions of the population through coordinated actions between the agents of the health system, agents of other systems and the communities, under the leadership of the department or district, which identifies priorities and establishes actions that are operationalized through inter-institutional and community agreements, with the support and facilitation of the MSPS. It stipulates that there must be opportunities for all populations, according to life course, ethnicity, disability status, gender or sexual identity or victim of armed conflict, and according to their geographical (territorial milieu where they live: urban , rural or dispersed rural), cultural, historical and social conditions, have at their disposal health services, procedures, actions and interventions, under conditions of acceptability, accessibility and quality. Similarly, the differential approach of the MAITE proposes the integration of a pre-existing Program of Psychosocial Care and Comprehensive Assistance to Victims (originating in Law 1448 of 2011, Article 137), which will be the procedures and interventions for comprehensive healthcare and psychosocial care, aimed at overcoming health and psychosocial effects related to the victimizing event. It also stipulates a comprehensive pathway of care for victims of gender violence, a protocol and model of comprehensive healthcare for victims of sexual violence. It additionally proposes a health sector response plan for the migration phenomenon containing two strategies: first, the enrolment of the population of returnees and regular migrants, and second, the development of care packages for groups and events prioritized in the Plan.

National Entities

35. The Office of Social Promotion, among the agencies attached to the ***Office of the Minister of Health and Social Protection***, coordinates the formulation and implementation of programs and projects targeting vulnerable populations (displaced populations, the disabled, older adults, early childhood, victims of armed conflict and intrafamily abuse, people with mental disorders and ethnic groups). This agency participates in the design of health models specific to ethnic groups and in the coordination of the public health plan with them and provides guidance on the pathway for access to the right to health to populations in a situation of displacement, through the Assistance and Reparations Group for Victims of Armed Conflict it implements the PAPSIVI. A process, which started six years ago, set out to address the psychosocial impacts and damage to the physical and mental health of the victims caused by or in relation to the armed conflict, in the individual, family and community spheres in order to mitigate their emotional suffering, contribute to physical and mental recovery and the reconstruction of the social fabric in their communities.

36. The ***Deputy Ministry of Public Health*** *and Service Provision* is comprised of the Directorates of Epidemiology and Demography; of Medications and Health Technologies; Healthcare Human Talent Development; Service Provision and Primary Care, and Promotion and Prevention. Dependent on the latter, the Deputy Directorate of Environmental Health is responsible for determining Environmental Health public policies and monitoring compliance with regulations at sub-national levels.

37. The ***Deputy Minister of Social Protection*** is the main relevant actor in the implementation of the Program through its articulation with IPS and EPS entities. It is part of the Directorates for Regulation of the Operation of Health Insurance, Occupational Risks and Pensions; of Regulation of Benefits, Costs and Rates of Health Insurance; of Sector Financing.

38. ***Administradora de los Recursos del Sistema General de Seguridad Social en Salud (ADRES),*** is responsible for the administration of the health system resources and payments and for maintaining the consolidated database for people affiliated to the mandatory social security system (*Base de Datos Única de Afiliados*, BDUA). In this sense, Program funds will be transferred to ADRES through the monthly UPCs, which finance the operation of the mandatory health insurance system.

39. ***The National Health Superintendence (Superintendencia Nacional de Salud, NHS)*** is the authority responsible for the set the policies of the inspection, surveillance and control of the constitutional and legal norms of the health sector and its resources. In this sense, as part of its mandate, NHS will help ensure the appropriate application of health resources and that the public and private actors subject to its surveillance are fulfilling their obligations.

40. ***The National Planning Department*** (DNP) is responsible for the preparation, socialization, assessment and monitoring of the PND and coordinates the inclusion of relevant comments by the National Planning Council, the CONPES and other civil society actors. The DNP performs the duties of Executive Secretariat of CONPES. The PND is the formal and legal instrument through which government objectives are set out and at the same time allows the assessment of government management. The legal framework of the PND is governed by Law 152 of 1994, which contains, among others, the general planning principles, the definition of the national planning authorities and instances, and the procedure for the preparation, approval, execution and assessment of the PND.

41. ***The CONPES***: It is the highest national planning authority and serves as an advisory body to the GoC in all aspects related to the economic and social development of the country. It coordinates and guides the agencies responsible for economic and social management in the Government, through the study and approval of documents on the development of general policies that are submitted in session. The most relevant CONPES documents in the framework of the project are: CONPES 3918 of 2018, to achieve the Sustainable Development Goals; CONPES 147 of 2012 on Preventing teenage pregnancy; CONPES 155 of 2012 on National pharmaceutical policy; CONPES 161 of 2013 on Gender Equality for women; CONPES 3550 of 2008 on Guidelines for the formulation of the comprehensive environmental health policy; CONPES 3874 of 2016 National policy for the integral management of solid waste; and CONPES 3950 of 2018 Strategy for the attention of migration from Venezuela.

Subnational Entities

42. The ***Departments*** must direct, coordinate and monitor the health sector and the SGSSS in the territory of their jurisdiction, taking into account national provisions on the subject. The ***Municipalities*** are in charge of directing and coordinating the health sector and the SGSSS within the scope of their jurisdiction. The ***Districts*** shall have the same powers in Health as the municipalities and departments, except for those that correspond to the intermediation function between the municipalities and the

Nation[5].

43. The ***Departmental and District Health Directorates*** carry out the inspection, oversight and control of the content, quality and reporting of the information that comprises the Quality Information System. The ***Offices of Director of Municipal Health*** carry out an ongoing active search of the Health Services Providers that operate in their respective jurisdictions, for the purpose of informing the Departmental Entities. The Departmental, District and Local Health Directorates, perform the inspection, oversight and control of the internal management of waste generated in healthcare activities.

International organizations

44. The ***Pan American Health Organization*** (PAHO) is the international organization specialized in public health in the Americas. PAHO are committed to ensuring that each person has access to the quality healthcare they need, and without falling into poverty. Through its work, it promotes and supports everyone's right to health, fosters cooperation between countries and works collaboratively with ministries of Health and other government agencies, civil society organizations, international agencies, universities, social security agencies, community groups and other partners. PAHO ensures that health is included in all policies and that all sectors do their part to ensure that people live longer and better years of life, because health is our most valuable resource.

Stakeholders from ethnic groups and indigenous Peoples

45. Colombia is a multiethnic and multilingual country in that 14.4% of people belong to an ethnic group that differs from the majority of society and there are four recognized ethnic groups: the indigenous population (3.4%), the Raizal Archipelago population of the San Andrés, Providencia and Santa Catalina Archipelago (0.08%), the black or Afro-Colombian population (10.5%), - of which the *Palenqueros* of San Basilio are a part from the municipality of Mahates in the Department of Bolívar- (0.02 %), and the Rom or Roma population (0.01%)[6].

46. The Office of Social Promotion of the MSPS deals with relations with indigenous peoples, black Afro-Colombian communities, *Raizales* and *Palenqueros*, and the Rom (Gypsy) People. They are populations whose social, cultural and economic conditions and practices distinguish them from the rest of society and who have maintained their identity throughout history, as collective subjects that affirm their individual origin, history and cultural characteristics (self- recognition), which are expressed in their worldviews, customs and traditions. According to the 2005 census of the DANE, 14.4% of the people in Colombia belong to an ethnic group. There is participation in consensus-building meetings where standards of care are established that respect their ethnic and cultural identity, forms of social organization and linguistic characteristics, without the need to create a special health system for each ethnic group.

47. The ***Permanent Coordination Workgroup with indigenous peoples and organizations*** is a space for articulation between the GoC agencies and the delegates of the indigenous organizations and the representatives of the Indigenous Peoples. Decree 1848 of 2017 establishes the Licensure System of Indigenous Health Insurance Enterprises (EPSI), applicable during the period of transition to the SISPI and other provisions are set forth. This decree comprises a set of requirements and procedures that determine the administrative, scientific, technical, cultural and financial conditions, to guarantee access to health services with a differential approach to its enrollees, considering the

[5] Articles 43, 44 and 45 of Law 715 of 2001.
[6] 2005 DANE Census

socio-cultural and geographical characteristics of indigenous peoples, to operate in the subsidized Health regime.

48. The ***National Social Protection Workgroup of black, Afro-Colombian, Raizales and Palenquero communities***, guaranteed the inclusion of the differential approach in health plans, programs and projects, as well as the prioritization of actions in disease prevention and health promotion for this population. In this context, the agreement was made, among other things, to cover 100% of the Afro population in the General Health System according to national and territorial powers, to launch a National Social Protection Workgroup for these communities with the participation of other entities from the health sector, such as the Colombian Institute of Family Welfare (ICBF), National Apprenticeship Service (SENA), MADS, Social Action (*Acción Social*), *Supersalud, Supersubsidio Familiar*, National Institute of Health, National Institute for Food and Drug Surveillance (INVIMA), Office of the Attorney General and Advocate's Office, among others.

49. The ***Health Workgroup for the Rom people***. Under the aegis of Decree 2957 of 2010, work on public health actions for the gypsy ethnic group needs to cover all members of the respective *Kumpañia* [7], and these last need as well to establish intercultural, qualitative and quantitative indicators of the public health situation of the population, and tracking and monitoring mechanisms, in order to verify the effect of these health actions, the impact of resources and the adoption of measures targeted at preserving or recovering the health of its members. Within the framework of the PND, guidelines are developed (pending) with directives and guidelines for socio-cultural adaptation and inclusion of the intercultural approach for the Rom people

Venezuelan migrant and refugee stakeholders

50. The ***migrations division reporting to the office of the Deputy Minister of Health*** manages Venezuelan migration Colombia receives through the Health Sector Response Plan to the Immigration Phenomenon. According to official estimates for August 2019, there are 1.4 million registered migrants and in 2018 the health system provided 800,000 consultations to more than 200,000 people of Venezuelan origin. Some reside under a PEP created by the Ministry of Foreign Affairs, which allows them access to health, education, work and childcare. Others are in the country within the time established for foreigners, and there are also migrants under an irregular situation (they overstayed, or they entered the country without authorization). Additionally, in the border areas there are movements of Venezuelans who enter Colombia and return to Venezuela with a TMF through the checkpoints set up in the border area (Pendular Migration). Among the management possibilities of the Response Plan, work is underway to find solutions to be able to enroll migrants the subsidized health regime who currently cannot meet the requirements provided in the SISBEN. The migrant population from Venezuela also includes victims of the Colombian internal armed conflict that left the country and that as a result of the political, social and economic upheaval in Venezuela, have returned to Colombia. The needs of migrants in transit to third countries also need to be considered. The increase in the number of migrants from Venezuela has generated healthcare needs for this population (among others) accelerating pressures on institutions, services, and related social aspects over a very short time.

