Public Disclosure Authorized

Project Information Document/ Integrated Safeguards Data Sheet (PID/ISDS)

Concept Stage | Date Prepared/Updated: 28-Sep-2018 | Report No: PIDISDSC25465

BASIC INFORMATION

A. Basic Project Data

Country	Project ID	Parent Project ID (if any)	Project Name
Paraguay	P167996		Paraguay Public Health Sector Strengthening (P167996)
Region	**Estimated Appraisal Date**	**Estimated Board Date**	**Practice Area (Lead)**
LATIN AMERICA AND CARIBBEAN	Jan 21, 2019	Mar 28, 2019	Health, Nutrition & Population
Financing Instrument	**Borrower(s)**	**Implementing Agency**	
Investment Project Financing	The Republic of Paraguay	Ministry of Health and Social Welfare	

Proposed Development Objective(s)

The objectives of this project are to: (i) expand access to health services (prevention, diagnosis and care) for maternal and child care and prevalent health problems to the poor and vulnerable populations in the national territory; (ii) strengthen the primary health care network in priority area; and (iii) improve the efficiency of public expenditures in health.

PROJECT FINANCING DATA (US$, Millions)

SUMMARY

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

DETAILS

World Bank Group Financing

International Bank for Reconstruction and Development (IBRD)	100.00

Environmental Assessment Category	Concept Review Decision
B - Partial Assessment	Track II-The review did authorize the preparation to

	continue

Other Decision (as needed)

B. Introduction and Context

Country Context

1. **Paraguay has experienced average growth rates of 4.7 percent over the last decade and is an upper middle-income country since 2016.** Paraguay's economic growth rate is higher than the regional average and is accompanied by sizeable reductions in poverty – between 2003 and 2017, moderate and extreme poverty decreased by 6.6 and 12.6 percentage points respectively.[1] The benefits of growth have also accrued to the population in the bottom 40 percent, increasing shared prosperity. Between 2006 and 2016, average income growth rate of those in the bottom 40 percent was 5.2 percent relative to 3.5 percent for the overall population. Nevertheless, in the past few years, poverty reduction has slowed down (poverty rates have stagnated at 7 percent since 2013). Much of the remaining poverty is now concentrated in rural areas and affects the most vulnerable populations: nearly half the extreme poor are children under 14 years, and indigenous populations have much higher poverty incidence. The economy also faces large output and price volatility that further exposes the poor and vulnerable to economic risks.

2. **Paraguay's strong growth was largely driven by export-oriented agriculture sector, followed by hydroelectric power generation.** This, together with good macroeconomic management, has allowed Paraguay to generate a fiscal surplus of 0.4 percent of GDP on average for the 2004-2016 period and maintain public debt below 25 percent of GDP. However, public spending is inefficient and the state struggles to provide quality public services to the population. Furthermore, neither key sectors are labor intensive and hence 71 percent of the population is self-employed in the informal sector.[2] Because access to public networks of health services differs by formality, those in the informal sector have access to poorer quality services. This in turn impedes their ability to make productive investments in their health and accumulate human capital, thereby perpetuating the cycle of poverty and vulnerability.

3. **The country is undergoing rapid demographic transition and urbanization.** 28 percent of the population is young (between 15-29 years of age). The demographic structure combined with the low unemployment rate promises a demographic dividend that can be exploited for next few decades. Nevertheless, to do so, it is imperative that the country simultaneously invests in creating productive labor market opportunities for their young population, and adequately equip the young to become productive members of the labor market. Paraguay is also the least urbanized country in South America, with only 60 percent of the population living in cities. The country is rapidly urbanizing, particularly in the greater Asuncion area. Between 2004 and 2014, the urban population grew at an average growth rate of 1.8 percent, faster than most South American countries. New job creation is concentrated in urban centers like Asuncion, where wages are also higher.

