Project Information Document (PID)

Appraisal Stage | Date Prepared/Updated: 11-May-2020 | Report No: PIDA29272

BASIC INFORMATION

A. Basic Project Data

Country	Project ID	Project Name	Parent Project ID (if any)
Uruguay	P173876	UY: COVID-19 Emergency Response Project	
Region	**Estimated Appraisal Date**	**Estimated Board Date**	**Practice Area (Lead)**
LATIN AMERICA AND CARIBBEAN	29-Apr-2020	21-May-2020	Health, Nutrition & Population
Financing Instrument	**Borrower(s)**	**Implementing Agency**	
Investment Project Financing	The Oriental Republic of Uruguay	Ministry of Economy and Finance, Ministry of Public Health	

Proposed Development Objective(s)

To strengthen the detection and response capacity of the Uruguayan National Health Integrated System to the threat posed by COVID-19

Components

Emergency Response to COVID-19
Implementation Management and Monitoring and Evaluation

PROJECT FINANCING DATA (US$, Millions)

SUMMARY

Total Project Cost	20.00
Total Financing	20.00
of which IBRD/IDA	20.00
Financing Gap	0.00

DETAILS

World Bank Group Financing

International Bank for Reconstruction and Development (IBRD)	20.00

Environmental and Social Risk Classification

Moderate

Decision

The review did authorize the team to appraise and negotiate

B. Introduction and Context

MPA Program Context

1. **An outbreak of the coronavirus disease (COVID-19) caused by the 2019 novel coronavirus (SARS-CoV-2) has been spreading rapidly across the world since December 2019, following the diagnosis of the initial cases in Wuhan, Hubei Province, China.** Since the beginning of March 2020, the number of cases outside China has increased thirteenfold and the number of affected countries has tripled. On March 11, 2020, the World Health Organization (WHO) declared a global pandemic as the coronavirus rapidly spreads across the world. As of May 1, 2020, the outbreak has resulted in an estimated 3.36 million cases and over 237 thousand deaths in 215 countries.

2. **COVID-19 is one of several emerging infectious diseases outbreaks in recent decades that have emerged from human contact with animals, resulting in major outbreaks with significant public health and economic impacts.** The last moderately severe influenza pandemics were in 1957 and 1968; each killed more than a million people around the world. Although countries are now far more prepared than in the past, the world is also far more interconnected, and many more people today have behavior risk factors such as tobacco use[1] and pre-existing chronic health problems that make viral respiratory infections particularly dangerous.[2] Scientists are still trying to understand the full picture of COVID-19's symptoms and severity. Reported symptoms in patients have varied from mild to severe, and can include fever, cough and shortness of breath. In general, studies of hospitalized patients have found that about 83 to 98 percent of patients develop a fever, 76 to 82 percent develop a dry cough and 11 to 44 percent develop fatigue or muscle aches. Other symptoms, including headache, sore throat, abdominal pain, and diarrhea, have been reported, but are less common. While 3.7 percent of the people worldwide confirmed as having been infected have died, WHO has been careful not to describe that as a mortality rate or death rate. This is because during an unfolding epidemic it can be misleading to look simply at the estimate of deaths divided by cases so far. Hence, given that the actual prevalence of COVID-19 infection remains unknown in most countries, it poses unparalleled challenges with respect to global containment and mitigation. These factors reinforce the importance of t strengthening the COVID-19 response across all IDA/IBRD countries in order to minimize the global risk and impact posed by this disease.

3. **This project is prepared under the global framework of the World Bank (WB) COVID-19 Response financed under the Fast Track COVID-19 Facility (FCTF).**

Country Context

4. **Uruguay's GDP per capita grew between 2002-2019 by 153 percent (constant PPP), more than most peer countries, largely due to monetary and fiscal policy reforms, as well as sound debt management supporting**

[1] Marquez, PV. 2020. "Does Tobacco Smoking Increases the Risk of Coronavirus Disease (Covid-19) Severity? The Case of China." *http://www.pvmarquez.com/Covid-19*

[2] Fauci, AS, Lane, C, and Redfield, RR. 2020. "Covid-19 — Navigating the Uncharted." New Eng J of Medicine, DOI: 10.1056/NEJMe2002387

resilience. However, in recent years, the economy was hit by external shocks, in particular, commodity price falls, several climatic events and recessions in Argentina and Brazil. Growth decelerated from 4.6 percent in 2013 to 1.6 percent in 2018 and 0.2 percent in 2019. Lower growth weakened the labor market, with employment declining across the economy. The employment rate fell from 57.2 to 56.7 percent between 2018 and 2019, while the participation rate remained unchanged at 62.2 percent, and unemployment rose to 8.9 percent from 8.3 percent in 2018. The increase in unemployment was greater for low-income groups: the rate for youths (14-24 years old) stood at 27.7 percent in 2019, and at 9.9 percent among women 25-39 years old.