Gender violence stakeholders

51. The ***National Violence Observatory*** (ONV) is an inter-sector space provided by the MSPS, in order to promote the generation, collection, analysis and dissemination of information on gender violence and how to approach it in a comprehensive manner in the national territory.

[7] *Conjunto de patrigrupos familiares pertenecientes a un mismo linaje Rom, o linajes diferentes que han establecido alianzas entre sí, que comparten espacios para vivir cerca o para itinerar de manera conjunta.*

52. The ***Integrated Information System on Gender Violence*** (SIVIGE) was built through the exchange and technical work carried out in the National Intersectoral and Inter-Institutional Coordination Mechanism for the comprehensive approach to gender violence[8]. Alongside the MSPS, the Ministry of Justice and Law, the DANE, the Presidential Counselor's Office for Women's Equality, and the National Institute of Legal Medicine and Forensic Sciences work on the formulation and implementation of the SIVIGE[9]. The goal of SIVIGE is to provide, integrate, harmonize and disseminate statistical information on gender violence, based on quality standards, the principles of official statistics and international standards, to support the design, implementation and assessment of public policies and the targeting of actions that allow approaching gender violence in a comprehensive manner to ensure the effective enjoyment of rights.

Mechanism for Petitions, Claims, Requests and Complaints (PQRSD)

53. A PQRSD is institutionalized in the GoC for all its ministries and divisions. Especially in the MSPS, the "Citizen Services" division implements a section where a petition, complaint, claim, suggestion or whistleblowing can be formulated respectfully through the MSPS PQRSD web form (https://www.minsalud. gov.co/atencion/Paginas/Solicitudes-sugerencia-quejas-o-reclamos.aspx). Any of these shall be processed by the Citizen Services Group, in accordance with the guidelines established in Resolution 3687 of August 17, 2016. Depending on the type of petition, the deadlines established for resolution are established between 10 and 30 days, although most should be settled within 15 days. Furthermore, users are instructed on the said page to refer to another division of the GoC if the request does not fall under the purview of the MSPS.

3.1.2. The key areas and environmental partners

54. The key areas and environmental partners in the Colombian Health System are focused on the management of HCW that has two instances, one within the health establishments (intramural) determined under MSPS policies, and another outside the Provider Entities (extramural) under the supervision of the MADS. Decree 351 of 2014 (compiled in Decree 780 of 2016 - Single Regulatory Decree of the Health Sector-) is for purposes of regulating from an environmental and health standpoint the integral management of waste generated in healthcare and other activities.

55. The Deputy Ministry of Public Health and Service Provision of the MSPS through the ***Deputy Director of Environmental Health*** is responsible for determining Environmental Health public policies and monitoring compliance with regulations at sub-national levels. It is also the governing body for the Integral Management of Hospital Waste and similar. The internal management of waste or hazardous waste, sharps, that with biological or infectious risk, is established in the Manual for the Integrated Management of Waste Generated in Health Services and other Activities (Decree 351 of 2014, compiled in Decree 780 of 2016), and includes the action carried out by the generator, which involves the coverage, planning and implementation of all activities related to minimization, generation, segregation, internal movement, internal storage and/or waste treatment within its facilities.

56. The ***MADS*** is the body governing environmental and renewable natural resource management. It directs the National Environmental System (SINA), formulates public policy in regard to WEEEs, and through the Chemical Substances, Hazardous Waste and Ozone Technical Unit Group is responsible for the Policy for Comprehensive Management of Solid Waste. It regulates the prevention and management of hazardous waste or waste generated within the framework of comprehensive

[8] Enshrined in in the foundations of the PND Law 1753 of 2015

[9] According to article 31 of Law 1719 of 2014 and article 12 of Law 1761 of 2015

management and establishes the requirements and procedure for the Registry of Generators of Waste or Hazardous Waste.

57. The ***National Institute of Health*** (INS) is the scientific-technical authority and has the purpose of reducing and/or mitigating the negative impacts that may be generated on the environment and health, through compliance with legal requirements and current environmental regulations. It promotes awareness, environmental training and communication in ongoing fashion, focusing its efforts on the proper management of solid waste, discharges and atmospheric emissions. It has developed the Integrated Waste Management Manual and establishes the assessment mechanisms through the monitoring and tracking programs.

58. The ***Institute of Hydrology, Meteorology and Environmental Studies*** (IDEAM) provides technical and scientific support to the SINA, it generates knowledge, produces reliable, consistent and timely information on the state and dynamics of natural resources and the environment. It is responsible for the Registry of Generators of Waste or Hazardous Waste, aimed at improving the knowledge of the issues associated with this type of waste, planning its management and establishing priorities for the definition of actions.

59. The ***National Institute for Food and Drug Surveillance*** (INVIMA) is the National Regulatory Agency and is a scientific-technical surveillance and control entity, which works through the application of the sanitary norms associated with the consumption and use of food, medicines, medical devices and other products under sanitary surveillance for the protection of individuals and the collective health of Colombians.

60. The ***Regional Environmental Authorities*** (*Regional Autonomous Corporations, Corporations for Sustainable Development, and Urban Environmental Authorities*) are responsible for the implementation of extramural hazardous waste policies (collection, storage, transport, treatment, use and/or final disposal of HCW) in accordance with the legal provisions and policies of the MADS.

61. The ***Regional Autonomous Corporations and those for Sustainable Development*** corporate entities of a public nature, created by law, integrated by the territorial entities which, because of their characteristics constitute the same ecosystem geographically or form a geopolitical, biogeographic or hydrogeographic unit, endowed with administrative and financial autonomy, their own assets and legal status, responsible by the law for managing, within the area of their jurisdiction, the environment and renewable natural resources and to advance their sustainable development. They are the top environmental authority at the regional level and are responsible for the sustainable and rational use of renewable natural resources and the environment in their respective jurisdiction, the promotion of scientific research and technological innovation, manage the regional land planning process to mitigate and deactivate pressures from inappropriate exploitation of the territory, and to foster, with the cooperation of national and international entities, the generation of appropriate technologies for the use and conservation of resources and the environment of their area of influence.

62. The ***Urban Environmental*** *Authorities* are present in municipalities, districts or metropolitan areas whose urban population is equal to or greater than one million inhabitants. They carry out the duties of the Regional Autonomous Corporations in their jurisdiction.

3.1.3. Laws, regulations and environmental and social policies.

63. Relevant laws, regulations and policies at the national level for the proposed Program were analyzed. The analysis covered whether there are any significant gaps that would prevent accomplishing the environmental and social goals included in the basic principles of the ESSA. Table N

° 1 provides a detailed analysis of the legal and regulatory framework applicable to the Program.

64. The provisions of the existing legal and regulatory environmental framework are adequate, the compilation of the rules in an updated decree facilitates their understanding and implementation. While the provisions of the Biomedical, Chemical and WEEE Waste Management Standards are being implemented by Departmental, District and Municipal authorities, efforts are required to improve the monitoring of the management of the different types of waste, both intra and extramural, by national authorities (MSPS and MADS).

65. The existing legislative framework is adequate to guarantee the social sustainability and interest of the marginalized and vulnerable population, including the population belonging to indigenous peoples, ethnic groups, and migrants.

66. Regulations for PQRSD Article 74 of the Political Constitution of Colombia guarantees that "All persons have the right to access public documents except in cases established by law." Law 1755 of 2015 regulates the Fundamental Right of Petition and replaces a title of the Code of Administrative Procedure and Administrative Law, for the purpose of providing all people with the right they have to submit petitions, complaints, claims, suggestions, etc., in a respectful manner to the authorities for reasons of general or specific interest and to obtain a prompt response.

67. In the case of the issuance of administrative acts (Laws, Decrees, Resolutions) there is a public consultation mechanism that consists in the web publication of the project and comments, criticisms and suggestions that, after being considered, are incorporated into the administrative process of the Ministry for their enactment. The mechanism is established under Law 1437 of 2011, especially in article 8 thereof on “Duty of information to the Public”.

Table N ° 1: Environmental and social laws, regulations and policies that are relevant to the proposed Program.

Policy / Applicable Law / Regulation	Objective and provisions	Relevance to the program and key conclusions
Political Constitution of 1991	Establishes collective and environmental rights (Chapter III. Articles 78 to 82)	Relevant conceptual framework
Law 99 of 1993	Ensure the adoption and execution of the respective policies, plans, programs and projects, in order to guarantee the fulfillment of the duties and rights of the State and of private citizens in regard to the environment and the natural heritage of the Nation.	Relevant conceptual framework
Law 715 of 2001	Established the powers of the Nation and territorial entities in the health sector, as well as the resources to be allocated to the territorial entities in accordance with the General Share Interest System. Article 43. Powers of health departments. Article 44. Powers of municipalities. Municipalities responsible for leading and coordinating the health sector and the SGSSS within the scope of their jurisdiction. Article 45. District powers in respect to health.	Relevant to the General Program, it establishes the responsibilities at the level of the territorial authorities for decentralization of the implementation of environmental health policies.
Law 1438 of 2011	Its objective is the strengthening of the SGSSS.	It is relevant to the Program because the health insurance and quality are consistent with the goals of the SGSS (generating conditions that protect the health of Colombians, with the well-being of the user as the central pillar and articulating core of health policies).
Law 1751 of 2015	Its purpose is to guarantee the fundamental right to health, regulate it and establish its protection mechanisms	Relevant to the Program
Decree 1609 of 2002.	Regulates the handling and overland transporting of hazardous goods	Pertinent, relevant to HCW transportation.

Policy / Applicable Law / Regulation	Objective and provisions	Relevance to the program and key conclusions
Decree Law 4109 of 2011	Operate and develop the public health surveillance and control system within the framework of the SGSSS. Coordinate the surveillance of risks and threats to public health and protect communities against them.	Pertinent
Law 1252 of 2008.	Sets forth prohibitions on environmental matters, referring to RESPEL.	Relevant to the management and final disposal of Hazardous Waste
Resolution 0371 of 2009	Establishing guidelines for the Management Plans for the Return of Post-Consumer Products such as Drugs or Expired Medications.	Relevant for the management and final disposal of waste generated by expired drugs.
Resol 18005/2010. Ministry of Mines and Energy	adopts the Regulation for the management of radioactive waste.	Relevant conceptual framework for the management of radioactive health-care waste establishments.
Decree 2972 of 2010	Establishes as part of the duties of the National Intersectoral Technical Commission for Environmental Health (CONASA) the "Promotion of the creation of Territorial Councils on Environmental Health (COTSA) by the member Ministries and guide their regulation".	Creation and maintenance of relevant technical spaces for decision-making, management and intersectoral coordination in addressing social and environmental determinants that affect the quality of life and health of the population.
Decree 351 of 2014.	Update the standard for waste generated in healthcare and other activities	Relevant conceptual framework
Decree 1076 of 2015	Single regulatory decree of the Environment and Sustainable Development sector.	Relevant conceptual framework that compiles and organizes the legislation for the management and final disposal of extramural RES.
Resolution 1536 of 2015	Establishes the process of Integral Planning for Health and provides the regulatory grounds for carrying out a Territorial Health Situation Analysis and the Characterization of the population enrolled in the Benefits Plan Administration Entities (EAPB).	Relevant because the EAPBs are responsible for compliance with the Policy in accordance with its users and their organizational forms.