Sectoral and Institutional Context

4. **Between 2003 and 2016, the Government of Paraguay (GoP) made significant investments in the health sector, which increased service coverage and utilization.** To make progress towards Universal Health Coverage (UHC), in 2008, the GoP started implementing Family Health Clinics (*Unidades de Salud Familiares*, USFs) and abolished user fees in the public health system. In 2009, it adopted a List of Essential Medicines to prioritize the procurement, distribution and availability of medicines. These reforms led to an increase in service coverage and utilization. The

[1] Data are from World Development Indicators, World Bank (2018). In 2003, the 8.3 percent of people lived with under $1.90 per day and 19.6 percent of people lived under $3.10 per day. In 2016, the figures were 1.7 percent and 7 percent respectively.
[2] Data are from EPH (2015). See Ruber, Elizabeth (2017). "Jobs Diagnostics Paraguay." World Bank Report – Jobs Series No. 9.

fraction of people not accessing health care services in the last three months increased from 16.4 percent in 2003 to 28.6 percent in 2016.[3] During the same period, the fraction of population that reported not accessing health care due to unaffordability fell from 16.6 to 3.9 percent. The biggest gains were observed between 2007 and 2009 (from 17.6 to 1.4 percent), coinciding with the abolishment of user fees and implementation of USFs.

5. **Despite significant improvements in the last two decades, Paraguay continues to perform worse than on other countries in the region on key health indicators.** Paraguay had better maternal and child health outcomes than the LAC average in 1990 but has since fallen behind the region (Table 1). Maternal mortality ratio (MMR) in Paraguay in 1990 was 150 per 100,000 live births, while the LAC average was 171. In 2015, Paraguay's MMR was 132 per 100,000 live births versus 92 per 100,000 live births for LAC. Similar patterns are observed in Infant Mortality Rate (IMR) and Under-5 Mortality Rate (U5MR). Out of 20 LAC countries, Paraguay is currently among the worst performers in Maternal and Child Health (MCH) outcomes – ranked 16th in MMR, and 14th in IMR and U5MR. Comparator countries in the region like Guatemala and Bolivia have made significant improvements in the same time.[4]

Table 1: Key Health Indicators for Paraguay and Comparator Countries Over Time

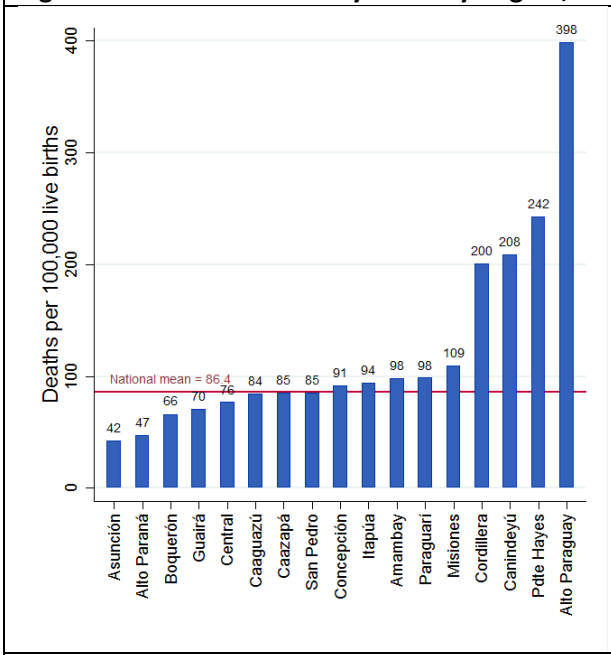
Country	Life expectancy (years)		Maternal mortality ratio (per 100,000 live births)		Infant mortality rate (per 1,000 live births)		Under-5 mortality rate (per 1,000 live births)	
	1960	2014	1990	2015	1990	2015	1990	2015
Paraguay	63.8	72.9	150	132	37.1	17.5	46.5	20.5
Argentina	65.2	76.2	72	52	24.4	11.1	27.6	12.5
Bolivia	42.1	68.3	425	206	85.6	30.6	124.4	38.4
Brazil	54.2	74.4	104	44	50.9	14.6	60.8	16.4
LAC	54.6	74.5	171	92	41.3	16.9	54.1	20.5
Albania	62.3	77.8	71	29	35.1	12.5	40.6	14.0
Armenia	65.9	74.7	58	25	42.5	12.6	49.8	14.1
Guatemala	45.5	71.7	205	88	59.8	24.3	80.9	29.1
South Korea	53.0	82.2	21	11	6.1	2.9	7.1	3.4
Chile	57.5	81.5	57	22	16.0	7.0	19.1	8.1
Uruguay	67.9	77.0	37	15	20.3	8.7	23.1	10.1
OECD	67.9	80.4	19	9	11.5	3.9	14.0	4.7