5. **The effects of the COVID-19 outbreak, immediately started to permeate through the economy, triggering a dramatic fall in economic activity and increasing pressure on the labor market.** Exports to China, Uruguay's main trading partner, experienced a sharp drop (49 percent) in February, leading to a fall of 10.9 percent in total exports year-to-year. Although exports began to recover in March and April in line with the rebound in industrial activity in China, they were still 23 and 30 percent lower than in March and April of 2019. This was partially compensated by higher export prices, as prices of Uruguayan products presented slight positive variations in February and March, and the plunge in oil prices, as Uruguay is an importer. In March, the National Social Protection Agency (BPS) registered 86 thousand new applications for unemployment benefits, around 5 percent of the total number of active workers contributing to the social security system, and almost 54 thousand in the first half of April. More than half of these applications come from workers in three sectors: commerce (33,000), hotels and restaurants (15,000) and manufacturing (22,000). [3]

6. **The economy is projected to enter recession in 2020 for the first time in two decades due to economic impact of COVID-19, increasing unemployment and poverty**. Domestic and global measures to mitigate the spread of the virus and save lives will have a negative effect on the entire economy, but particularly on commerce (except supermarkets and pharmacies), manufacturing, hospitality and cultural and recreational activities. Tourism will be particularly hard hit in 2020 and recover slightly in 2021, due to the persistent perception of risks associated to the pandemic, the potentially remaining (partial) travel restrictions, and the projected slow recovery in Argentina. Agriculture has also been affected, due to lower external demand, but will likely recover more quickly due to signs of recovery in China. Manufacturing will also likely gain dynamism as restrictions are lifted and Brazil's economy gathers strength over the medium term. On the contrary, the shock will be felt strongly in commerce (except supermarkets and pharmacies), manufacturing, hospitality and cultural and recreational activities. As some of these sectors are big employers (e.g., commerce and hospitality represent 23 percent of all workers and 29 percent of informal workers), this will have substantial negative implications for unemployment and incomes.

7. **However, there are major risks to the outlook, related to the potential for a larger and/or more protracted impact from COVID-19.** The longer the epidemic and related restrictions last, the larger the contraction of domestic and external demand. Furthermore, delays in executing large investment projects related to the new paper mill project could deepen the recession, while heightened financial market turbulences could further pressure the foreign exchange market, pushing inflation even higher. This would have a greater impact on the poor. In the absence of broader protection measures beyond the extraordinary unemployment subsidy announced on March 18, 2020[4], the materialization of major job losses in retail and hospitality sectors could lead to increases in national poverty rates, especially if these jobs are not reinstituted after one quarter.

[3] World Bank World Economic Indicators, Central Bank of Uruguay, and Ministry of Economy and Finance of Uruguay.
[4] The government has issued measures to create a temporary unemployment insurance scheme that complements the existing one and provides salary replacement in case of partial suspensions (Ministerial resolution 143 dated March 18, 2020).

Sectoral and Institutional Context

8. **Uruguay has one of the most developed and complex health systems in Latin America.** The National Health Integrated System (NHIS) establishes unique rules for public and private health service insurers and a common Integrated Health Care Plan (PIAS) for everyone. Coverage is provided under the following two schemes: (i) the National Health Insurance (NHI), the country's sole national insurer financed through a uniform, basically contributory scheme that provides coverage to formal workers and their families and retirees (73 percent of the population), managed by the National Health Board (JUNASA); and (ii) the Health Public Provision, financed through the public budget, that covers the population without formal work and its families, including the most vulnerable groups (25 percent of the population), through the State Health Services Administration (ASSE), a public network of hospitals and primary health care facilities. ASSE currently also serves 20 percent of NHI beneficiaries, receiving financing from the National Health Fund (FONASA). Table 1 below describes the NHIS current structure.

