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

Appraisal Stage | Date Prepared/Updated: 05-Apr-2018 | Report No: PIDISDSA23930

BASIC INFORMATION

A. Basic Project Data

Country	Project ID	Project Name	Parent Project ID (if any)
Bolivia	P164453	Health Service Delivery Network Project	
Region	**Estimated Appraisal Date**	**Estimated Board Date**	**Practice Area (Lead)**
LATIN AMERICA AND CARIBBEAN	02-Apr-2018	14-Jun-2018	Health, Nutrition & Population
Financing Instrument	**Borrower(s)**	**Implementing Agency**	
Investment Project Financing	Plurinational State of Bolivia	Ministry of Health, Ministry of Health - Agencia de Infraestructura en Salud y Equipamiento Medico (AISEM)	

Proposed Development Objective(s)

The project development objective (PDO) is to improve access and quality of health service delivery in select health networks.

Components

Strengthening Health Service Delivery Networks
Improving Quality of Health Service Delivery and Human Resource Capacity Development
Project Management

Financing (in USD Million)

Financing Source	Amount
International Bank for Reconstruction and Development	252.00
International Development Association (IDA)	48.00
Total Project Cost	**300.00**

Environmental Assessment Category

B - Partial Assessment

Decision

The review did authorize the preparation to continue

B. Introduction and Context

Country Context

1. **Bolivia made remarkable economic and social progress during the commodity boom (2004-2014).** Boosted by gas and mining exports and public investment, economic growth averaged roughly 5% during this period. Strong economic growth and prudent macroeconomic management allowed for sizable fiscal and current account surpluses that contributed to accumulating considerable macroeconomic buffers: international reserves and public savings at the Central Bank increased from 13 to 46% of GDP and from 8.6 to 24% respectively over this period. This macroeconomic performance, in combination with the Multilateral Debt Relief Initiative[1], resulted in a sharp decrease in public debt from 98% of GDP in 2003 to less than 40% in 2014. High economic growth and high commodity prices nearly tripled the per-capita income (Atlas method) in one decade; from US$970 in 2004 to US$2,800 in 2014. This improvement was especially pronounced for the bottom 40% as higher commodity prices and growing domestic demand favored rural economic activities and non-tradeable sectors. As a result, Bolivia experienced one of the largest reductions in poverty and inequality in the Latin American and Caribbean (LAC) region. Between 2002 and 2014, the national poverty rate among the country's estimated 11 million population declined from 63% to 39%. National extreme poverty fell from 39% to 17%, and the Gini coefficient dropped from 0.60 to 0.48.

2. **Although the Government has managed to cushion the effect of lower commodity prices on economic growth, the new normal has resulted in sizable macroeconomic imbalances and a slowdown of poverty reduction.** A less favorable external context has reduced GDP growth from a peak of 6.8% in 2013 to an estimated 4.2% in 2017; however, the Government of Bolivia has cushioned the slowdown through expansionary fiscal and monetary policies. This policy stance has caused substantial current account and fiscal deficits, estimated at 5.9 and 6.5% of GDP in 2017 respectively, which were financed by external debt, Central Bank financing to State Owned Enterprises, and the reduction of macroeconomic buffers. Public debt increased from 37% of GDP in 2014 to an estimated 50% in 2017, Central Bank international reserves fell from 46% to an estimated 29%, and public savings at the Central Bank declined from 20% to an estimated 14%. In this context, poverty reduction lost momentum as labor income in sectors that employ the poor (agriculture, mining, and construction) saw little or no growth. Poverty has hovered around 39% between 2013 and 2015, as the reduction of rural poverty (from 60 to 55%) was offset by an uptick of urban poverty (from 29 to 31%). Similarly, after having decreased by 0.12 points between 2006 and 2011, the Gini coefficient has fluctuated around 0.47 since 2011.

3. **Bolivia's low human development indicators reflect the challenges of the country's complex social structure.** In 2016, Bolivia ranked 118 out of 188 countries on the Human Development Index, life expectancy at birth is 68 years and has continued to steadily increase over the past 30 years, and the literacy rate is 95%.[2] Bolivia has historically been divided geographically and ethnically, with wide income gaps between the poorer highlands and the wealthier lowlands. Many indigenous groups have been subject to social and economic exclusion for decades. The effects of these divisions persist, reflected in dramatic variances in health indicators

[1] The Multilateral Debt Relief Initiative (MDRI) provided for 100%relief on eligible debt from the IMF, IDA and AfDF to a group of low-income countries, including Bolivia. The initiative aimed to help eligible countries advance toward the Millennium Development Goals (MDGs) focused on halving poverty by 2015.