Policy / Applicable Law / Regulation	Objective and provisions	Relevance to the program and key conclusions
Decree 780 of 2016	Single Regulatory Decree of the Health Sector (Compiles Decree 351/2014).	Relevant conceptual framework that compiles and organizes the legislation for the management, treatment and final disposal of extramural RES.
Decree 284 of 2018.	Comprehensive management of WEEEs.	Relevant conceptual framework for the management of WEEEs.
Law 1806 of 2016	Establishes the State policy for the Integral Development of Early Childhood from Zero to Forever within the framework of the Integral Protection Doctrine.	Relevant conceptual framework that connects Healthcare from the beginning of life.
Decree 1953 of 2014	Create a special regime to put into operation the Indigenous Territories regarding the administration of the indigenous peoples' own systems, in accordance with the provisions established herein, until such time as the law that is the subject of article 329 of the Political Constitution is enacted. (SISPI).	Conceptual framework relevant to health policies for indigenous peoples.
Decree 1397 of 1996	Creates the National Commission of Indigenous Territories and the Permanent Coordinating Workgroup with the peoples and organizations.	Conceptual framework for coordination with indigenous Peoples.
HEALTH AND SAFETY AT WORK		
LAW 1562 OF 2012	"Under which the Occupational Risk System is modified and other provisions on Occupational Health are issued".	Relevant conceptual framework for the operators of the HCW management system.
DECREE 1072 OF 2015	"Whereby enacting the Single Regulatory Decree of the Labor Sector" - Chapter 6. Defines the mandatory guidelines to implement the Occupational Health and Safety Management System.	Conceptual framework relevant to the Occupational Health and Safety Management System.
DECREE 52 OF 2017	"Whereby article 2.2.4.6.37 of Decree 1072 of 2015, Single Regulatory Decree of the Labor Sector, on the transition for the	Conceptual framework relevant to the Occupational Health and Safety Management System.

Policy / Applicable Law / Regulation	**Objective and provisions**	**Relevance to the program and key conclusions**
	implementation of the Occupational Health and Safety Management System is modified".	
RESOLUTION 0312 OF 2019	"Whereby the Minimum Standards of the Occupational Health and Safety Management System SG-SST are defined".	Conceptual framework relevant to the Occupational Health and Safety Management System.
Colombian Technical Standard NTC OHSAS 18001	Good practices	Good practices relevant to the Occupational Health and Safety Management System.
Occupational Risk Assessment Institute of Hygiene and Safety of Spain- INSHT. GTC 45 of 2012. NTC 4114 Industrial Safety - Performing Planned Inspections. NTC 3701.		
CONPES		
CONPES 147 of 2012	Pregnancy prevention in adolescence.	Reproductive Health Diagnosis and Management Plan.
CONPES 155 of 2012	National pharmaceutical policy.	Drug acquisition diagnosis and management plan.
CONPES 161 of 2013	Gender equality for women.	Gender Equality Diagnosis and Management Plan.
CONPES 3550 of 2008	Guidelines for the formulation of the comprehensive environmental health policy.	Management of hazardous waste inside health establishments
CONPES 3874 of 2016	National policy for the integral management of solid waste.	Management of hazardous waste outside health establishments, and their final disposal.

Policy / Applicable Law / Regulation	Objective and provisions	Relevance to the program and key conclusions
CONPES 3918 of 2018	For the achievement of sustainable development goals.	Diagnosis and Management Plan on background in the prevention of cervical cancer.
CONPES 3950 of 2018	Strategy for the attention of migration from Venezuela.	Integration into the health systems of migrants arriving in Colombia from Venezuela.
PARTICIPATION		
Law 1757 of 2015	Its purpose is to promote, protect and guarantee modalities of the right to participate in political, administrative, economic, social and cultural life, and also to control political power.	Relevant for citizen participation mechanisms.
Resolution 2063 OF 2017	For the purpose of adopting the PPSS, and applying to the members of the health system, within the framework of its powers and duties.	Pertinent
MECHANISM FOR PETITIONS, CLAIMS, REQUESTS AND COMPLAINTS (PQRSD)		
Resolution 3687 of 2016	Regulates the processing of requests, complaints, claims, whistleblowing, congratulations and requests for access to information made to the MSPS.	Articulation of users with the MSPS and other GoC bodies for access to information, requests, complaints, claims, whistleblowing, congratulations.

4. PROGRAM CAPACITY AND PERFORMANCE ASSESSMENT

4.1. Capabilities to implement the program's environmental and social management system

68. The capability of the institutions to effectively implement the program's environmental and social management system is considered adequate considering the regulations (extensive regulatory framework) developed through a process of consensus-building and discussion in the agreements that make up the PND and that are latter reflected in the CONPES documents, Laws, and Decrees.

69. The "Program to improving the quality of health care services and efficiency in Colombia" is based on strengthening the MSPS for the SGSSS. The MSPS leads the formulation of the PPSS, which aims to guarantee the right of citizens to be engaged in the decision-making of the sector that affects or interests them on the part of the members of the SGSSS, in order to comply with the Statutory Health Law.

70. The organizational and administrative structure of the MSPS described in the previous section demonstrates that the institutional capability (personnel, budget, availability of implementation resources, training, etc.) is adequate in light of the current evidence to carry out responsibilities defined under the Program's system. A division of responsibilities exists under the same approach that, when embodied in consensus-building processes, strengthens the system, even if the processes may be longer than expected.

71. Under the mandate of the National Constitution of 1991, Colombia is a decentralized unitary Republic, with autonomy of its territorial, democratic, participatory and pluralistic entities. Under this mechanism of administrative decentralization, a large part of the State administration is performed in shared fashion between the administrative entities at the central and territorial levels (departments, municipalities and districts). This national status makes the implementation of the Program automatic without the need to generate specific implementation arrangements for the program, providing immediate effectiveness and efficiency in inter-institutional articulation.

72. The approach to environmental issues involving the MSPS and MADS is fully integrated and is reflected in the operational sequences at the subnational levels.

73. The processes of drafting regulations undergo steps of public consultation before their final authorization. Some standards are "compiled" into unique standards to update and promote implementation.

74. To address and reduce inequities, the Government has established consultation mechanisms such as “Workgroups” and “Pathways” for the socio-cultural adaptation and inclusion of the intercultural approach for ethnic groups, indigenous peoples, and vulnerable populations. These are spaces where they build consensus and establish standards of care that respect their ethnic and cultural identity, forms of social organization and their own linguistic characteristics.

75. As in all areas of government, the MSPS has a system of procedures for Petitions, Complaints, Claims, Suggestions and Whistleblowing.

5. ENVIRONMENTAL AND SOCIAL SYSTEMS ASSESSMENT (ESSA)

5.1. Introduction to the ESSA and general description.

76. ESSA is a Program document prepared by Bank staff for a thorough assessment of: (1) the systems that the GoC implements to manage the benefits, risks and environmental and social impacts that are associated with the program to improve the quality and efficiency of the Colombian health system; and (2) the institutional capability of the government to plan, monitor and report on environmental and social management measures under the Program.

77. Its findings have the goal of ensuring that programs supported by PforR financing are implemented in a manner that maximizes potential environmental and social benefits and avoids, minimizes or mitigates adverse environmental and social impacts and risks. These findings contribute to the preparation of the Program Action Plan (PAP) that the government is expected to use to close the significant gaps in existing environmental and social management systems in line with the sustainability principles of the PfoR.

78. From an environmental point of view, the ESSA assesses the system, capability and performance of the government through the review of national and sectoral laws relevant to the Program, regulations, protocols on public health issues, but specifically HCW management services (RES) (handling, transport and final disposal). It also assesses aspects of occupational health and safety (OHS) in health centers and their associated services system (transportation for collection and disposal of RES).

79. From the Social standpoint, the ESSA assesses that equal access to the Health System is guaranteed for all residents, including vulnerable groups, with a focus on gender and indigenous peoples as well as ethnic minorities. It is intended to ensure that there are no prejudices or discrimination against individuals or communities included in the scope of the Program, particularly considering indigenous peoples, ethnic groups, the lesbian population, gays, bisexuals, transsexuals, and intersex people (LGBTI), people with rare diseases and women in a condition of lawful abortion[10], minority groups and the less favored or vulnerable, especially in cases where there may be adverse impacts or where the development benefits have to be shared.

[10] Judgment of the Court. Judgment C-355/06

ESSA Basic Principles

Basic Principle 1: *Applicable*
The procedures and processes for environmental and social management are designed to (a) promote environmental and social sustainability in the design of the Program; (b) avoid, minimize or mitigate adverse impacts; and (c) promote informed decision-making related to the environmental and social effects of a Program.
Basic Principle 2: *Not applicable*
The procedures and processes for environmental and social management are designed to avoid, minimize or mitigate the adverse impacts on natural habitats and physical cultural resources that stem from the Program.
Basic Principle 3: *Applicable*
Protect public and worker safety against the potential risks associated with: (i) the construction and/or operation of facilities or other operational practices within the framework of the Program; (ii) exposure to toxic chemicals, hazardous waste and other hazardous materials within the framework of the Program; and, (iii) the reconstruction or rehabilitation of infrastructure located in areas prone to natural hazards.
Basic Principle 4: *Not applicable*
Land acquisition and loss of access to natural resources are managed in a manner that avoids or minimizes displacement, and helps the persons affected to improve, or at least restore, their livelihoods and living standards.
Basic Principle 5: *Applicable*
Due attention is paid to cultural appropriateness and equitable access to the benefits of the program, paying special attention to the rights and interests of indigenous peoples and the needs or concerns of vulnerable groups. |
Basic Principle 6: *Applicable*
Avoid exacerbating social conflicts, especially in fragile states, post-conflict areas or areas subject to territorial disputes.

Among the six basic principles that guide the analysis of the ESSA (Bank Policy and the Bank Directive for PforR), from an environmental and social standpoint, four are considered relevant to the Program.