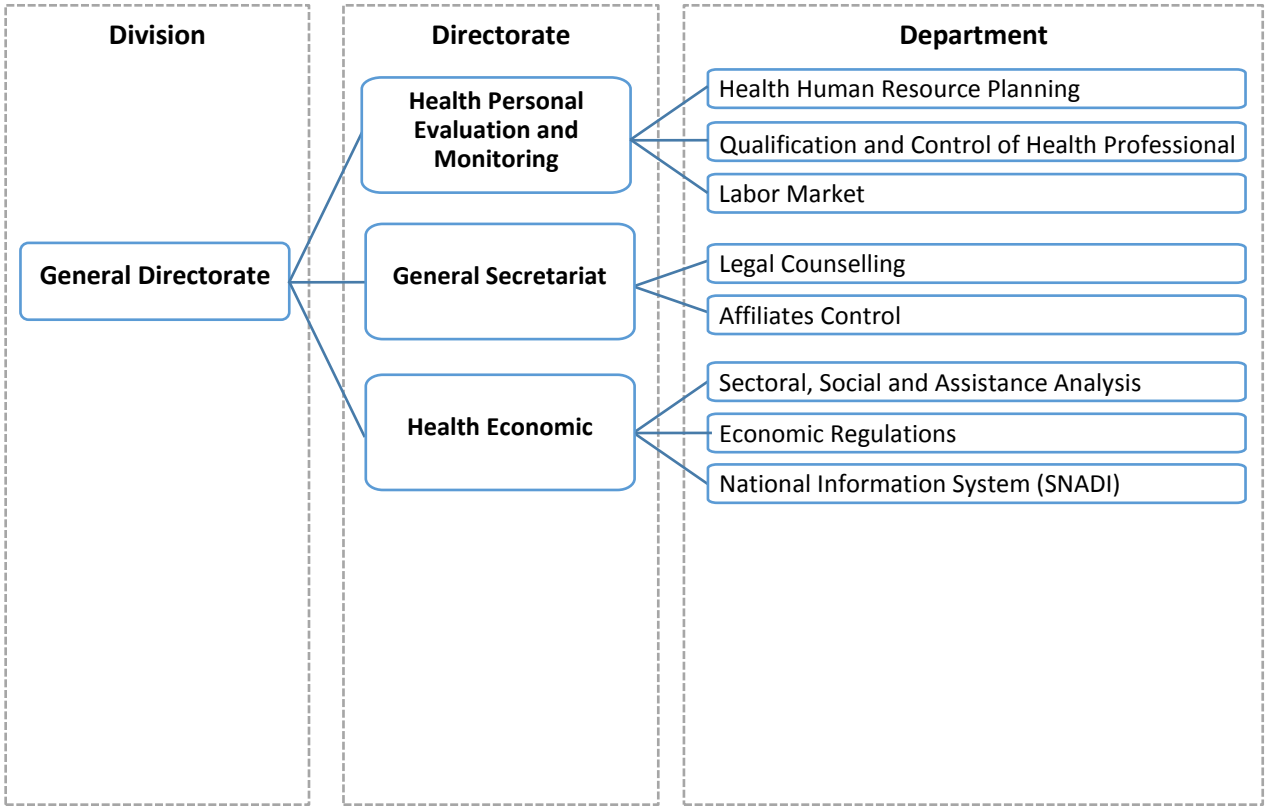
Table 1 - Basic Architecture of the NHIS

	Health Public Provision	NHI
Regulation	Ministry of Public Health (MSP) - General Health Directorate (DIGESA)	MSP; JUNASA; FONASA; General Directorate of JUNASA that oversees the functioning of the NHI and the control of the health service capacity and management of health providers
Financing source	Public budget	Personal contributions by workers and pensioners, employer contributions, voluntary contributions and government subsidies
Financing agent	Ministry of Economy and Finance (MEF)	BPS
Service delivery	ASSE; State's University hospital; State's Insurance Bank	Integrated public and private providers: ASSE, collective health care institutions (IAMC) and integrated insurers
Benefit plan	PIAS	PIAS

Source: WB Report No. 80084-UY- Republic of Uruguay Integrated National Health System-2012

9. **JUNASA is a deconcentrated and collegiate body, created by Law 18,211 under the Ministry of Public Health (MSP), responsible for administering the NHI and ensuring compliance with the guiding principles and objectives of the NHIS.** It has decision-making power over everything pertaining to the NHI and is made up of Executive Branch representatives: two from the MSP, one from the Ministry of Economy and Finance (MEF) and one from the BPS. JUNASA also includes a Health Service Providers (HSP) representative, a representative for HSPs' employees and a representative for users of public and private health provider systems. From the perspective of social participation, all the groups involved in the organization of the NHIS (institutions, workers, users) are represented in the JUNASA. JUNASA is chaired by the General Directorate of JUNASA. The functional structure of JUNASA is as follows:

Figure 1 –Functional Structure of the National Board of JUNASA

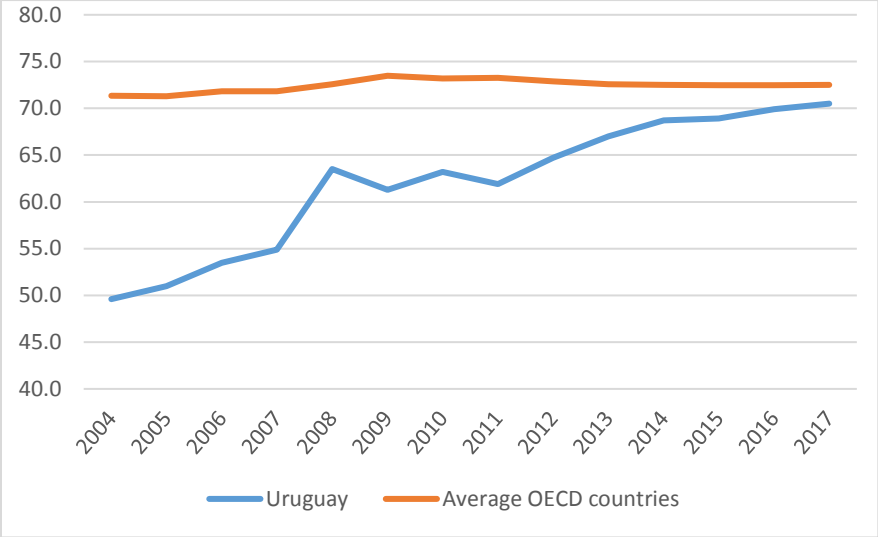


10. **The NHI finances HSP through capitation payments adjusted by: (i) age- and sex-risks and (ii) performance linked to a pre-defined set of health goals.**[5] In terms of the health care model, the NHIS introduced a substantial shift in the epidemiological focus towards preventive interventions and a reorientation towards an integrated approach.