[2] Plan Sectorial de Desarrollo Integral Para Vivir Bien 2016-2020

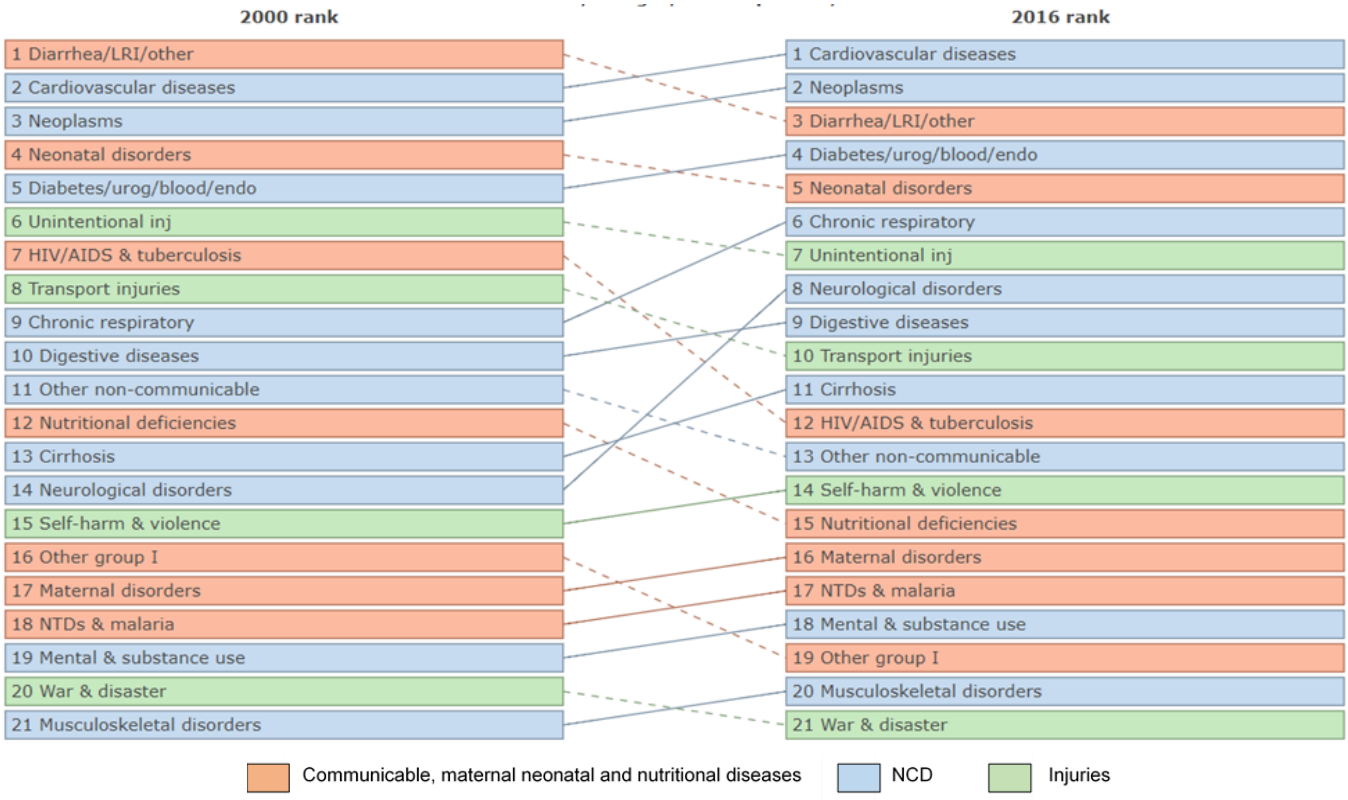
in different areas of the country, and substantial variations in health care among income quintiles.

Sectoral and Institutional Context

4. **Despite progress, Bolivia's human development indicators remain among the lowest in LAC.** While infant mortality has markedly declined from 82 deaths per 1,000 live births in 1990 down to 24 deaths per 1,000 live births in 2015, Bolivia's infant mortality rate remains the highest in South America.[3] Maternal mortality has been on the decline, at 206 deaths per 100,00 live births in 2015, but is triple the average for the LAC region.[4] As of 2012, 59% of total deaths are caused by non-communicable diseases (NCDs), namely cardiovascular diseases (CVDs) (24%); cancers (10%); diabetes (4%) and other NCDs (21%).[5] Figure 1 shows how NCDs continue to become the greater causes of death between 2000 – 2016. Given this epidemiological profile, it is imperative that primary care facilities serve as the principal gateway to higher level care, and have a solid referral system in place to refer more complex cases to secondary and tertiary levels. Without this option, primary health care (PHC) facilities lose credibility in the community by not being able to refer complex cases to higher level facilities. This scenario undermines the overall quality and access to health services.

[3] Encuesta de Demografía y Salud (EDSA), 2016
[4] WHO, UNICEF, UNFPA, World Bank Group, and the United Nations Population Division. Trends in Maternal Mortality: 1990 to 2015. WHO, 2015.
[5] World Health Organization, Noncommunicable Diseases Country Profiles, 2014

Figure 1 Bolivia, causes of death 2000 - 2016 (male and female)



Source: Institute of Health Metrics and Evaluation, http://www.healthdata.org/

5. **More than 80% of Bolivia's health service delivery system is comprised of public facilities, complemented by social security (5.7%), private organization (5.7%), NGOs (3.2%), churches (2.3%), and other smaller government entities.** Primary health care facilities make up 92% of all public health facilities in the country, followed by 6.3% secondary and only 1.9% tertiary facilities. The National Health Sector Plan 2016-2020 (*Plan Sectorial de Desarrollo Integral Para Vivir Bien* 2016-2020) estimates that 65% of medical human resources are in urban areas and 35% in rural areas. The density of human resources in health in Bolivia is 14.1 per 10,000 inhabitants (including doctors and nurses) in the public subsector. Highly qualified medical personnel are scarce: in 2015, there were an estimated eight medical doctors for every 10,000 population, and five licensed nurses for every ten medical doctors. Most medical specialists are concentrated in tertiary care (45%); 20% at secondary and 35% in primary care. The limited number of specialized doctors are so overburdened with treating patients that they do not have time to mentor medical residents and interns. In addition, doctors trained overseas may not return to practice medicine in Bolivia or they may return to the country and leave after a short period of time.