5.2. ESSA methodology

80. Initially, information was collected from secondary data sources that were validated and supplemented through consultations and interviews with the key stakeholders. Officials and technicians from different divisions of the MSPS were also interviewed to gather evidence, functional knowledge and concerns.

81. Existing regulatory and policy frameworks were analyzed: environmental and social, worker health and safety. Legal and regulatory requirements were assessed, including those related to environmental conservation, pollution prevention, occupational health and safety and public safety, social inclusion and the transparency and accountability mechanism, and the social and environmental aspects related to the Program.

82. The operational procedures, existing institutional capability and the viability of the effective implementation of the Program activities were reviewed. Existing gaps are identified for remediation.

83. As part of the ESSA's preparation, discussions and consultations were held with key stakeholders at the MSPS and MADS. Specifically, special emphasis was placed on the offices of director connected to the Program's boundaries. Within the orbit of the MSPS and reporting to the Minister's Office: The Office of Social Promotion, the Ethnic Affairs Group, Assistance and Reparations Group for Victims of Armed Conflict, the Cooperation and International Relations Group and the migration division. Reporting to the Office of Deputy Ministry of Public Health: The Directorate of

Promotion and Prevention, the Management Group for Promotion and Prevention, the Directorate of Medications and Health Technologies, the Directorate of Healthcare Human Talent Development, the division for public disclosure of indicators for public hospitals AI Hospital, the Deputy Directorate of Environmental Health, the Directorate of Service Provision and Primary Care and its Deputy Directorate of Service Provision, and the Deputy Directorate of Healthcare Infrastructure. Reporting to the Deputy Minister of Social Protection: The Deputy Directorate of Health Insurance Costs and Rates. Within the orbit of the MADS, consultations were carried out with the Chemical Substances, Hazardous Waste and Ozone Technical Unit Group; the Deputy Directorate of Environmental Studies of the IDEAM. The consultations began on May 14, 2019, the interviews were conducted during a World Bank mission to Bogotá between May 27 and 31, 2019, hosting a workshop with the authorities of the Deputy Directorate of Environmental Health of the MSPS and MADS to complete and validate the sections regarding environmental issues. A new mission in Bogotá was carried out between August 12 and 16, 2016 and allowed drilling down into the social aspects of the ESSA.

6. ENVIRONMENTAL AND SOCIAL RISK SCORES

6.1 Risks and social considerations associated with the Program

84. This section provides an overview of the social risks associated with this Program, which are based on three of the ESSA Basic Principles (BP), BP 1, BP 5 and BP 6. BP 1 covers general aspects of environmental and social management, aims to promote environmental and social sustainability in the design of the Program, avoid, minimize or mitigate adverse impacts and promote informed decision making related to the environmental and social impacts of the Program. For BP 5 on Indigenous Peoples and vulnerable groups, the objective is to give due consideration to cultural suitability and equal access to the benefits of the Program, paying special attention to the rights and interests of indigenous peoples and the needs or concerns of vulnerable groups. BP 6 considers social conflicts, especially in fragile states, post-conflict areas, and has the goal of avoiding the exacerbation of social conflicts in fragile states, post-conflict areas or areas subject to territorial disputes. Basic Principle 4, land acquisition, is not relevant because the Program does not provide for any land acquisition, given that the Program is not compatible with any construction, so there will be no need for expropriations or resettlements as a result of the project, nor any limitation to access or use of land.

85. **Basic principle 1.- Summary of the findings**: The Program is expected to have positive impacts on population health, including the most vulnerable sectors, as well as women and children, and the adult population, including dispersed rural populations. The positive impacts are achieved through the expansion of access and use of efficient quality health services, by those enrolled in the SGSSS, from both the contributory and subsidized regime.

86. The ESSA results confirm that the current GoC system for managing the social aspects of the Program to improve the quality and efficiency of the Colombian health system has several strengths based on a current high enrolment coverage (94.4% in 2018[11]) to the SGSSS, a solid legal framework to improve equitable and inclusive access to EPS , a decentralized management system, with autonomy of its territorial, democratic, participatory and pluralistic entities established at the constitutional level. There are also long-standing institutional mechanisms based on the PND and the documents of the CONPES, so that a variety of stakeholders have partition spaces regarding the Health System, including procedures for PQRSD at the national and local level.

87. **Basic principle 5.- Summary of findings**: The Program has a low probability of any negative social impact.

88. A key social problem identified is related to inequalities in health care services in districts that are remote or connected with ethnic or indigenous minorities. The gaps in the provision of health services to ethnic minorities and indigenous peoples have been identified and assessed by the GoC in the document "Bases of the National Development Plan 2018-2022" and in the specific CONPES, establishing the steps to be followed and the key actors involved[12].

89. The Program further supports the State's indigenous health agenda, which is culturally appropriate, by improving the quality of medical care in all districts and also trying to overcome inequality in the provision of medical care among the poorest and most backward districts of the state. The Program supports equality in distribution and affordability, to overcome cultural, ethnic, migrant, returnee Colombians, victims caused by or in connection with the armed conflict, or gender for access or participation. It shall consider how to alleviate cultural, financial or physical barriers that hinder the

[11] Health Situation Analysis (ASIS) Colombia, 2018 Directorate of Epidemiology and Demography, MSPS.
[12] See paragraphs 8 and 9 of this document

participation of socially marginalized or disadvantaged groups (for example, dispersed populations, the poor, the disabled, children, the elderly, indigenous peoples or ethnic minorities, among others).

90. This Program is expected to generate fundamental social benefits, particularly through its efforts to strengthening quality and efficiency outcomes in the provision of health services in Colombia. The GoC will proactively continue the development of the inclusion workgroups and pathways provided in the CONPES for ethnic groups, continuing with the process to complete the SISPI (Complete Stage II of "Preparation of the Base Document, and validation of the 5th component" and Stage III "administrative act of the MSPS and submission to the Permanent Coordination Workgroup". For black, Afro-Colombian, *Raizales* and *Palenqueros*, and the Rom peoples' communities, it will conclude with the guidelines, directives and guidance for socio-cultural adaptation and inclusion of the intercultural approach that considers their standards of care that respect their ethnic and cultural identity, forms of social organization and linguistic characteristics for each ethnic group.

91. **Basic principle 6.- Summary of findings**: no exclusion of any group in terms of caste, religion or geography is expected for the activities of the Program. Furthermore, the country's health sector has been responding to the phenomenon of Venezuelan migration since 2015 and has recently strengthened its plan. The attention of returnee Colombians, who had left Colombia as a result of the armed conflict, has also been incorporated. However, increasing demand for services has increased the burden on primary care centers and local hospitals. In the case of victims caused by or in relation to the armed conflict, in the individual, family and community spheres, the PAPSIVI has been implemented, containing a set of activities, procedures, and interdisciplinary interventions designed by the MSPS for comprehensive health care and psychosocial care. The Program will also contribute to addressing the concerns that the GoC has seen in the first stage of PAPSIVI over the course of almost six years, and a second stage remains to be implemented.

92. A key concern from recent times is linked to the migration of population from Venezuela. This influx of Venezuelan migrants and Colombian returnees is generating significant fiscal, economic and social pressures on health institutions and services, particularly in receiving areas. Priorities that emerge in the migration process are associated with: (i) Psychosocial impact due to network fragmentation; (ii) Pregnant women, children and adolescents without access to promotion and prevention actions; (iii) Gender violence, trafficking in persons, etc; (iv) Risks associated with transmissible events; (v) Chronic decompensated conditions (mental health, AHT, diabetes and asthma among others); and (vi) Overloaded health systems, leading to demanding overload of use of inputs (medicine, personnel, etc).

93. Approximately 1.4 million Venezuelans receive assistance through different strategies depending on whether their status is linked to the PEP, or TMF, among other mechanisms which include vaccination systems for children, birth care, initial emergency care, etc. However, there are still difficulties caused by the migrants' own irregularities (illegal entry, stays beyond time allowed), as well as by not being able to enroll in the subsidized health regime for not complying with the requirements set forth in the SISBEN.

94. The Program, by improving efficiency and quality, will also contribute to strengthening the SIVIGE with the objective of providing, integrating, harmonizing and disclosing statistical information on gender violence.[13], (visibility tool for prevention and monitoring of protective measures, care, reparation and access to justice for victims of gender violence or people at risk of being its victims).

95. The general social risk was cataloged as "***low***" because there is a diagnosis based on participatory consensus and mechanisms to service health-related social demands. The Program

[13] Physical, psychological, sexual and economic violence.

additionally has a low probability of any negative social impact given that it includes the inclusion of indigenous peoples, ethnic minorities and other vulnerable communities linked to dispersed rural populations, the victims of the armed conflict and returning Venezuelan and Colombian migrants. As no construction is planned, no expropriations or resettlements will be carried out.

96. The analysis of the health and gender situation includes the identification of historical, political, social, economic, cultural and health aspects that produce differences in the relations between men and women. According to statistics from the DANE, in the second quarter of 2018 the participation rate for men was 74.8% and 53.6% for women; the employment rate for men was 69.3% and 46.9% for women; and the unemployment rate for women was 12.4% and 7.4% for men. There is also evidence of segregation of occupations by gender, with women working more in-service sectors. All these figures show the disparity between men and women - women being at a clear disadvantage - the same occurs in the expression of poverty.

97. In Colombia, the rates of violence against women are higher than the Latin American average. According to data from the Coroner's Office, between January and February 2019, 138 homicides of women, 2,471 cases of domestic violence, 3,263 cases of alleged sexual crime, 5,501 interpersonal violence and 5,877 cases of partner violence were recorded. According to the Forensic report, from the Coroner's Office, in 2018, 10,794 cases of violence against children and adolescents in the country were reported.

98. The Program has a low probability of any negative social impact and will mitigate several of these risks, based on six pillars that support health sector quality improvement: (1) certification of medical care providers; (2) accreditation of medical care providers; (3) mandatory quality indicators; (4) quality improvement plans for medical care providers; (5) healthcare human resources, and (6) citizen participation.

Recommendations on social aspects.

99. The project has a low probability of any negative social impact. Based on the assessment, the table below presents the key social problems identified and the recommendations or the way forward in regard thereof.