11. **Health is a top priority for the government.** Since 2005, public spending on health as a percentage of total health expenditure as shown in Figure 2 has increased until almost converging with the OECD average (as of 2017). Total health expenditure reached 9.3 percent of GDP in 2016 and health per capita expenditure reached US$ 1472.[6] In conjunction, health indicators have improved with the country achieving high immunization and prenatal care coverage and decreasing maternal and infant mortality rates.

[5] WB Report No. 80084-UY- Republic of Uruguay Integrated National Health System, 2012
[6] Source: OECD and MSP, Projection. Lic. Leticia Zumar, MEF, in Cooperación Sur-Sur sobre "Reforma sectorial de salud en Paraguay: aprendiendo de las experiencias vecinas de Chile y Uruguay", 1º y 2 de abril de 2019, Montevideo, Uruguay.

Figure 2. Public Health Expenditures as Percentage of Total Health Expenditures



Source: OECD and MSP, Lic. Leticia Zumar, MEF, Uruguay in Cooperación Sur-Sur sobre "Reforma sectorial de salud en Paraguay: aprendiendo de las experiencias vecinas de Chile y Uruguay", 1º y 2 de abril de 2019, Montevideo, Uruguay

12. **A robust health care system, an egalitarian society and low poverty levels contribute to Uruguay's high ranking in several well-being indices, such as the Human Development Index,[7] the Social Progress Index[8] and the Economic Freedom Index.**[9] Low birth rates and an increasing life expectancy (over 77 years in 2017) have resulted in a demographic transition like that of developed countries and an associated rise in non-communicable diseases (NCDs), which are the leading cause of death and burden of disease. Three NCDs (circulatory system, neoplastic and respiratory system diseases) account for more than 60 percent of all deaths. Ten out of the 15 diseases that cause the highest number of Years of Life Lost (YLL) and Years of Healthy Life Lost (DALYs) in Uruguay are NCDs.[10]

13. **Despite a robust health system, Uruguay is at a substantial risk for the spread of COVID-19 due to local transmission and the possibility of a rapid increase in existing cases**. As of May 3, there were 655 positive cases in the country, with 17 deaths, all with existing health preconditions.[11] Of the existing cases, 10 were in intensive care. Following the first two weeks of testing, the number of daily cases has fallen and remained steady over the past few days. Uruguay's long border with Brazil, a country with growing outbreaks and over 91.5 thousand existing cases as of May 1, 2020, could increase the risk of imported cases.

14. **In addition, Uruguay's demographic structure and the health status of its population make the country more vulnerable to COVID-19**. After several decades of low mortality and birth rates, Uruguay is in an advanced stage of demographic transition, with an aging population resulting from an increase in life expectancy, decline in mortality and below replacement fertility levels. According to international evidence, those most affected by

[7] Uruguay's HDI value for 2018 is 0.808, positioning it at 57 out of 189 countries and territories (*http://hdr.undp.org/sites/all/themes/hdr_theme/country-notes/URY.pdf*)
[8] Score 77/100; rank 41/149 *(https://www.socialprogress.org/?tab=2&code=URY)*
[9] Overall score is 69.1; World Rank 47 *(*https://www.heritage.org /index/country/uruguay*)*
[10] PPENT-MSP 2015. Estudio de Carga de Enfermedad.
[11] 4.89 per 1 million people.

COVID-19 are the elderly and those suffering from NCDs, who are also most vulnerable to climate-related diseases and impacts. In Uruguay, 14.42 percent of the population is over 65 and there is a high prevalence of NCDs.

15. **The challenges to Uruguay's health system and ability to implement measures as a response to COVID-19 are exacerbated by the observed and anticipated impacts of climate change.** Extreme climate events, mainly floods and droughts, have already adversely affected the country's society and economy, particularly the most vulnerable communities (e.g. major losses in housing, urban infrastructure, in addition to psychosocial impacts). Climate projections indicate a rise in mean annual temperature of 1.5 degrees Celsius by 2050, coupled with an increase of annual hot days (with temperatures above 35 degrees Celsius) by 10.2 days in 2050[12]. These climate impacts have clear links to human health through direct exposure (e.g. heat waves, floods and droughts) as well as indirect pathways (climate impacts on water, food and air quality). Rising temperatures and recurrent heat waves, for instance, can create severe health impacts including the proliferation of diverse pathogens, vector-borne diseases, increased dehydration and other respiratory diseases. Observed and anticipated climate change impacts, in particular climate-induced natural disasters, also pose challenges to the infrastructure of the health system, thereby limiting the effective response in cases of public health emergencies. Noting that lower respiratory infections are among the leading health risks in Uruguay, the emergence of COVID-19 and the exposure to climate change impacts are intensifying currently observed risks and vulnerabilities.