6. **Public health services in Bolivia are financed through taxes and basic services should cover all levels of health care (including hospital referrals).** Total health expenditure as a percentage of GDP (from 3.6% in 2010 to 4.5% in 2014) and total health expenditure per capita have risen considerably in the last decade.[6] In 2014, total health expenditure per capita reached US$209, with 72% of total expenditure in the public sector.

[6] *World Bank, World Development Indicators*

Conversely, out-of-pocket expenditures (as a percentage of total health expenditure) have steadily decreased from 27.8% in 2010 to 23% in 2014 due to the injection of additional funds (mainly from general revenues) into the health system and efforts to reduce financial barriers to access. An analysis of equity in health care utilization relative to need in Bolivia indicates that utilization is still concentrated among wealthier income groups. Although services provided in public facilities seem to be equally distributed across socioeconomic groups, wealthier income groups tend to utilize services provided by social security and private for-profit facilities. Hospital health services, regardless of type of provider, tend to be more concentrated among higher socioeconomic groups. [7]

7. **Access to secondary and tertiary care across the country varies substantially.**[8] Over the past two decades, solid progress has been made in terms of access to prenatal care (from 79% to 96%), births in health facilities (from 57% to 88%) and births attended by health personnel (from 61% to 90%). Nevertheless, the referral system for emergency obstetric care is still a challenge and this barrier is responsible for many maternal and infant deaths today. While critical and ongoing health issues in Bolivia still include high mortality rates for maternal and infant mortality, Bolivia is faced with a new challenge of an increasing incidence of NCDs, their complications and related deaths. The trend of NCDs in Bolivia has been incremental since 2000, which includes the diseases of highest risk and prevalence in the country. Primary care services cannot provide additional diagnostic testing required for management of most NCDs. Therefore, having access to a higher level of care would allow for the implementation of clinical guidelines (and care pathways) to better manage the increasing burden of the most prevalent NCDs in Bolivia.

8. **The Government has a strong commitment to improving the health network system in the country through its National Hospital Plan 2015-2020 which aims to upgrade and modernize service delivery.** A rapid assessment of the existing health service networks conducted in 337 municipalities[9] showed that in many networks, people do not have access to secondary services. For example, in the Southern Zone of La Paz network, there are 750,000 inhabitants with only 14 health centers and only one level 2 hospital with no access to a tertiary hospital. The proposed project will address these issues by improving access to and quality of primary care networks and to secondary and tertiary care services in select areas.

9. **Over the past decade, investments in primary health care have increased access to basic services, but continuity of care is still a significant issue.** Continuity of care is concerned with the quality of care over time and is defined as "a process that must involve the patient and all members of the health care team and includes coordination across a patient's health needs and providers." Evidence shows that continuity of care is an important contributor to improving quality of care and better outcomes ranging from reductions in mortality and morbidity, better access, and less instances of re-hospitalization and use of emergency services.[10] In Bolivia, hospital infrastructure is old and inadequate; resulting in limited access to good quality secondary and tertiary care. Previous World Bank investments in the health sector mainly focused on improving primary health care and maternal and child health, but these investments also face the same network challenges in terms of supporting continuity of care. Only two previous projects[11] targeted the hospital sector including a maternity hospital, small specialized pediatric oncology unit and twenty-two health centers. These facilities are functioning

[7] *Fuertes, CV. 2016. Universal health coverage: Bolivia. Global Network for Health Equity (GNHE). Available at: http://gnhe.org.*
[8] Encuesta de Demografía y Salud (EDSA), 2016
[9] Rapid assessment of health service networks. *"Diagnóstico General de Redes de Salud,"* December 2017
[10] World Health Organization, World Health Report: Primary Health Care – Now More than Ever. 2008.
[11] Health Sector Reform APL II (P074212) approved in 2001; and Expanding Access to Reduce Health Inequities Project (APL III) -Former Health Sector Reform - Third Phase (APL III) (P101206) approved in 2008.

well and providing services despite human resource challenges.

10. **The proposed project will contribute to the Government's broad reform program of hospital networks supported by multiple sources of financing.** In this context, the proposed World Bank project will support interventions that will have a national scope, such as updating national clinical guidelines and training of public health providers. Other activities have a targeted geographic focus of selected health networks. Given that the National Hospital Plan 2015-2020 is a central part of the National Economic and Social Development Plan 2016-2020 (PDES), it is financed by the national budget and donor funds. In 2017, the Inter-American Development Bank (IDB) has been partially funding the National Hospital Plan. The Government of South Korea is also financing hospital civil works in the framework of the National Hospital Plan.

C. Proposed Development Objective(s)

Development Objective(s) (From PAD)

The project development objective (PDO) is to improve access and quality of health service delivery in select health networks.

Key Results

- Number of network referral centers operational with at least 60% of the required medical staff and providing health services
- Percentage of health facilities supported in the targeted networks that fulfill the licensing standards[12]
- Percentage of doctors checking the MoH clinical guidelines application at least once in the last 60 days

D. Project Description

11. **The proposed project in the amount of US $300 million will strengthen Bolivia's health services network, mainly access to secondary and tertiary levels in select areas, and improve the quality of health service delivery nationwide.** The project will support the strengthening of health service delivery in selected networks including the design, construction and equipping of network referral centers (nine level 2 hospitals and one level 3 hospital), and rehabilitation and equipping of existing facilities in the targeted networks. Currently, these ten networks cover an estimated population of 3.8 million who do not currently have a proper referral hospital in place. The health service delivery networks were selected based on the following criteria: (i) networks without a functioning health network referral center and population without access to higher levels of health care; (ii) distance to an alternative referral hospital; and (iii) epidemiological profile and health indicators that merit the proposed intervention. In a few cases, for example in the municipality of San Ramon, where the total population is relatively small, higher level of care is needed given the distance to secondary or tertiary care in a widely dispersed area.