Table N° 2 Recommendations on social aspects

Key social issues identified	Assessment / Key findings	Recommendations / Way forward
Reduce the gaps in comprehensive care of children belonging to ethnic groups from early childhood to adolescence, particularly in rural areas and in hard-to-reach territories	Increase the comprehensive care of children belonging to ethnic groups from early childhood to adolescence, particularly in rural areas and in hard-to-reach territories, and endeavor for harmonization in the definition of prioritized care, with that set forth in the life plans of ethnic peoples and communities regarding childcare and development. The competent institutions and instances of the National Family Welfare System (SNBF) and of the Intersectoral Commission for Comprehensive Early Childhood Care (CIPI) will accompany territorial entities and ethnic communities and authorities in the inter-institutional and intersectoral management of prioritized care within the framework of comprehensive attention to early childhood, childhood and adolescence with an ethnic differential approach. The ICBF, in coordination with SNBF entities, will design and implement a model of comprehensive ethnic care for children, adolescents and families in these communities, to allow arrival to dispersed or difficult to access territories in an articulated and relevant manner. The model will be built jointly with the communities, starting with a pilot exercise with the four villages of the Sierra Nevada de Santa Marta.	Proactively continue holding the inclusion workgroups and pathways provided for in the CONPES for ethnic groups.
Reduce the opportunity gaps for ethnic groups	Pact for equal opportunities for ethnic groups: indigenous, black, Afro, and Rom. Generation of differentiated	***For Indigenous Peoples***: Move forward for the purpose of completing the SISPI. Especially to complete Stage II

Key social issues identified	Assessment / Key findings	Recommendations / Way forward
	actions that create conditions of equality in access to goods and services, especially to land, to advance in the materialization of the rights of those who are subject, under the principle of progressivity and taking into account their worldview and traditions.	(Preparation of the Base Document, and validation of the 5th component) and Stage III (administrative act of the MSPS and submission to the Permanent Coordination Workgroup. ***For black Afro-Colombian, Raizales and Palenquero communities, and the Rom people***: Move forward for the purpose of concluding with the guidelines, directives and guidance for socio-cultural adaptation and inclusion of the intercultural approach that considers their standards of care that respect their ethnic and cultural identity, forms of social organization and linguistic characteristics for each ethnic group. In the case of Indigenous Peoples and Ethnic Groups, a documented record of the participation of stakeholders shall be established, which will include a description of the stakeholders consulted, a summary of the opinions received and a brief explanation of how opinions were considered, or the reasons why this did not happen.
Migrations	The health sector's response Plan to the migratory phenomenon of Venezuelan migrants and refugees, is comprised of indicative actions fundamentally targeted towards health care in Colombian territory of people entering the country as migrants. Several years of experience are in hand in this regard. Within the framework	Move forward in advancing mechanisms to identify migrants to implement insurance mechanisms, to contribute to the particular health of migrants and to the protection of Colombian public health. It is implemented through a census list or equivalent instrument coordinated by the MSPS Migration division.

Key social issues identified	Assessment / Key findings	Recommendations / Way forward
	of this Plan, migrants registered in the PEP (approximately 600,000), children and those who come in for emergency care born in Colombia (Resolution 8470 of August 5, 2019 of the National Registry of Civil Status established that the children of Venezuelan citizens born in the country as of August 19, 2015 shall be Colombian. The measure begins to apply from next August 20 and covers more than 24,500 children born in Colombia in the last four years and whose parents are Venezuelan, as well as those born during the next two years).	
HCW Management at Territorial Level	Design of agendas and strategies exist for the incorporation of the issue of environmental health in interinstitutional and intersectoral spaces in health and environment at the territorial level (COTSA).	Continue with the implementation of the national and regional outreach and awareness plan that is provided for in Decree 284 of 2018 to identify and integrate national lines of action with regional needs.

6.2. Environmental risks and considerations associated with the Program

100. This section provides an overview of the environmental risks associated with this Program, which are based on three of the ESSA Basic Principles (BP), BP 1 and BP 3. BP 1 covers general aspects of environmental and social management, and its goal is to promote environmental and social sustainability in the design of the Program, avoiding, minimizing or mitigating adverse impacts and promoting informed decision-making related to the environmental and social impacts of the Program. BP 3 is intended to protect public and worker safety against the potential risks associated with the provision of health services.

101. The Program's activities target the quality and efficiency aspects of the existing Colombian health system. The operational phase may have certain impacts and risks, including medical waste and other solid and liquid waste within the health and transportation facilities and disposal of solid medical waste. If not managed well, these activities will pose a threat to the environment, public health and safety at work.

102. **Basic principle 1.- Summary of findings**: Certain interventions under the Program would require sustaining current mitigation actions and sustainable approaches to better manage the environmental effects of the Program. These include, among others: (i) Issues related to the generation, collection, segregation, storage, transportation, handling and disposal of biomedical, solid and hazardous waste. It is important to pay special attention to the collection of information and the timely control connected with HCW flows, in the case where it is necessary to carry out interventions by making informed and timely decisions (eg: availability of consumables in the case of mass vaccination campaigns, increases in laboratory diagnoses, or surgical or cytotoxic treatments); and (ii) Reduce the risk of getting infections inside health facilities.

103. With a coverage on the order of 94.4% enrolment in the SGSSS, large variations in the generation of health-care waste due to the project are not expected. The possible (minor) increases could be due to improvements in the quality of benefits and early diagnoses of diseases such as cancer or diabetes. Another cause of increases in health services benefits might be due to the enrolment of migrants. It is important to remember that a large majority are already receive services under different schemes, some through enrolment in the SGSSS, or through other schemes that include vaccination systems for children, birth care, initial emergency care, etc. The problem of possible increasing burdens from waste generated by the IPS requires special attention so that its management is maintained within the parameters established by the regulatory frameworks. An adequate forecast of patients to be serviced in the EPS, the types of diagnoses and medical practices to be carried out allow estimating the material, human and budgetary resources necessary for the adequate handling and final disposal of RES. Its adequate management and the timely information regarding volumes and streams of HCW generated allow adapting possible gaps just in time.

104. The remotest places might have disadvantages for the final treatment of HCW and WEEEs related to the lack of economic attractiveness of providers of said service linked to the low volumes generated. The Directorate for Healthcare Human Talent Development is working on the regulation of Law 1917 of 2018 "Residencies Law" in which the intent would be to incorporate incentives for adequate territorial distribution of human talent in health.

105. **Basic principle 3.- Summary of findings**: Certain interventions of the medical practices of the health system could expose IPSs and beneficiaries to risks associated with exposure to hazardous materials, infections, radiation, as well as sharps, etc. This would require the integration of mitigation actions provided in the inspection, oversight and control (IVC) actions of sanitary and environmental risks in the workplace; improvement of the physical and psychosocial environment at work, promotion of occupational risk insurance, among others, within the framework of the General Occupational Risks System (SGRL). These include, among others: (i) the improvement of occupational health and safety practices for infection control, and protocols to address accidental spills; (ii) Provide protective clothing and personal safety equipment, as necessary; and (iii) Ensure safe storage, segregation, transportation and disposal of hazardous waste. Additionally, in the current design of the Program, physical infrastructure construction is not expected, including the rehabilitation, improvement and operation of existing healthcare facilities, which is why no impacts related to works, construction, or occupation of new habitats are expected outside the current footprint of the health system.

106. The analysis allowed identifying the environmental risks in the sanitary waste management system: (i) Risks of infection for medical and healthcare personnel, and for patients with: needle and sharps punctures, exposure to blood and liquids in health centers, laboratories, emergency medical care services, medical posts, medical waste at disposal sites (temporary, transitory and / or final); (ii) Risks of infection of patients in healthcare facilities with inadequate epidemiological and infectious control / inadequate (infection transmitted through air, water and / or the use of poorly sterilized medical instruments; (iii) Air, soil and water contamination risks due to improper handling and management of sanitary waste; and (iv) Risk for the management and disposal of chemicals and

radioactive materials (generated in cancer centers, therapies, dialysis centers, X-rays, among others).

107. Some 4,467 facilities providing health services reported their information in the Registry of Hazardous Waste Generators in the 2017 fiscal year. According to the RESPEL report of 2017, with generation of 46,431 tons, 86% of their generation comes from the activities of hospitals and clinics with hospitalization (68%), medical practice activities without hospitalization (11%), other human healthcare activities (3%), diagnostic support activities (3%) (laboratories) and in early childhood education activities (2%). These correspond to the Y1 A4020 stream which has been exhibiting a sustained increase since its registration.

108. An increase in medical practices and HCW generation can overload the personnel dedicated to its management and/or demand the incorporation of personnel for these tasks. Therefore, it is necessary to uphold continuous training efforts in the management of RES. In addition to the inclusion of modules on the management of HCW in the training of human talent, there are opportunities in equalizing knowledge and skills in the most remote places, especially in safety regulations for patients and health establishment personnel in regard to infectious diseases, and sharps, among others.

109. The integration of mitigation actions is provided in Colombian regulations, especially provided in the inspection, oversight and control (IVC) actions of health and environmental risks in workplace settings; improvement of the physical and psychosocial environment at work, promotion of occupational risk insurance, among others, within the framework of the SGRL. These include, among others: (i) the improvement of occupational health and safety practices in healthcare facilities through the design of Infrastructure, infection control, and protocols to address accidental spills; (ii) Provide protective clothing and personal safety equipment, as necessary; and (iii) Ensure safe storage, segregation, transportation and disposal of hazardous waste. All aspects are provided in the national regulations described in the regulations section that includes good industry practices.

110. The proposed Program is expected to increase positive environmental benefits in the health sector. It will help improve the quality of health services that cover aspects of better environmental hygiene and waste management, based on better access to information, and the training of human talent. Together with the improvement and specialization of health services, standardized hospital management practices for medical waste, safety and health at work are expected to lead to greater dissemination and awareness and improve the collection and transport of medical waste in the most remote areas.

111. The rules related to air quality, proper management of HCW and prevention of environmental pollution, and legislation related to occupational health and safety must also be followed. All these activities are subject to the control of regional or municipal authorities, and include inspection, oversight and control (IVCS) actions. Resolution 1229 of 2013 of the Ministry of Health, established that the sanitary IVC needs to be performed with a risk-based focus. The INVIMA designed and implemented a risk-based health surveillance model, which allows creating a risk profile for each of the entities monitored and thus generate a *ranking* to determine the levels and frequencies of inspections.

112. During the assessment the general adequacy of the environmental systems, of the institutional and legal framework for the management of medical waste at the IPS level was confirmed. The categorization and segregation system of RES, the integral management plans for hospital waste and similar are implemented within the Colombian health sector. The integral management of waste generated in healthcare and other activities[14] has two instances, one within the health establishments (intramural) under the oversight of the MSPS, and another outside the Provider Entities (extramural)

[14] Decree 351 of 2014 (Compiled in Decree 780 of 2016 - Single Regulatory Decree of the Health Sector-)

under the oversight of the MADS. At the sub-national levels, the Departmental, District and Local Health Directorates are responsible for the management of intramural RESs, being under the inspection of the MSPS. At an extramural level, the external management of the HCW is under the purview of the *Regional Environmental Authorities*[15].