16. **Though the number of beds in Uruguay (2.4 per 1,000 inhabitants) and the number of doctors (50.5 per 10,000 inhabitants) is higher than in many other Latin American countries, the health system could easily become over stressed if the number of cases were to increase considerably**.[13] Uruguay had at the beginning of the pandemic a total of 625 Intensive Care Units (ICU) beds, 80 percent owned by IAMCs and Insurance Companies providing services to the NHI and 20 percent (125) owned by ASSE, providing services to the NHI and to its own beneficiaries. ICU bed numbers represent 0.18 beds for 1,000 inhabitants, which is low compared to ICU beds in OECD countries.[14] Furthermore, there is the risk that the health system could be debilitated by high COVID-19 health worker infection rates (as of May 3, 15 percent of the positive cases were health workers). The Government is increasing the ICU capacity through its own resources (allocated to ASSE), international development partner financing, private sector, grants and NGOs.

17. **While additional ICU beds and medical supplies for the main health public provider, ASSE, is directly supported through public funding, the NHI is undergoing financial stress because of insufficient revenues to finance the additional cost imposed by the COVID-19 pandemic.** Expenditures have risen primarily from increased testing (which is key to reduce virus circulation), spending on the expansion of ICU beds and critical care equipment, and intensive care costs related to critical patients suffering from acute respiratory distress.

18. **Following the first COVID-19 local cases, Uruguay acted swiftly[15] by formulating a comprehensive COVID-**

[12] Sources: Climate Change Knowledge Portal; Uruguay's Fourth National Communication to the UNFCCC; IHME, *Uruguay*.
[13] PAHO.org
[14] As example, ICU beds x 1,000: Canada 1.95; France 3.09; Mexico 1.38; Italy 2.62; Spain 2.43; Chile 1.99 (OECD, 2018) https://data.oecd.org/healthcare/hospital-beds.htm
[15] Beginning on March 2020, the Government implemented social distancing measures, population movement controls, and a strong social awareness campaign; strengthened the epidemiological surveillance of passengers at the points of entry to the country; followed by the closing of all educational establishments, international borders and the airport.

19 Preparedness and Response Plan[16] **(COVID-19 PRP),aligned with the WHO's SPRP**[17] **and including critical steps**[18] **organized in three response levels: (i) Alertness and readiness level; (ii) Level of imminent risk of spread; and (iii) National multi-sectoral coordinated response level.** The COVID-19 PRP is aimed at slowing transmission, delaying outbreaks and providing optimized care for all patients, especially the seriously ill, as well as minimizing the impact of the epidemic on the health system and social services and, consequently, on economic activity. The Plan supports the nine components that the WHO proposed globally to scale up country operational readiness and response. In addition, the Government has also implemented measures to cushion the economic impact of the pandemic on households and enacted a Coronavirus Fund Law.[19] The Law temporarily lowers the salaries of high salaried public servants and political officials, as well as high pensions, by up to 20 percent, to attend the health emergency derived from the coronavirus pandemic.

19. **The Government has requested WB financial support to help ensure an appropriate and timely implementation of key activities under the Plan**, including the provision of specific supplies and logistic support to contain and mitigate the epidemic, support in financing early detection to mitigate the pandemic expansion and adequate treatment for COVID-19 patients to minimize the associated morbidity and mortality due to the outbreak. Regardless of the country's high-income classification the role of health as a global public good reinforces the importance of supporting the country's response to the pandemic to reduce the spread of the disease.

20. **Given Uruguay's health system structure, output-based financing was identified as an appropriate approach for the allocation of a substantial share of the Project's funds.** Given that the PIAS does not currently possess the health services required to confront the COVID-19 pandemic, the JUNASA needs to acquire those additional services from HSPs so as not to face shortfalls in health services provision. This Project, jointly with other financial sources, will help the country respond to the outbreak by supporting the financing of specific outputs for diagnosis and treatment of COVID-19 patients for NHI beneficiaries. ASSE's beneficiaries will benefit from the increased budget allocation and the provision of medical equipment and PPE that will be financed through the proposed Project. This innovative approach that relies on the utilization of outputs builds on lessons learned from the preparation and implementation of other WB Projects[20] supporting the response to the COVID-19 outbreak which mainly support the financing of inputs. Difficulties related to the availability and timely provision of critical goods due to increased demand led to a different operational model that is more suitable for Uruguay's health system.

21. **Donors and International Financiers actions:** In addition to this loan, Uruguay has sought international financing from FONPLATA[21], Andean Development Corporation (CAF), European Investment Bank (EIB), and the Inter-American Development Bank (IADB) to face the pandemic, with direct support to the health sector for approximately US$ 41.3 million and budgetary support for social and economic sectors for US$ 460 million. In

[16] https://www.paho.org/uru/index.php?option=com_content&view=article&id=1509:planes-de-contingencia-de-uruguay-frente-a-covid-19&Itemid=451

[17] https://www.who.int/docs/default-source/coronaviruse/srp-04022020.pdf

[18] (1) country-level coordination; (2) planning and monitoring; (3) risk communication and community engagement; (4) surveillance, rapid-response teams and case investigation; (5) control at points of entry; (6) support for national laboratories; (7) infection prevention and control; (8) case management; and (9) operations support and logistics.