Source: World Development Indicators, World Bank (2018)

6. **Poor health outcomes at the country level also mask substantial inequalities across regions.** MMR in the remote and sparsely populated region of Alto Paraguay was 296 per 100,000 live births, which was four times the national average and eight times the rate for Asuncion (Figure 1). Similarly, U5MR is highest in the Boquerón department (27 per 1,000 live births), 1.5x above the national average (Figure 2). Regional health outcomes are generally uncorrelated with poverty rates, which suggests that factors other than income are the main driver of poor performance.[5]

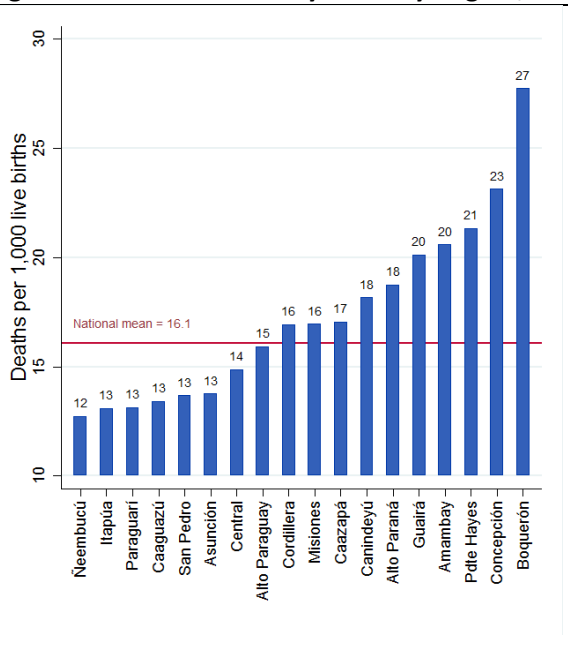
[3] Data are from the Encuesta Permanente de Hogares, EPH. The survey asks respondents about their health care need and utilization behavior in the three months prior to the survey.
[4] "Structurally similar" countries were identified for the SCD and PER based on
[5] As an example, the poorest region in the country, Caazapá, where 33.5 percentage of the population was classified as poor in 2016, has MMR and IMR rates that are very close to the national mean.

Figure 1: Maternal Mortality Ratio by Region, 2016



Source: Department of Statistics, Ministry of Health of Paraguay, 2016

Figure 2: Under-5 Mortality Ratio by Region, 2016



Source: Department of Statistics, Ministry of Health of Paraguay, 2016

7. **As the burden of diseases shifts towards chronic and non-communicable diseases (NCDs), Maternal and Child Health (MCH) issues and communicable and vector-borne diseases remain a concern.** With the demographic transition, NCDs such as diabetes, hypertension, cardiovascular disease and cancer are becoming increasingly common. In 1990, NCDs accounted for 53 percent of total disability-adjusted life years (DALYs) and increased to 69 percent in 2016 (**Error! Reference source not found.**). In 2015, there was also an abrupt rise in confirmed cases of dengue – from 2,634 in 2014 to 17,028 in 2015. Tuberculosis (TB) incidence has remained high, increasing marginally from 33.8 per 100,000 population in 2014 to 34.9 in 2015. Similarly, in 2016, while Paraguay had similar HIV/AIDS incidence as the LAC average (0.5 percent versus 0.6 percent), antiretroviral therapy coverage rate was much lower in Paraguay (35 percent versus 50 percent).[6] These patterns reflect the double burden of diseases the country is facing and requires targeted actions on both fronts.

8. **Public spending on health as a percentage of GDP in Paraguay increased from 1.7 percent in 2003 to 4.4 percent in 2016 and the public sector spends close to the World Health Organization's (WHO) target of 5 percent of its GDP on health**. In absolute terms, Paraguay spends more per capita ($400 in 2011 purchasing power parity dollars) than comparator countries such as Bolivia and Guatemala, but less compared to other richer countries such as Argentina, Brazil, Chile and Uruguay.[7] These patterns in spending and outcomes suggest that while there is room for increasing government outlays for health, efficiency of spending may be a bigger problem. This is also supported by the level of out-of-pocket (OOP) expenditures, which account for more than half of total health

[6] Data are from World Development Indicators (2018). The vertical HIV transmission rate is also higher in Paraguay than the neighboring countries – 12.5 percent in Paraguay, 4.4 percent in Argentina, 5.1 percent in Chile, and 2.6 percent in Uruguay. See: Garcia, Patricia, Angela Bayer and Cesar P Carcamo (2015). "The Changing Face of HIV in Latin America and the Caribbean" *Curr HIV/AIDS* 11(2): 146-157.