6.3. Adaptation of the health system to climate change and extreme methodological events

113. Climate change and the increase in extreme weather events (heat waves, droughts, floods, storms, etc.) require a clear determination to adapt the systems, in this case human health in general and vulnerable groups in particular. In the Third National Communication on Climate Change, Colombia has identified the climatic relationship with human health, due to temperature and precipitation differences in climatic lapses, as well as the relationship with the vector *Aedes aegypti* as a vector of a significant number of viruses that affect the Colombian population (dengue, in particular). The increase in the minimum nighttime temperatures in the foothills of the Andes and with changes in the hydrological cycle induced by the phenomenon of the *El Niño*-Southern Oscillation (ENSO) favor the development of vectors.

114. Approximately 23 million and 13 million Colombians live in areas of endemic transmission of dengue and malaria, respectively, and about 85 percent of the Colombian territory has ecological, climatic and epidemiological characteristics adequate for malaria transmission. A mere two-degree increase in temperature (from 24 ° C to 26 ° C) has been shown to more than double the number of infectious mosquitoes, which links temperature and precipitation variations with an increase in the incidence of diseases transmitted by malaria and dengue fever vectors. Compared to the 2000-2005 incidence rates, an increase of 11 percent and 35 percent is expected in cases of malaria and dengue (76,641 and 228,553, respectively) for 50- and 100-year scenarios, due to the climate change-driven increase in global temperature and precipitation.

115. The “Guidelines for the Formulation of Plans for Adaptation to Climate Change, from the Environmental Health Component” were proposed by the Deputy Directorate of Environmental Health of the MSPS in 2016. In addition, "Sector Plan of the Health Sector" is being elaborated in its broadest character, within the framework of the National Climate Change Adaptation Plan.

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[15] Regional Autonomous Corporations, Corporations for Sustainable Development, and Urban Environmental Authorities.

Table N ° 3: Level of concern with the possible environmental impacts and risks associated with the operation and use of healthcare facilities.

Environmental Impacts / Risks	Current state	Level of concern
HCW Management. The amount of medical waste is likely to increase with the expansion of services in the EPS. Increased demand for management, treatment and final disposal. More energy costs of management, treatment and final disposal.	1) Complete regulatory framework. 2) Enforcement System established 3) Institutional capability varies by region, with more resources in large populated centers. 4) Less positive situation of isolated and remote sites	**Low** In most of the IPS and health authorities that treat HCW adequate capabilities are in place according to regulations.
Management for final disposal of HCW	1) Complete regulatory framework. 2) Ex post monitoring, auditing and enforcement information system, grouped by environmental authority 3) Institutional Capability in managers. Greater difficulties in sites with low population density and far from treatment centers. 4) Unfavorable situation of isolated and remote sites	**Low** It is important to keep the reporting system on generation, management and final disposal of HCW up to date in order to make timely and informed decisions.
WEEE generation Increase in the generation of WEEE	1) Complete regulatory framework. 2) Monitoring, auditing and enforcement information system 3) Management systems and final disposal 4) Need for continuous information of possible generators. 5) Need for searches of integral uses of the WEEE. 6) There is a WEEE Management Plan with recovery of e-waste components in initial stages.	**Low** It is necessary to uphold the training system for those responsible for acquiring electronic devices and equipment, for users, and for those responsible for inventories for the fast and adequate management and final disposal of the components.
Chemical waste (expired medications, radioactive, cytotoxics, cytostatics)	1) Post-consumption programs for certain RESPEL (expired medications, lead acid batteries and pesticide containers, among others) were established. 2) Educational campaigns are promoted and informative at all levels.	**Low** It is important to keep the reporting system on generation, management and final disposal of this type of waste, especially in the initial states of incentives in the

Environmental Impacts / Risks	Current state	Level of concern
		diagnosis of cancer, in order to make timely and informed decisions.

Table N ° 4 Key risks and gaps and potential measures to align with the ESSA Basic Principles

Activities group Outcomes area	Key risk and gaps	Potential measures to align with the ESSA Basic Principles
Improve the quality of the health services in the SGSSS.	***Environment*** No environmental risks and gaps. ***Social*** No social risks and gaps.	Not applicable
Efficiency. This outcomes area supports the GoC in the implementation of measures aimed at improving efficiency in the provision of health services	***Environment*** No risks and gaps environmental. The HCW generated with the increase in the EPS benefits are treated under the regulatory and administrative frameworks provided by the GoC. The implementation of tools to promote the rational use of medications prevents the generation of chemical waste. ***Social*** No social risks and gaps generated by the Program.	The Environmental Health surveys at the intramural level of the IPS are standardized and improved. More frequent collection of information and segmentation of waste streams, for better analysis, to provide information to decision makers.
Migration.	***Environment*** No specific environmental risks or gaps were identified. ***Social*** Activities related to improving the attention of migrants have a positive impact on the target population as well as on the public health of the entire Colombian people.	Move forward in advancing mechanisms to identify migrants to implement insurance mechanisms, to contribute to the particular health of migrants and to the protection of Colombian public health. It is implemented through a census list or equivalent instrument coordinated by the MSPS Migration division

6.4. Gap analysis

116. The following table analyzes the capabilities gaps to address the risks identified in the previous stage and that will serve to make the recommendations of the ESSAs and the actions that are a part of the Program Action Plan (PAP).

Institution / Key Actor	Roles and Responsibilities	Gap analysis
Office of Social Promotion (MSPS)	PND 2018-2022 XII. Equality of Opportunity Pact for ethnic groups: indigenous, black, Afros, *Raizales, Palenqueros* and Rom. Generation of differentiated actions that create conditions of equality in access to goods and services, especially to land, to advance in the materialization of the rights of those who are subject, under the principle of progressivity and taking into account their worldview and traditions.	**For Indigenous Peoples:** Completion of the SISPI is pending. Stage I (survey of the territory, proposal of SISPI with 5 components) has been completed, with compliance with Stage II (Preparation of the Base Document, and validation of the 5th component) pending and Stage III linked to the issuance of the administrative act of the Ministry of Health and submission at the Permanent Coordination Workgroup. The SISPI is articulated, coordinated and complemented with the SGSSS (Article 74 of Decree 1953 of 2014). **For black Afro-Colombian, Raizales and Palenquero communities, and the Rom people**: Concluding the guidelines, directives and guidance are pending for proper socio-cultural adaptation and inclusion of the intercultural approach that considers their standards of care that respect their ethnic and cultural identity, forms of social organization and linguistic characteristics for each ethnic group.
	PPSS: its objective is the intervention of the community in the organization, control, management and enforcement of the institutions of the health system as a whole. For this, the territorial and departmental territorial entities must consolidate their information and that of the actors responsible for the processes of social participation in health of their jurisdiction and report it to the MSPS with a term until March 15, 2019, which must be sent according to the matrix and the instructions.	There is a need for modification of the information collection by 2020 since the reporting of both the formulation of the plans and the monitoring of these will be done through the PISIS platform.
Department for Social Prosperity (DPS)	Achieve the integral protection of early childhood, childhood and adolescence and promote family strengthening, through an articulated and timely response of the State under the principle of co-	The population belonging to ethnic groups exhibits disadvantages in health indicators in regard lack of insurance, infant mortality, maternal mortality ratio, and malnutrition as the main cause associated with mortality in the exclusive case of the indigenous population.

Institution / Key Actor	Roles and Responsibilities	Gap analysis
Colombian Institute of Family Welfare **National Family Welfare System**	responsibility with the family and society. Assess and track the status of achievement of the rights of children and adolescents.	Populations belonging to ethnic groups have are more disadvantaged than the non-ethnic population in not attending school, lagging school attainment and access to early childhood care. The interventions are insufficient, with only 26% of children aged 0 to 5 belonging to ethnic groups having had access to comprehensive priority care in early childhood
Office of Social Promotion / Assistance and Reparations Group for Victims of Armed Conflict (MSPS)	PAPSIVI: addressing the psychosocial impacts and harm to the physical and mental health of the victims caused by or in relation to the armed conflict, in the individual, family and community spheres in order to mitigate their emotional suffering, contribute to physical and mental recovery and the reconstruction of the social fabric in their communities.	Establish the conditions for the implementation of the second Phase from 2020 when Law 1448 of 2011 ceases to be in force.
Migrations (MSPS)	Design of the Health Sector Response Plan to the Immigration Phenomenon. This plan is indicative, emphasizing the actions that need to be designed by each territorial entity to address individuals in the territories and communities affected by the migration phenomenon originating in the Bolivarian Republic of Venezuela.	Absence of concrete definitions regarding the scope of health coverage, and complementary financing options for migrants from Venezuela. Identifying and measuring the risks and impacts on the health and customs of migrants and the host society remains pending. Completing definitions and implementing health information systems linked to the migratory phenomenon remains pending.
Office of Deputy Director of Environmental Health (MSPS)	Determination of Environmental Health public policies and random enforcement of compliance with regulations at sub-national levels.	The analysis of the internal management of HCW is ex post, which does not allow guaranteeing the flow of information if changes occur in the patterns of generation of HCW (quantities, types). In this manner, the information for a modification of policies, needs for inputs and resources, could be late in the face of trends in general increases in the HCW or of a particular waste stream that would demand a timely or specific treatment.

Institution / Key Actor	Roles and Responsibilities	Gap analysis
Ministry of Environment and Sustainable Development (MADS)	This agency governs environmental management and renewable natural resources. It leads the National Environmental System (SINA).	The decentralization of clinical waste management at sub-national levels generates knowledge of waste management ex post through an annual report (IDEAM-MADS) regarding the external management of RESs for the year ended. There is no breakdown of information for the subcategories: Y1.1: For pathological waste, Y1.2: for bio sanitary waste, Y1.3: For waste Sharps; and Y1.4: For animal waste. If there were modification in HCW generation patterns (quantities, types), the information for a modification of policies, needs for inputs and resources, could be late in the face of trends in general increases in the HCW or of a particular waste stream that would demand a timely or specific treatment.
National Environmental Licensing Authority (ANLA)	Responsible for the projects, works or activities subject to licensing, permits or environmental formalities complying with environmental regulations.	
Institute of Hydrology, Meteorology and Environmental Studies (IDEAM)	Provides technical and scientific support to the SINA, it produces reliable, consistent and timely information on the state and dynamics of natural resources and the environment.	
Territorial Health Entities at the Departmental, District and Municipal level	Design of agendas and strategies for the incorporation of the issue of environmental health in relevant instances, enabling the creation of interinstitutional and Intersectoral spaces on health and the environment at the territorial level (COTSA).	At the national level, capability gaps are recognized in the most remote places. It will be necessary for territorial authorities to carry out information and training activities for key actors in regard to the proper management of HCW (sharps, infectious waste, chemical substances, among others) and their impact on the environment and health. It is necessary to strengthen the participation of social and community organizations for their participation in relevant decision-making processes and to build awareness and community participation mechanisms at the territorial level.
Territorial Health Entities at the Departmental, District and Municipal level	They are responsible for inspection, oversight and control health (IVCS) in the internal management of RES.	No significant gaps have been identified. At the departmental and district level, the IVCS plans of the respective jurisdiction are established, in coordination with INVIMA, in accordance with the national ICVS plan. The tracking performed by the MSPS is document-based and spaced in time to exercise oversight.
The Regional Autonomous Corporations and those for Sustainable Development,	shall grant or deny the environmental license for the construction and operation of facilities whose purpose is the storage, treatment, use, recovery	Uneven territorial availability of WEEE recovery and management operators. The recovery of materials is influenced by market variations.