[19] Ley 19874 "Fondo Solidario COVID-19".

[20] AR and PY COVID-19 Emergency Response Project (P173767 and P173876, respectively)

[21] FONPLATA is the name brand for the Financial Fund for the Development of the Plata Basin (*Fondo Financiero para el Desarrollo de la Cuenca del Plata*, in Spanish)

addition to this proposed project, the WB is also preparing a US$ 400 million project[22] to support Uruguay to face the effect of the pandemic. It has also received donations from private companies and NGOs for US$ 4.9 million (mainly dedicated to purchasing supplies and medical equipment) and from United Nations agencies for US$ 0.681 million (mainly supporting the development of social and communicational aspects of the strategy to face the pandemic). In addition, The United Nations in Uruguay is supporting the national Government's response to the COVID-19 pandemic in four principal areas: (a) supporting the health and emergency system address the pandemic (the MSP and the SINAE); (b) focusing on the population most vulnerable to COVID-19; (c) generating data and analyses to design post-crisis recovery policies (economic, labor, sanitary and social); and d) producing training and communication material to prevent the spread of the pandemic.

C. Proposed Development Objective(s)

22. The Project objective is aligned with the results chain of the COVID-19 SPRP.

Development Objective(s) (From PAD)

23. To strengthen the detection and response capacity of the Uruguayan National Health Integrated System to the threat posed by COVID-19

D. Project Description

24. **The proposed Project will consist of two components.** The first component will support the identification, isolation and provision of care to patients with COVID-19 in a timely manner in order to minimize disease spread, morbidity and mortality while preparing the health system for increasing levels of demand for care. The second component will support Project management implementation and monitoring and evaluation activities. The total Project costs are US$ 20 million

Component 1: Emergency Response to COVID-19 (US$19.92 million)

25. **This component would provide immediate support to Uruguay in limiting COVID-19 local transmission through containment strategies and strengthening of the health system's capacity to treat COVID-19 critical cases**. It would support the enhancement of disease detection capacity by financially supporting the expansion of the MSP's testing strategy to ensure prompt case finding and contact tracing, consistent with WHO guidelines in the Strategic Response Plan and providing inpatient care to critical patients affected by COVID-19. The component has two subcomponents described below:

26. ***Subcomponent 1.1 Case Detection, Confirmation, Contact Tracing, Recording, Reporting*** **(US$10.19 million).** This sub-component would help MSP develop its disease surveillance strategy for early detection and confirmation of COVID-19 cases among the NHI beneficiaries through the expansion of testing. Increased COVID-19 testing of the covered population will: (i) permit identification of positive cases; (ii) allow for active contact tracing of new cases; (iii) support the epidemiological investigation with data; (iv) strengthen risk assessment (including by adding additional risks posed to the population, such as those related to climate change impacts into the assessment itself); and (v) provide up-to-date data for guiding decision-making and response and mitigation activities (also taking a comprehensive approach and including other relevant data and wider mitigation activities, including

[22] UY COVID-19 Response and Resilience to Shocks DPL (P172796)

those related to climate change, where applicable). Testing NHI-covered health personnel will protect them and limit contagion through early diagnosis. The subcomponent will finance the unit cost of COVID-19 Testing outputs paid out of FONASA, which include all of the administrative, assistance, and professional services, as well as medical supplies, and equipment required to test an individual for COVID-19, according to available and approved technologies for NHI beneficiaries at the HSP.

27. ***Subcomponent 1.2. Health System Strengthening*** **(US$9.73 million).** Assistance to the health care system to provide optimal medical care and minimize risks for patients and health personnel, including for frontline workers, by providing them with the appropriate protective equipment and hygiene materials. This will allow protecting staff against other climate-related diseases, in particular unforeseen emerging zoonoses. The Project would strengthen clinical care capacity by supporting FONASA's payment of NHI beneficiary hospitalization services in specialized units of selected HSPs, under approved treatment guidelines, with trained health workers and applying hospital infection control guidelines.

28. **As COVID-19 would place a substantial burden on inpatient health care services, this subcomponent will finance the unit cost of Hospitalization outputs** (inpatient hospitalization days for COVID-19 health care treatment practices) for NHI beneficiaries paid out of FONASA in order to expand access to inpatient care**.** The hospitalization outputs include all of the administrative, assistance, and professional services, as well as the medical supplies, drugs, and equipment required to provide moderate, intermediate and intensive care services per day for COVID-19, according to available and approved technologies. Also, this subcomponent will support public network primary health care facilities and hospitals cope with the increased service demand posed by the outbreak, by financing the procurement of protective medical supplies, especially personal protective equipment (PPE), masks, gloves, inter alia, and medical equipment. These latter activities will be financed on an input basis.

29. **By incorporating observed and anticipated climate change risks into sub-components 1.1 and 1.2, the Project will strengthen the disease surveillance system and the health system's capacity. Thereby, it** will also enhance the system's resilience and ability to respond to a wider range of health threats in the future, including climate-related ones.