12. **The project will also support efforts to improve the overall quality of health service delivery and capacity development of human resources,** including: (i) training of clinical specialists; (ii) development and updating of clinical care standards including the use of mobile phone technology to apply clinical standards

[12] Licensing is the process by which a governmental agency grants time-limited permission to the health facilities or health care organization to operate. Licensing standards are established to ensure that the facilities meet minimum standards to protect the public's health and safety.

through the use of quality check lists; (iii) updating, elaboration and implementation of accreditation standards; and (iv) establishment of health information systems in the new hospitals while working to ensure compatibility with the existing National Health Information and Surveillance System (*Sistema Nacional de Información en Salud y Vigilancia Epidemiológica* – SNIS).

The Project has three components:

13. **Component 1: Strengthening Health Service Delivery Networks (US$243 million).** This component will support the strengthening of ten health service delivery networks that serve an estimated 3.8 million population. A complete assessment of the networks' situation and identification of adjustment and rehabilitation needed will complement the rapid assessment study of all networks conducted during project preparation which provided data for demographic, socioeconomic and health indicators for health networks nationwide. *The component will finance:* (i) rehabilitation or expansion of existing lower level facilities (i.e. health posts, health centers), and in few cases new primary health centers; (ii) medical equipment and furniture for health centers, (iii) management tools to better coordinate services provided in the selected health networks; and (iv) infrastructure, equipment, training and supervision to build ten new hospitals that will serve as health network referral centers of the targeted networks. Table 1 describes the types of services provided at each level of care.

Table 1. Services provided by level of care

Level of care	Scope of services provided
Primary healthcare facilities	PHC facilities are where the first-contact (entrance to the health system) should take place. Services are undifferentiated (no specialists) provided by General Practitioners, pediatricians, nurses and community health workers mainly through ambulatory services (some facilities may include short term admissions). Some facilities can include other health workers to expand the scope of the services based on the demand. The facilities include: • Health posts (services provided a few days a week or month) • Health centers (services provided daily) • Health centers that include a few beds for short term admissions These facilities refer patients to level 2 hospitals when the patient needs: specialized services, admission, tests or other technology not available in PHC.
Level 2 hospital	Level 2 hospitals provide differentiated services in four main specialties: Internal medicine, Pediatrics, General surgery and Obstetrics/Gynecology. Other specialties provided usually include: Cardiology, Neurology, Ophthalmology, Anesthesiology, Neonatology, Gastroenterology, Nephrology, Orthopedics, Mental health, etc. These services apply a medium level technology such as Laboratory, Radiology, Endoscopy, etc. In addition, these hospitals can support medical residence programs.
Level 3 hospital	Level 3 hospitals provide differentiated services as do the level 2 hospitals, but include all medical specialties and several sub-specialties. Most services require high level technology, including MRI, Cardiology Cath Labs, Radiotherapy, etc. The hospital hosts full medical residency programs. Patients are admitted on a referral from level 2 hospitals and directly from PHC facilities when needed.

14. **The ten new network referral centers to be supported by the project are:**

a. ***Hospital in La Paz*.** This tertiary hospital located in the Southern Zone of La Paz, will be the head hospital network in the Southern District of the department of La Paz that has an estimated population coverage of more than 750,000 inhabitants. Currently the network in this southern zone of La Paz only has a level 2 hospital that is not well equipped with the required technology or expertise to handle acute cases. This means there are no facilities nearby to refer complex or acute cases; requiring patients to seek out higher level care in central La Paz (at least one hour away) where the existing level 3 hospital has limited capacity and cannot fulfill the existing demand. This scenario also presents additional challenges for the poor, given the costs of transportation and other implied costs. Given its location, the new hospital will also support the networks of neighboring municipalities and districts. The network of the Southern Zone of La Paz will also be strengthened through the rehabilitation of existing primary care centers, and provision of equipment and clinical and administrative/management training to be able to provide primary and secondary level health services and avoid bypassing primary and secondary facilities and overburdening the new tertiary hospital. This network also includes 14 primary care services (health centers and health posts) and one secondary level hospital that will also be supported.

b. ***Nine level 2 hospitals (head hospitals of local networks at department level) and their corresponding networks.*** Project interventions will be turn-key operations in five departments as detailed in Table 2. All of the new level 2 hospitals would become the head hospitals of local primary health care networks, which currently operate without a reference hospital.

Table 2. Health Networks to be supported by the project

Department	Network	Number of municipalities covered by the network	Municipality where the hospital will be built	Level of network referral center	Population coverage
La Paz	La Paz*	87	Southern La Paz	3	2,719,344
			Caranavi	2	
Cochabamba	Quillacollo	7	Quillacollo	2	367,488
	Ivirgarzama	3	Puerto Villaroel	2	99,913
Santa Cruz	Andrés Ibáñez	4	La Guardia	2	199,772
	Ñuflo de Chávez	6	San Julian	2	116,652
	Velasco	3	San Ignacio de Velasco	2	69,828
	Warnes	2	Warnes	2	108,888
Beni	Mamoré	3	San Ramon	2	12,817
Potosi	Uncia	4	Uncia	2	87,272
TOTAL		**119**			**3,781,974**
*Although the municipality of Caranavi has its own network (rural 7), it is located within the larger network of the Departament of La Paz.					