Institution / Key Actor	Roles and Responsibilities	Gap analysis
Large Urban Centers and the environmental authorities created by Law 768 of 2002	and/or final disposal of hazardous waste, and the construction and operation of sanitary landfills for hospital waste and the construction and operation of facilities whose purpose is the storage, treatment, use (recovery/recycling) and/or final disposal of WEEE and waste batteries and/or accumulators.	
At the health center level	The generators, deactivation service providers and providers of the special hospital waste and similar cleaning services, design and implement the Comprehensive Management Plan for Hospital and Similar Waste *(Plan de Gestión Integral de Residuos Hospitalarios y Similares,* PGIRH) according to the activities they perform, having as their starting point their institutional commitment of a sanitary and environmental nature, which shall be: real, clear, with proposals for continuous improvement of the processes and targeted at minimizing risks to health and the environment.	No gaps have been identified. The audits of the PGIRH are carried out at least once a year by the departmental or municipal Comptroller.

7. ESSA RECOMMENDATIONS FOR THE PROGRAM ACTION PLAN

117. The priority areas identified in the Program and the corresponding indicators related to disbursements (DLI) do not recommend activities/actions that would cause significant damage to the environment and/or result in adverse environmental and social impacts that are sensitive, diverse or unprecedented or irreversible.

118. The ESSA proposes the following Program actions related to DLI Disbursement Indicators, specifically with DLI N ° 1, 2 and 4.

DLI 1: will contribute to "*Updated regulation for certification and accreditation for health insurance companies (EPSs) and health care providers (IPSs) to improve quality of care, including environmental management standards and disaster readiness*".

119. These are measures targeting environmental health management[16] and the management of RES, as well as the procedures for licensure and accreditation in health provided in the current regulations and in the update processes. The proper segregation of HCW entails a decrease in waste to be incinerated. Compliance with the procedures established for the licensure and accreditation of EPS - IPS consider scenarios connected with climate change provided in the regulatory frameworks and in the respective policies of Colombia (Urban planning, permits for dumping liquids and atmospheric emissions, Structural vulnerability study - Seismicity, floods, displacements-, Emergency and disaster plan, Contingency plan for floods and displacements).

120. **Program Action[17] 1: Monitor health inspection, oversight and control actions (IVCS)**. As at present, the reporting is annual for the year ended, progress will be made towards the identification of mechanisms that allow reporting within more limited time frames which the Office of Deputy Director of Environmental Health accesses, and which will have information available to contribute to the generation of the corresponding public policies. It is advisable that the information allow seasonal analysis to link the impacts of the effects of climate change on the health system and its subsequent generation of RES.

121. **Program Action 2: Promote a modification of information about the HCW stream** that allows displaying data breakdowns making it available to the Office of Deputy Director of Environmental Health for the sub-categories: Y1.1 (pathological waste), Y1.2 (bio sanitary waste), Y1.3 (sharps waste); and Y1.4 (animal waste). To be performed jointly between MADS and the Office of Deputy Director of Environmental Health.

DLI 2: *Incentives in payment systems to achieve better quality of care and efficiency.*

122. This includes measures for improving access to health services, early detection of breast cancer, social participation, Environmental Health and its consequence in the generation and management of RES. The program actions align with the DLI 1 described above (Program Actions 1 and 2).

DLI 4: contribute to *Number of eligible migrants affiliated to health insurance scheme (SGSSS).*

123. They are integrated with actions that contain measures for access focused on equality, gender, and social participation included in the migration phenomenon.

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[16] Environmental Health: encompassing environmental factors that could influence health and is based on disease prevention and the creation of environments conducive to health (WHO).
[17] Program Action corresponding to the PAP (Program Action Plan).

124. **Program Action 3: Move forward in advancing mechanisms to identify migrants** to allow implementing insurance schemes contributing to the specific health of migrants and to the protection of Colombian public health. It is implemented through a census list or equivalent instrument coordinated by the Office of the Director of Insurance of the MSPS.

PAP action	DLI / PAP	Date due	Agency responsible	Completion measurement
HCW Management Monitoring of IPS plans. Increase oversight and control activities on this kind of establishments by the Environmental Authorities Establish mechanisms for collecting timely information for decision-making.	PAP	Annual reports.	1) Environmental Health	1) Audit reports 2) Statistical information of waste streams by categories, discriminating waste streams for Y1 in subcategories. 3) information loaded into the RESPEL system annually.
Treatment and final disposal of RES: Discriminate waste streams for Y1 in subcategories of this type of Y1 waste Y1.1: pathological waste, Y1.2: bio sanitary waste, Y1.3: sharps waste Y1.4: animal waste Action shall be taken to this end by: 1) Access by the Office of Deputy Director of Environmental Health (SSA) to the functionality in the Registry of Hazardous Waste Generators for each of the sub-categories. 2) Communication and awareness-building 3) Analysis of the information collected and articulation between SSA and MADS for future HCW policy designs	PAP	1) and 2) By effectiveness / 3) One year after effectiveness / 4) Two years after effectiveness	MADS/Office of Deputy Director of Environmental Health	1)Minutes of agreement or similar that facilitates the access of the SSA to the functionality in the Registry of Hazardous Waste Generators for each of the sub-categories 2) Notes or communications informing on the availability of the new functionality and the importance of its use. 3) Technical reports of conclusions.
Indigenous peoples: (SISPI) Implement the Stakeholder participation process to move forward in the pending stages:	PAP	Stage II (Six months after effectiveness) Stage III (One year after effectiveness)	MSPS Social Promotion	1) Documented record of stakeholder participation, including a description of the stakeholders consulted, a

1) Stage II (Preparation of the Base Document, and validation of the 5th component) and 2) Stage III linked to issuing the administrative act of the Ministry of Health and submission at the Permanent Coordination Workgroup (MPC).				summary of the opinions received and a brief explanation OF how opinions were considered, or reasons why this did not happen 2) Idem 1) and MPC Minutes
For black Afro-Colombian, *Raizales* and *Palenquero* communities, and the Rom people: Implement the stakeholder participation process to move forward in pending stages to achieve the guidelines, directives and guidance for proper socio-cultural adaptation and inclusion of the intercultural approach that considers their standards of care that respects their ethnic and cultural identity, forms of social organization and linguistic characteristics, without the need to create a special health system for each ethnic group.	PAP	1) Six months after effectiveness 2) One year after effectiveness	MSPS Social Promotion	1) Documented record of stakeholder participation, including a description of the stakeholders consulted, a summary of the opinions received and a brief explanation OF how opinions were considered, or reasons why this did not happen 2) Document under construction in conjunction with. ethnic groups according to the PND guidelines.
Migrations	DLI 4	Regulation by Effectiveness Enrolments yearly	MSPS Directorate for Regulation of the Operation of Health Insurance, Occupational Risks and Pensions.	MSPS regulation to change the enrolment mechanisms for migrants from Venezuela that register and are regularly published (with PEP). Venezuelans enrolled within the framework of the decree

8. CONCLUSIONS & RECOMMENDATIONS

125. The ESSA concludes that the Program has **low** environmental and social risk. The risks of the Program when dealing with HCW are reasonably covered by Colombian regulations and institutional capabilities but will require attention to address other environmental challenges that arise from the possibility of increasing diagnoses and treatments in the health sector. The institutional configuration has the potential to develop the capacity required to deal with the potential environmental risks and challenges. The Program has a low probability of any negative social impact. No land acquisition is expected given that the Program is not compatible with any construction. The results areas focus on the quality and efficiency of medical care throughout the country and are expected to contribute, in the long term, to better health outcomes and to the financial sustainability of the health system. The Program additionally includes the inclusion of indigenous peoples, ethnic minorities and other vulnerable communities linked to dispersed rural populations, the victims of the armed conflict and Venezuelan migrants and returnee Colombians.

9. THE CONSULTATION PROCESS

126. For the preparation of the ESSA, the evaluation of the systems began with the compilation of information on the National Constitution and the regulations of Colombia. In addition, secondary data sources were consulted that were validated and complemented through consultations and interviews with the main stakeholders. Officials and technicians from different areas of the MSPS were also interviewed to gather evidence, functional knowledge and concerns.

127. The consultations began on May 14, 2019, the interviews were conducted during a World Bank mission to Bogotá between May 27 and 31, 2019, with a workshop with the authorities of the Deputy Directorate of Environmental Health of the MSPS and MADS to complete and validate the sections of environmental issues.

128. A new mission in Bogotá was carried out between August 12 and 16, 2016 to intensify the social aspects of ESSA. For the evaluation of environmental and social systems, focus of the program "*Improving Quality of Health Care Services and Efficiency in Colombia*", extensive consultations were carried with the main Program implementing agencies, the MSPS and MADS. Specifically, special emphasis was placed on the offices of director connected to the Program's boundaries. Within the orbit of the MSPS and reporting to the Minister's Office: The Office of Social Promotion, the Ethnic Affairs Group, Assistance and Reparations Group for Victims of Armed Conflict, the Cooperation and International Relations Group and the migration division. Reporting to the Office of Deputy Ministry of Public Health and Service Provision: The Directorate of Promotion and Prevention, the Management Group for Promotion and Prevention, the Directorate of Medications and Health Technologies, the Directorate of Healthcare Human Talent Development, the division for public disclosure of indicators for public hospitals AI Hospital, the Deputy Directorate of Environmental Health, the Directorate of Service Provision and Primary Care and its Deputy Directorate of Service Provision, and the Deputy Directorate of Healthcare Infrastructure. Reporting to the Deputy Minister of Social Protection: The Deputy Directorate of Health Insurance Costs and Rates. Within the orbit of the MADS, consultations were carried out with the Chemical Substances, Hazardous Waste and Ozone Technical Unit Group; the Deputy Directorate of Environmental Studies of the IDEAM.