Component 2: Implementation Management and Monitoring and Evaluation (US$ 0.08 million)

30. **This Component would provide support for the strengthening of public sector project management and coordination, including coordination of activities, financial management (FM) and procurement.** Financing would be used to strengthen the relevant areas within the MEF and MSP involved in Project implementation through the recruitment of additional, qualified personnel to carry out overall administration, procurement, and FM. To this end, the Project would finance operating costs associated with project coordination, monitoring, implementation, and evaluation.

31. **Large volumes of personally identifiable information and sensitive data are likely to be collected and used in connection with the management of the COVID-19 outbreak under circumstances where measures to ensure the legitimate, appropriate and proportionate use and processing of that data may not feature in national law or data governance regulations, or be routinely collected and managed in health information systems.** In order to guard against data abuse, the Project will incorporate best international practices for dealing with data in such circumstances. Such measures may include, by way of example, data minimization (collect only data that is necessary for the purpose); data accuracy (correct or erase data that is not necessary or is inaccurate), use limitations (data is only used for legitimate and related purposes), data retention (retain data only for as long as

it is necessary), informing data subjects of use and processing of data, and allowing data subjects the opportunity to correct information about them, etc. In practical terms, the proposed operation will ensure that these principles apply through assessments of existing or development of new data governance mechanisms and data standards for emergency and routine healthcare, data sharing protocols, rules or regulations, revision of relevant regulations, training, sharing of global experience, unique identifiers for health system clients, strengthening of health information systems, etc.

Legal Operational Policies

	Triggered?
Projects on International Waterways OP 7.50	No
Projects in Disputed Areas OP 7.60	No

Summary of Assessment of Environmental and Social Risks and Impacts

32. The Project will be implemented at the national level, so beneficiaries will be the population at large. This Project will neither finance nor support civil works and all the Project investments are planned to take place on existing infrastructure. The activities supported by the Project therefore are not expected to have adverse physical environmental impacts. The social impacts of the Project are also expected to be positive, as activities will support the strengthening of the detection and response in the fight against COVID-19.

33. Environmental risk rating for this Project is Moderate. Risks are limited and manageable related to use and disposal of medical supplies, use of cleaning and disinfection chemicals, and waste-related issues that are already managed appropriately in the NHIS's HSP. The project will neither finance nor support any civil works and all the Project procurable goods will be installed and used in existing public health care facilities. Project funds will support the purchase of medical supplies and equipment, including personal protection equipment for health facilities workers in the public sector. The MSP and the HSP have in place mechanisms for medical waste management disposal of: (a) laboratory waste, (b) hospital and infectious waste, and (c) environmental risk management in general, which meet the WHO protocol for managing infectious waste. Environmental and social risk management and training will be developed by the MSP as it be needed to prevent, minimize and mitigate any negative impact of the management of Health Care Waste, including other hazardous waste that can be expected to increase in volume and challenge the existing management capacity, from the generation of laboratory waste, and the hospitalization of the sick.
34. The social risk rating for this Project is Low. The Project is expected to have only positive social impacts, as the services to be provided through this project will be directed to the NHI, which provides care and epidemiological containment to 70% of total population and include the most vulnerable population for COVID-19, the retirees; and all the supplies to be acquired will be directed to the public providers of the NIHS, where care is provided irrespective of ability to pay and coverage include the historically excluded groups. The Project will not involve resettlement or land acquisitions. The funds will be used to enhance existing mechanisms of epidemiological control and health care, through already established programs and protocols. Key activities supported under the Project are aligned with the COVID-19 SPRP developed by the WHO.

35. The overall Environmental and Social risk is rated as Moderate due to the low social risk and the moderate environmental risk combined.

36. Citizen Engagement. The COVID-19 PRP has been published on the MSP's dedicated website (http://coronavirus.uy). In addition, the Government has established different grievance mechanisms: (i) a toll-free telephone number (0800-1919); (ii) a WhatsApp number (098-999-999); (iii) an online chatbot; (iv) a Facebook Messenger channel; and (v) apps for Android and IOS. All these channels also work as sources of information and assistance for early diagnostic and quarantining advice. Uruguay has a procedure for the processing of complaints and claims of users of health services regulated since 2002 by Decree No. 395/002, having been updated in 2019 through Decree No. 192/019. JUNASA will monitor this feedback mechanism as the project's GRM to ensure that any project-specific issues are included in a project GRM log that is managed quickly, responded to, and settled.

E. Implementation

Institutional and Implementation Arrangements

37. **The Project will be implemented by the MEF and the MSP. The MEF will implement the Project through the Project Coordination Unit (PCU) that is implementing the Improving Service Delivery to Citizens and Businesses through E-Government Project (P161989).** The PCU reports to the Director of the Multilateral Organizations Relations Unit within the General Directorate Secretariat of the MEF. The PCU will be responsible for overall Project coordination and will provide fiduciary and administrative support on financial management (FM), procurement, environmental and social issues and monitoring and evaluation activities. The selection of this institutional arrangement capitalizes on the existing PCU's capacity and will facilitate the rapid launch of the Project upon effectiveness.