15. **Execution of civil works, provision and installation of medical and non-medical equipment** (including options for management equipment contracts), and related trainings will be financed by the project through

turn-key contracts to reduce transaction costs and ensure that the hospitals will be operational. Supervision of the turn-key contracts will also be financed by the project. During project preparation, the Government is conducting a pre-investment (pre-design) study[13] that will define the technical requirements for the level 3 hospital in La Paz, with technical input from the Bank team. This pre-design study will provide the scope of services for the level 3 hospital and prepare the technical specifications required in the bidding documents for the recruitment of the construction firm for the level 3 hospital. Existing standard technical specifications and designs for level 2 hospitals will be updated.

16. **Component 2: Improving quality of health service delivery and human resource capacity development (US$49 million).** This component will support human resources capacity development as well as the development and implementation of tools and standard operating procedures (SOPs) for the management of the new hospitals and their networks. Activities supported by this component will be implemented on a national level with priority placed on: (i) supporting the training of human resources needed to close the gap to start the operation of the new hospitals, and (ii) increasing the national capacity of medical residency programs to allow these programs to satisfy the country needs of medical specialists. Finally, a citizen engagement survey will be incorporated in the overall design of the project, through a patient satisfaction survey.

17. **Subcomponent 2.1: Training medical specialists, other professionals and critical personnel.** This subcomponent will support strategies to reduce the existing gaps of medical specialists, other health professionals, and nurses. To deal with some of the short-term staffing needs, the project will finance: (i) training in other countries through implementing mainly grants and other arrangements with residence programs in other countries; (ii) arrangements with strategic partners (well recognized academic centers and medical residence programs in other countries) to support and expand the modernization and scale-up of medical education programs in the country, and facilitate the transfer of knowledge; (iii) local, short-term trainings or outside courses on hospital management and other critical areas (post-graduate certification); (iv) training for physicians working in urban intercultural settings on sensitivities towards indigenous cultural aspects in order to improve the quality of culturally sensitive health services; and (v) technical assistance (TA), medical education supplies and medical training equipment.

18. **Subcomponent 2.2: Developing, updating and dissemination of national clinical care (care pathways) standards and other governance related regulations.** This subcomponent will finance TA, training and support the design and updating of IT tools for dissemination, and use of a database of evidence-based clinical practice guidelines and recommendations on the care of patients with specific conditions. This subcomponent will also support the implementation of quality checklists and an application for smartphones including the updated clinical guidelines. The adaptation of the guidelines will be monitored through the project at departmental level and specifically in the hospitals targeted by the project, based on technical audits to be developed by external firms contracted by the Ministry of Health (MoH). In a country context where medical training is still a significant problem, the use of clinical guidelines will promote interventions of proved benefit (and discourage ineffective ones) that have the potential to reduce morbidity and mortality and improve quality of life.

19. **Subcomponent 2.3: Supporting the link between the SNIS (health information systems) and the new hospitals' information systems.** This subcomponent will finance TA, IT equipment, telecommunication networks and training to support the development of an interface between the existing SNIS and the new hospital information systems to be implemented in the new hospitals, as well as other information systems that

[13] *"Informe técnico de condiciones previas ampliado"*

form part of the health care information framework (*Sistema Único de Información en Salud (SUIS*). The subcomponent will also contribute to updating the SNIS to incorporate international standards (i.e. HL7[14]) which will allow for a more fluid exchange of data between the data and applications running (including a standard clinical record) in SNIS and the hospital information and management systems. Finally, the project will support a national maternal mortality study that will provide updated data from 2012.

20. **Component 3: Project Management (US$8 million).** Project management will be strengthened through two implementing entities: the Agency for Infrastructure in Health and Medical Equipment (AISEM), and a Project Implementing Unit (PIU) located in the Project Management Unit (UGESPRO) housed in the MoH, both bound to policies of the MoH and staffed with civil servants and consultants as needed to provide support, TA and capacity building. Component 3 will finance the related operating expenses, equipment, furniture, vehicles and personnel necessary for the execution of the project, in the areas of contract management, procurement, financial management, technical and monitoring and evaluation. This component will also finance the auditing of the hospital works and annual financial audits.

E. Implementation

Institutional and Implementation Arrangements

21. **The project will be implemented through two entities: AISEM and a PIU within UGESPRO (MoH).** AISEM will have overall responsibility for the technical supervision and fiduciary activities for the execution of Component 1 and part of Component 3. AISEM will coordinate with the MoH on specific technical aspects related to norms, regulations and monitoring of results. AISEM and the MoH will have bi-monthly meetings to agree on inputs and actions needed to implement the project and the Procurement Plan. Agreements will be reflected in minutes that will be included in semi-annual Project progress reports. The PIU within UGESPRO will be responsible for the execution of the technical and fiduciary activities of Component 2 and part of Component 3. Further details will be outlined in the Project Operation Manuals (POMs) for each respective implementing entity. The proposed implementation arrangements are in line with the current distribution of roles and functions of the Government's National Health Sector Plan and the National Hospital Plan.