129. A draft ESSA report was shared with the GoC and with civil society by email for consideration and opinion. The findings of the draft ESSA report were disclosed in a disclosure workshop organized in Bogotá, at the World Bank office, on October 3 and 9. The participants included representative from several institutions and organizations: For the GoC, representatives of the Department of

Environmental Health, Office of Social Promotion, the Directorate of Sector Financing, and the International Cooperation and Relations Group under the Ministry's Office participated in the MSPS. In addition, Civil Society participated members of the Health Technology Assessment Institute (IETS).

130. The participants endorsed the findings of the draft ESSA report, while emphasizing issues such as the rectory of the MSPS in the generation of health policies and the implementation of the IVC by subnational authorities. Civil society representatives identified three new vulnerable groups (LGBTI, rare diseases, and women in a condition of lawful abortion) to improve primary healthcare access for underserved groups. A summary of this public consultation meeting is presented in Annex A.

131. The document was enriched by the interaction of the workshops and the MSPS will publish it for a period of 15 days on the website of the Ministry for public comments before the end of ESSA.

ANNEX A

10. Dissemination workshop of ESSA

132. The findings of the draft ESSA report were disclosed in a disclosure workshop organized in Bogotá, at the World Bank office, on October 3 and 9. The participants included representative from several institutions and organizations: For the GoC, representatives of the Department of Environmental Health, Office of Social Promotion, the Directorate of Sector Financing, and the International Cooperation and Relations Group under the Ministry's Office participated in the MSPS. In addition, Civil Society participated members of the IETS.

133. The workshop began with introductory comments from the ESSA head of the World Bank, who introduced the PforR instrument and the main provisions of the "*Improving Quality of Health Care Services and Efficiency in Colombia*" program. After the introduction, the findings and recommendations of the Environmental and Social Systems Assessment were presented.

134. The comments that emerged from this discussion and which were then presented as text corrections in the digital format by the MSPS are presented in the following table, with responses from the World Bank team.

Comments	Replies / resolutions
The rectory of the regulatory framework is done by the Ministry, but the internal management is supervised by the secretaries of health by competition established in the regulatory framework.	Although it was expressed in repeated paragraphs of the document that this is the situation, the word "vigilance" was replaced in one section by "rectory" to clear the doubt generated by the wording.
On a comment from the MSPS that the risks and impacts are reduced with good practices in waste management.	From the Bank team it is recalled that for the application of good practices, it is necessary to have a good diagnosis of the state of the situation that allows for planning of resources (human, material, and economic among others) and the elaboration of adequate budgets.
With respect to the recommendation to "move towards a more limited deadline report" on the HCW reports. The MSPS informs that the term cannot be limited since it is a provision established by the Regulatory Framework established in article 2.8.10.9 of Decree 780 of 2016. In addition, the GoC clarifies that internally by hospitals there are administrative groups for the internal management of waste that can make decisions when there is a risk situation.	The BM specialist recalls that the ESSA "recommends moving towards a more limited time report, or partial reports that can be accessed by the Deputy Directorate of Environmental Health" in order to overcome the current barrier that implies that information is collected at the level territorial at the end of the calendar year, it is turned to the national level where it is processed and published in the RESPEL report a year later. The report of the year RESPEL available in 2019 has the generation and treatment of the RES of the year 2017. The ESSA does not impose a modification of the regulations, it recommends that GoC study the best alternatives to have adequate information for the generation of policies public. For this, it was incorporated with the agreement of the SSA in the PAP that a "Minutes agreement or similar that

And also, when there is a risk or complaint situation, the secretaries may and may make visits without prior notice to verify internal management.	would facilitate the access of the SSA to the functionality in the registry of Hazardous Waste Generators for each of the subcategories" would be established.
Clarification of the term Kumpañia was requested.	Kumpañia, Kumpania, or Kumpañy (plural) It is important to highlight that it is the way in which the legal representations of the ROM people with the GoC are identified. The MSPS itself recognizes Kumpañy in the departments of Antioquia, Atlántico, Córdoba, Nariño, Norte de Santander, Santander, Sucre, Tolima and in Bogotá D.C. It is clarified with a footnote "Set of family patrigroups belonging to the same Rom lineage, or different lineages that have established alliances with each other, that share spaces to live nearby or to travel together".
The MSPS recommends using the term "waste generated in health care" throughout the document as it is used in the regulatory framework. In some sections a summary expression "Waste from Health establishments" had been used.	"Health facility waste" was replaced by "waste generated in health care".
In paragraph 55, the MSPS observed that "The current Resolution is 1164 of 2002, which regulates the manual for the integral management of hospital waste and the like"	The indicated in the ESSA was maintained since the aforementioned Decree 351 of 2014, compiled in Decree 780 of 2016, is a more current norm and includes the indicated norm. Article 2.8.10.17
The GoC consults on the reference in the gap analysis on the expression of "territorial comptroller". In addition, the same comment informs that there is no participation of the MSPS in these follow-ups.	It is informed and corrected in the table by Departmental or Municipal Comptroller. During the evaluation, there was access to reports of "Departmental or municipal comptrollerships" where the progress and status of the PGIRH were reported. During the interview process, it was reported that the MSPS (Deputy Directorate of Ambiental Health) followed up on this, but before the current information is removed from the table.
The GoC comments on the wording of the DLIs	The head of ESSA uses the DLIs that are in application at this stage of the program design process and were updated in the ESSA to the most current version. Regardless of the wording, in the current circumstances, they do not imply modifications to the purpose of the ESSA.

11. Participants in the interview and workshop process

- Giovanni Gonzalo Rodriguez Vargas, Subdirección de Salud Ambiental, Ministerio de Salud y Protección Social.
- Diego Escobar Ocampo Coordinador Grupo de Sustancias Químicas, Residuos Peligrosos y Unidad Técnica de Ozono.
- Ana Milena Hernandez Velasquez, Ministerio de Ambiente.
- Lisbet Naidu Preciado Guevara, Ministerio de Ambiente.
- Adriana María Zapata Maya, Subdirección de Estudios ambientales del Instituto de Hidrología, Meteorología y Estudios Ambientales (IDEAM).
- Samuel García, Dirección de Prestación de Servicios y Atención Primaria, Desempeño Hospitales Públicos.
- Jorge Suárez, asesor Despacho Viceministro de Salud, Divulgación pública de indicadores para hospitales públicos AI Hospital.
- Luis Gabriel Bernal, Dirección de Desarrollo del Talento Humano en Salud.
- Julio Sáenz Beltrán, asesor del despacho del Viceministro de Salud Pública y Prestación de Servicios – Migración.
- Diana Cabanzo, Ministerio de salud y Protección Social - Banco Mundial / migración.
- Plinio Alejandro Bernal, y Rodolfo Burgos, Migraciones.
- Pilar Otero, Mariana Matamoros, Diana Valero Fuentes, y Oscar Sisa de la Oficina de Promoción Social (PAPSIVI).
- Gina Carrioni, Dirección General de Promoción Social Grupo Asuntos Étnicos y Género.
- Felix Regulo Nates Solano, Dirección de la Regulación de Beneficios, Costos y Tarifas del Aseguramiento en Salud.
- Ana Milena Montero, Subdirección de Prestación de Servicios.
- Augusto Ardila, Subdirección de Infraestructura en Salud.
- Benerexa Marqués, comisionada indígena de salud - Wintwkwa IPS Gerente.
- Adriana Dueñas Contreras, Subdirección de Salud Ambiental, Ministerio de Salud y Protección Social.
- Diego Moreno Heredia, Subdirección de Salud Ambiental, Ministerio de Salud y Protección Social.
- Santiago Perea Oficina de Promoción Social, Ministerio de Salud y Protección Social.
- Marby Astrid Perez Nuñez, Dirección de Financiamiento Sectorial, Ministerio de Salud y Protección Social.
- Jorge Vélez Grupo de Cooperación y Relaciones Internacionales dependiente del Despacho del Ministro.
- Dr. José Luis Gutiérrez, Instituto de Evaluación Tecnológica en Salud (IETS).
- Leonardo Arregocés, Instituto de Evaluación Tecnológica en Salud (IETS).

12. Civil Society Organizations to which the ESSA draft was sent

Organización	Apellido	Nombre
Movimiento de Autoridades Indígenas de Colombia - AICO	Bello	Oscar Cruz
Instituto de Evaluación Tecnológica en Salud (IETS)	Gavilán González	Luis Alejandro
Instituto de Evaluación Tecnológica en Salud (IETS)	Arregocés	Leonardo
Instituto de Evaluación Tecnológica en Salud (IETS)	Gutiérrez	Dr. José Luis
Instituto de Evaluación Tecnológica en Salud (IETS)	Robayo	Adriana
Instituto de Evaluación Tecnológica en Salud (IETS)	Pinzón Suarez	Jazmin Joanna
Fundación Mujeres por Colombia	Londono Polo	Isabel
Asovenezuela	Varela	Zoraida
Autoridades Indígenas de Colombia AICO	Sandiño	César Armando
Casa de la mujer	Sanchez	Olga Amparo
Colombia Diversa	Franco García	Daniela
Colombia Diversa	Sanchez	Marcela
Conferencia Nacional de Organizaciones Afrocolombianas	Cuesta Pino	Emigdio
Consejo Regional Indígena del Cauca CRIC	Lame	Neis Oliverio
Gestión Estratégica de Riesgos TRUST	Borda	Ernesto
Instituto de Investigaciones Ambientales del Pacífico - IIAP	Klinger Brahan	William
Organización Indígenas de Antioquia OIA	Domicó	José Leonardo
Organización Nacional Indígena de Colombia ONIC	Arias	Luis Fernando
Proceso de Comunidades Negras (PCN)	Santos Caicedo	José
SISMA mujer	Mejia Duque	Claudia María
SISMA mujer	Cabrera	Linda María
Centro Internacional de Responsabilidad Social y Sostenibilidad	Pichot Restrepo	Erick
Centro Internacional de Responsabilidad Social y Sostenibilidad	Ramírez López	Steve
Foro Nacional Ambiental - Fescol	Fernanda Valdés	María
Foro Nacional Ambiental	Rodríguez	Manuel
Bioluna Fundación Medio Ambiental	Marin	Sabrina
Corporación Ambiente Y Desarrollo	Aviles Pineda	Omaira Patricia
Fundación Para El Desarrollo Sostenible Del Medio Ambiente	Ruiz	Nelson Fernando

ANNEX B

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