38. **On procurement, the PCU will coordinate with the MEF's Central Procurement Unit (*Unidad Central de Adquisiciones* -UCA), which includes a system for the centralized purchase of medicines, medical and related supplies, among others.** They will also be responsible for promoting competition and ensuring market access for purchasing agencies. The UCA's mandate includes the acquisition of goods and services according to the quantity and quality required, conditional on transparency and accessibility for the bidders in a timely manner, and at a fair price.

39. **The PCU will work in a coordinated manner with MSP through the JUNASA, which is responsible for implementing the COVID-19 response at the NHIS.** The JUNASA will be responsible for technical aspects related to Project implementation. In addition, the PCU will have a dedicated Project fiduciary team, comprised of a Procurement Specialist and an FM Specialist, responsible for managing the procurement and FM process and other technical and administrative support staff as required. The PCU will also coordinate with the MSP through the Environmental and Occupational Health Division under the General Direction of Health (*Dirección General de Salud* - DIGESA) and the Department of Sectorial, Social and Welfare Analysis under the JUNASA the activities required to accomplish the Project's WB environmental and social standards. Both the PCU and the MSP would receive administrative support (technical, financial, procurement, M&E, environment and social) from a small number of additional personnel as needed.

40. **An Operations Manual detailing processes and procedures governing the Project will be adopted in a manner acceptable to the Bank.** It will include detailed guidelines and procedures for Project implementation, including with respect to: (a) administration and coordination; (b) monitoring and evaluation (including indicators); (c) financial management; (d) procurement; (e) accounting procedures; (f) environmental and social standards; (g) corruption and fraud mitigation measures; (h) a grievance redress mechanism; (i) personal data collection and processing in accordance with applicable national law and good international practice; (j) roles and

responsibilities for Project implementation; and (k) the eligibility criteria, validation, and payment mechanisms for Outputs, including the calculation of the Unit Costs; and such other arrangements and procedures as shall be required for the effective implementation of the Project, in form and substance satisfactory to the Bank.

41. **Component 1 will support the financing of predefined Unit Costs for outputs paid out of FONASA for supporting the NHI's response to the COVID-19 outbreak.** Under Subcomponent 1.1 and 1.2, the outputs refer to COVID-19 Testing outputs and Hospitalization outputs respectively. The outputs will have standardized and predefined unit costs. These costs will be reviewed and updated periodically during the project cycle, to be able to adjust them to the dynamic nature of input prices, in particular in a scenario of shortage of medical supplies resulting from the pandemic. The cost will be based on a technical analysis and may be revised during Project execution, based on the Bank's No Objection to the Borrower's request. Table 2 below summarizes the steps in the process of execution and payment of predefined outputs out of FONASA, and their subsequent financing by the Bank.

Table 2. Process of execution and payment to FONASA of predefined outputs

1	JUNASA defines the technical specifications of the outputs and purchases them through public bidding or direct contracts. These processes will determine the price of each service to be paid out of FONASA to the selected HSP.
2	Each selected HSP pre finances and provides the defined outputs to NHI's beneficiaries.
3	The HSP then prepares periodically consolidated care reports (Patient Listings) including the information about the patients that received the defined outputs and the type and quantity of the outputs rendered to them and sends them to JUNASA.
4	JUNASA, based on the Patient Listings, validates the outputs delivered to NHI's beneficiaries (The Patient Listings must be signed by the Medical Director of each HSP, the care service provided needs to be registered in the Electronic Medical Records, etc.)
5	Payment of validated outputs to the HSP through the BPS is made out of FONASA
6	JUNASA prepares and submits to the PCU every three months, a report listing all the outputs payed to the HSPs out of FONASA. PCU values (in local currency) the outputs using the standardized and predetermined Unit Costs. The total value of these services constitutes the eligible expenditures financed under the Project (to be reimbursed into FONASA).
7	The PCU transfers into FONASA via the Designated Account (with a passthrough the Operational Accounts/COVID 19 General Fund) for these expenditures.
8	This process (and the eligibility of the reported expenditures) will be subject to ex-post review by the external Financial Statement auditors, as part of the audit of the Financial Statements of the Project

CONTACT POINT

World Bank

Luis Orlando Perez

Sr Public Health Spec.

Daniela Paula Romero
Operations Officer

Borrower/Client/Recipient

The Oriental Republic of Uruguay

Implementing Agencies

Ministry of Economy and Finance
Ricardo Figueroa
PCU Coordinator
ricardo.figueroa@mef.gub.uy

Ministry of Public Health
Luis González Machado
Director of the National Health Board
drgmachado@gmail.com

FOR MORE INFORMATION CONTACT

The World Bank
1818 H Street, NW
Washington, D.C. 20433
Telephone: (202) 473-1000
Web: http://www.worldbank.org/projects

APPROVAL

Task Team Leader(s):	Luis Orlando Perez Daniela Paula Romero

Approved By

Environmental and Social Standards Advisor:		
Practice Manager/Manager:		

Country Director:	Jordan Z. Schwartz	11-May-2020