22. **Component 1 (Strengthening Health Service Delivery Networks) and a portion of Component 3 (Project Management) will be implemented by AISEM**. This implementing entity will have direct technical and fiduciary responsibilities under Component 1, including procurement, contract management, financial management, disbursements, safeguards, and monitoring of the activities. AISEM will develop project activities under its own structure which includes a staff of Director General, Technical Director, Administrative Director, Environmental and Social Safeguards Specialist, Architect, Procurement Specialist, Financial Management (FM) Specialist and a legal advisor. The project will support consultants within AISEM with fiduciary expertise, including: Financial Management Specialist, Accountant, Budgetary Specialist, Procurement Specialist and administrative support. On the technical side, AISEM will require specialists in Infrastructure (engineer), architecture, two bio-medical specialists, monitoring and evaluation, medical doctor specialized in hospitals, legal counsel, among other areas. The project supported staff in AISEM will report to the AISEM Director General.

23. **Component 2 (Improving quality of health service delivery and human resource capacity development)**

[14] Health Level 7 (HL7) refers to a set of international standards for transfer of clinical and administrative data between software applications used by various healthcare providers.

and a portion of Component 3 (Program Management) will be implemented by a PIU located in UGESPRO housed in the MoH. The PIU within UGESPRO will be comprised of the following positions: (i) Project Coordinator; (ii) Monitoring & Evaluation Specialist; (ii) Legal Advisor; (iii) Financial Management Specialist; (iv) Procurement Specialist; and a (v) support team. The PIU will also be staffed with specialists in: (i) Hospital Management; (ii) Training of Human Resources; (iii) Health Regulations; and (iv) Health Information Systems.

24. **The respective roles of the PIU within UGESPRO and AISEM will be clearly detailed in two separate POMs** to ensure that all relevant implementers understand the project objectives and implementation procedures. Both POMs will outline the required composition and frequency of the coordination meetings between AISEM and the PIU within UGESPRO.

25. **The Bank's implementation support strategy will be based on the nature of the project, its risk profile as well as on lessons learned from previous projects.** The strategy is designed to be flexible so that it can be revised during project implementation if any challenges become evident. The implementation support strategy focuses primarily on the risk mitigation measures defined in the Bank's Systematic Operations Risk Rating Tool (SORT) and on supporting the client in various efficient ways as described below.

    a. ***Technical and Operations Support.*** The World Bank's implementation support will include the following activities: (a) providing technical guidance and advice; (b) ensuring timely production of annual implementation plans; (b) tracking the progress of project indicators to monitor the implementation of project components, and (c) ensuring that project implementation is in line with the POMs. A lead health specialist/medical doctor (task team leader) and two senior operations officers (one in the country office) will perform the day-to-day supervision of all operational aspects of the project, while also coordinating with the client. The project team has the benefit of country based team members including FM Specialist, Procurement Specialist and Environmental and Social Safeguards Specialists. Frequent implementation support missions will include the full Bank team with the support of an engineer/architect and a medical equipment specialist as needed.

    b. ***Coordination with Development Partners***. Throughout the project, the World Bank will coordinate with key partners through the Health Donors Group which meets monthly and is convened by the World Bank.

    c. ***Fiduciary Support.*** In the area of FM, the World Bank will review the project's financial management system, including, but not limited to, accounting, reporting, internal controls, and compliance with financial covenants. An FM specialist based in the World Bank's country office will help both implementing entities review interim unaudited financial reports, annual project audits, and external audits (as relevant), and carry out on-site FM supervision twice a year. In terms of procurement, a country based World Bank procurement specialist will support: (a) training of staff in both implementing entities and providing them with detailed guidance on the World Bank's Procurement Guidelines as needed; (b) reviewing procurement documents and providing of timely feedback to the project procurement team; (c) providing guidance to the MoH on the implementation of the Procurement Framework; and (d) undertaking post-procurement reviews.

    d. ***Information and Communication*****.** A communications strategy will support project implementation in different areas of intervention. The strategy will cover the implementation of various consultative

and accountability processes, including a grievance redress mechanism.

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

While interventions implemented by component 2 will have nationwide impact, project interventions in component 1 will take place in five departments: Beni, Cochabamba, La Paz, Potosi, and Santa Cruz. Project interventions will be turn-key operations in urban areas of La Paz (La Paz city and the urban municipality of Caranavi), Santa Cruz (urban municipalities of San Julian, La Guardia, San Ignacio de Velasco, and Warnes), Cochabamba (urban municipalities of Quillacollo and Puerto Villaroel), Beni (municipality of San Ramon) and Potosi (municipality of Uncia) . The project will build ten new hospitals: one Level 3 and nine Level 2. Given the urban setting, forests nor natural habitats are of concern.

G. Environmental and Social Safeguards Specialists on the Team

Juan Carlos Enriquez Uria, Environmental Safeguards Specialist
Angela Maria Caballero Espinoza, Social Safeguards Specialist

SAFEGUARD POLICIES THAT MIGHT APPLY

Safeguard Policies	Triggered?	Explanation (Optional)
Environmental Assessment OP/BP 4.01	Yes	The project will finance the construction of one large hospital (Level 3) and nine medium sized hospitals (Level 2). For the Level 3 hospital in La Paz and two Level 2 hospitals in Caranavi and Uncia, the final locations are not yet confirmed. Therefore, an Environmental and Social Management Framework (ESMF) was prepared. For the remaining level 2 hospitals, an Environmental Impact Assessment (Plan de Aplicación y Seguimiento Ambiental/Programa de Prevencion y Monitoreo, PASA/PPM according with the Bolivian regulation) has been conducted for each of these hospitals prior to appraisal. All of the hospital design and construction will follow environmental guidelines as established in national legislation and World Bank guidelines for the environment, environmental health and safety, and

		health care facilities. The construction will be turn-key and include health care waste treatment facilities (autoclave and grinder) thus eliminating any potential issues with health care waste management (HCWM) from the outset. During construction, potential adverse environmental impacts are closely related to changes in project site topography, ground clearing, excavations and leveling for the construction, alterations to surface and ground hydrological characteristics affecting surface and groundwater quality, traffic movement, and obstruction and generation of noise and dust during the operation of heavy project construction machinery. Most of the adverse impacts are short-term, occurring only during the project construction phase. The project will also support the strengthening of local health networks through critical renovations of several level one facilities (e.g. health centers and health posts) and potentially at level 2 hospitals, procurement of new equipment and capacity building activities as needed.
Natural Habitats OP/BP 4.04	No	This policy is not triggered as all activities are to be undertaken in an urban setting.
Forests OP/BP 4.36	No	This policy is not triggered as all activities are to be undertaken in an urban setting.
Pest Management OP 4.09	No	The project is not expected to support the procurement of pesticides and therefore the policy is not triggered.
Physical Cultural Resources OP/BP 4.11	Yes	The project does not expect to find physical cultural resources but given the nature of civil works, including excavation, this policy is triggered on a precautionary basis.
Indigenous Peoples OP/BP 4.10	Yes	The Social Assessment (SA) prepared by the Borrower confirmed that indigenous people are the overwhelming majority of the direct project beneficiaries in the targeted health networks. According to the National Census 2012, indigenous people (IP) represent 51.51% of the total project's population. Identified IPs in the project health networks are: Aymara (75%), Quechua (15%), Chiquitano and Monkox (1.9% and 0.3% respectively), Leco (0.8%), Kallawaya (0.7%), Tacana (0.4%), Guaraní (0.3%), Mosetén (0.2%), Tsimane

Chiman (0.1%), Guarayo (0.1%), Jach'a Pacajaqui (0.04%), Ayoreo (0.03%), Uchupiamonas (0.03%), Urus (0.03%), Araona (0.01%) and Other IP-Minorities (4.9%). Given this, the OP/BP 4.10 is triggered and the elements of an Indigenous People Plan (IPP) such as the cultural pertinence approach (free, prior and informed consultations during the project cycle and participatory planning processes) are included in the overall project design and reflected in a Social Management Framework (SMF) which is presented as a separate document that also includes the SA. Given this, a separate IPP or IPPF were not required.

Given the high dispersion of the indigenous population in the selected Health Networks and the conflict around the health sector during the project preparation, semi structured interviews were applied to undertake the process of free, prior and informed consultation with indigenous peoples. The following selection criteria were considered to choose where to apply this instrument: i) Networks with a large indigenous majority and ii) Networks with indigenous minorities. These criteria have allowed to collect representative information from the ten Health networks; Consultations were developed in the Ñuflo de Chávez Network of the Department of Santa Cruz, Rural Network 7 in the Department of La Paz and the Quillacollo Network in the Department of Cochabamba. A total of 170 beneficiaries (33.5% men) and (66.5% women) were interviewed in 29 indigenous communities of 10 Municipalities in an area covered by three of the targeted health networks. Given the consultation process has not been applied as a quantitative instrument, therefore the "sample" method does not apply. The information collected about the opinions of indigenous population must be read globally (aggregated). The majority of consulted beneficiaries (95%) expressed their satisfaction, consent and support to the construction of new hospitals in the health networks in which they live. Negative impacts were not identified.

Between the positive impacts, the beneficiaries identified that the project will: (a) improve the

		infrastructure and equipment of health services; (b) decrease transportation from rural areas to capital cities avoiding bad road conditions and transportation problems. The identified measures to mitigate social risks include: (i) to ensure access to the health networks for indigenous populations living in distant communities, the “Mochilas de la Vida” will be provided as part of the health services equipment in communities of the targeted networks; (ii) to improve the quality of health services for the vulnerable population, particularly indigenous women, the project will provide training on humanization in the health attention for physicians working in urban intercultural settings (included in Component 2); (iii) a regulation to improve intercultural communication, will be drafted based on the Law 045 Ley contra el racismo y toda forma de discriminacion. This regulation is meant to be implemented to improve intercultural communication and increase the users’ confidence in the health system. This regulation will be included in Component 2 of the project.
Involuntary Resettlement OP/BP 4.12	Yes	In compliance with the World Bank Operational Policy Involuntary Resettlement (OP/BP 4.12), and consistent with Bolivian law, the Borrower prepared a Resettlement Policy Framework (RPF) that encompasses procedures and requirements to develop a Resettlement Plan for the Southern La Paz Hospital, the Caranavi Hospital and the Uncia Hospital which will be prepared during project implementation, if needed, given the exact location of these projects are not confirmed by appraisal. The RPF includes clear methodologies for mitigation measures for all possible types of permanent and temporary physical impacts on land, assets, and economic activities that the proposed project might cause. There will be no land acquisition in the project. The policy is triggered as a proactive measure to mitigate impacts mainly related to temporary limitations. Compensation is not being considered. For the subprojects of the level 2 hospitals: Quillacollo, La Guardia, San Julián, Puerto Villarroel, San Ignacio de Velasco, Warnes and San Ramon, the policy is not triggered since the Borrower confirmed

		that land tenancy, assets and economic income of the hospitals' land neighbors, will not be affected by the new construction. These three hospitals will be built on available terrain that is being transferred, to be owned by the utility.
Safety of Dams OP/BP 4.37	No	This policy is not triggered given the project will not support the construction or rehabilitation of dams nor will it support other investments which rely on the services of existing dams.
Projects on International Waterways OP/BP 7.50	No	This policy is not triggered as project activities will not be conducted on international waterways.
Projects in Disputed Areas OP/BP 7.60	No	This policy is not triggered as project activities will not be conducted in disputed areas.

KEY SAFEGUARD POLICY ISSUES AND THEIR MANAGEMENT

A. Summary of Key Safeguard Issues

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

Potential adverse environmental and social impacts are site-specific and reversible; these impacts can be easily addressed by applying appropriate prevention and mitigation measures. The ESMF and PASAS/PPMs (Planes de Aplicación y Seguimiento Ambiental/Programa de Prevencion y Monitoreo, according with the Bolivian regulation) prepared by AISEM will provide guidance on potential issues that could arise during project implementation. The Bank has reviewed and approved the ESMF and PASA/PPMs. These instruments were consulted with key stakeholders before appraisal (March 2, 2018), and were disclosed locally through the MINSALUD (March 16, 2018) and WB websites (March 30, 2018).

Design and construction will follow environmental guidelines as established in national legislation and World Bank guidelines for the environment, environmental health and safety, and for the health care facilities. All of the construction will be turn-key and include health care waste treatment facilities (autoclave and grinder) thus eliminating any potential issues with health care waste management (HCWM) from the outset.

2. Describe any potential indirect and/or long term impacts due to anticipated future activities in the project area:

The civil works will require a variable number of workers during variable periods of time depending on the dimension of the hospitals that will be built. The construction and the construction supervision firms will be specialized companies responsible to perform the civil works in 5 years or less . It is expected to have between 30 and 300 workers, including architects, engineers and other employees. Labor influx issues could emerge.

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

The construction companies will adopt effective measures to ensure Codes of Conduct based on the principles of integrity, professionalism, respect, gender equality, to avoid mistreatment and discrimination. Key measures to ensure the mitigation of labor influx would be: (i) requirements for the contractor and supervision consultant to have adequate staff in charge of environmental and social compliance measures; (ii) a requirement for the contractor to

prepare a strict “Contractor’s Personnel Code of Conduct” linked to Bolivian Law 348 to prevent gender-based violence; and (iii) monitoring and enforcement of the contractor’s observance of the Code of Conduct by the supervision consultant.

4. Describe measures taken by the borrower to address safeguard policy issues. Provide an assessment of borrower capacity to plan and implement the measures described.

Based on the interactions during the project preparation, the Borrower’s capacity to address social issues and relevant safeguard policies is considered adequate. However, to ensure the monitoring and compliance of OP/BP 4.10 and OP/BP 4.12 and of the social safeguard instruments (e.g. Resettlement Policy Framework and Social Management Framework [which is part of the ESMF]), the recruitment of a social development specialist in the PIU team is indispensable.

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

The Project implementation team, will include as part of the Project Operations Manual, specific instruments that will lay out the GRM during the project cycle. The guidelines will be continuously updated to facilitate planning, implementation and informed decision-making, dialogue and cooperation to ensure the Project sufficiently conducts outreach to the indigenous populations that are part of the estimated Project beneficiaries.

B. Disclosure Requirements

Environmental Assessment/Audit/Management Plan/Other

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

"In country" Disclosure

Bolivia

16-Mar-2018

Comments

Resettlement Action Plan/Framework/Policy Process

Date of receipt by the Bank	Date of submission for disclosure
	12-Mar-2018

"In country" Disclosure

Bolivia

16-Mar-2018

Comments

Indigenous Peoples Development Plan/Framework

Date of receipt by the Bank	Date of submission for disclosure
	12-Mar-2018

"In country" Disclosure

Bolivia
16-Mar-2018

Comments

Given indigenous people (IP) represent the majority of the project's population beneficiaries, all the elements of an Indigenous People Plan (IPP) are included in the overall project design and reflected in a Social Management Framework (SMF) which is presented as a separate document that also includes the SA. Given this, a separate IPP or IPPF were not required.

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

OP/BP/GP 4.01 - Environment Assessment

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

OP/BP 4.11 - Physical Cultural Resources

Does the EA include adequate measures related to cultural property?
Yes
Does the credit/loan incorporate mechanisms to mitigate the potential adverse impacts on cultural property?
Yes

OP/BP 4.10 - Indigenous Peoples

Has a separate Indigenous Peoples Plan/Planning Framework (as appropriate) been prepared in consultation with affected Indigenous Peoples?
No

OP/BP 4.12 - Involuntary Resettlement

Has a resettlement plan/abbreviated plan/policy framework/process framework (as appropriate) been prepared?
Yes
If yes, then did the Regional unit responsible for safeguards or Practice Manager review the plan?
Yes

The World Bank Policy on Disclosure of Information

Have relevant safeguard policies documents been sent to the World Bank for disclosure?
Yes
Have relevant documents been disclosed in-country in a public place in a form and language that are understandable and accessible to project-affected groups and local NGOs?
Yes

All Safeguard Policies

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

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