[7] The comparator countries include three types: structural comparators that have similar economic and social indicators, including Guatemala, Armenia, Bolivia and Albania; regional comparators that include Argentina, Brazil, and the LAC average; and aspirational comparators that include Chile, Uruguay, South Korea and the OECD average.

spending.[8] OOP expenditures also put the poor and vulnerable population at a greater risk of catastrophic and impoverishing expenditures on health.[9] Using a $3.20-a-day poverty line, estimates suggest that 9.9 percent of the population are at risk of catastrophic expenditures on health, while 3.1 percent are at risk of impoverishing expenditures. The rural population (15.1 percent vs. 6.1 percent in urban areas), those in the poorest quintile (22.6 percent vs. 0.5 percent in the richest quintile) and the indigenous population (16.0 percent vs. 3.9 percent for non-indigenous) face greater financial risks.

9. **Inefficiencies also arise due to the fragmentation of the public health system, which results in duplicated networks of service provision and inequalities in access to health services due to segmentation of the population.** The two main providers are (i) the Ministry of Public Health and Social Welfare ("Ministerio de Salud Pública y Bienestar Social, MSPBS"), which has the mandate to provide health services free of charge to the whole population; and (ii) the Social Security Institute ("Instituto de Prevision Social, IPS") which provides insurance coverage to the formally employed. Both operate their independent network of health facilities with little coordination among each other. Together they cover 90 percent of the population's health needs. The remaining are covered by private providers, police and military institutions, and the University of Asuncion Hospital. Although the percentage of people covered by IPS-health increased from 10.3 percent in 2003 to 18.5 percent in 2016, 74 percent of the population still lacks insurance linked to public or private formal employment and relies primarily on the MSPBS networks for their health needs.

10. **Budget allocation in the public sector is based on historical precedence, which is uncorrelated with demand and health outcomes.** MSPBS directly allocates resources such as infrastructure, human resources, medical supplies and pharmaceuticals to health facilities based on historical budget, which also makes it difficult to target resources towards specific priorities or geographical areas. Reorienting the financing scheme towards financing of outputs rather than inputs could help better target healthcare demand, prioritize specific areas, and improve outcomes and lower costs. Similarly, because MSPBS is mandated to provide care for all conditions, it is difficult for the sector to target resources towards specific priorities arising out of the epidemiological profile of the population. To tackle priority areas, other countries have experimented with financing pre-defined benefits packages or diagnostic related groups (DRGs) or financial allocation to specific goals in selected lines of care, while continuing traditional budget allocation[10]. Similar interventions could help Paraguay adapt the health network to better address both the changing epidemiological profile and the budget efficiency allocation as discussed above.

11. **Another source of inefficiency is the poor functioning of the primary health sector, and consequently the high utilization of hospitalization services.** In 2016, 39.6 percent of all health care visits to MSPBS facilities were received in hospitals, while USFs[11] accounted for only 5.3 percent of visits. This is because the process of the formation of USFs has been slow – at the end of 2017, only 801 of the 1,500 planned USFs were formed, reaching 40 percent of the population. Furthermore, the existing USFs don't always provide adequate resolution to health

[8] The high levels of OOP expenditures on health also make Paraguay an outliner in total health spending as a percentage of GDP, exceeding the levels for OECD.

[9] A household is defined to be at risk of catastrophic expenditures in health if their health budget exceeds a certain percentage of income. A household is defined to be at risk of impoverishing expenditures in health if income net of health expenditures pushes them below the poverty line (Wagstaff, 2008).

[10] For example, Plan Nacer in Argentina followed this scheme.

[11] USF (Unidad de Salud Familiar) is a special type of primary health care facility (PHCF).

problems (for example frequent shortfalls in the List of Essential Medicines occur and not always diagnosis methods are available), overloading hospitals. Additionally, the system generates little incentives for good provider performance. Providers are paid fixed salaries and benefits, and no compensation is tied to individual or health facility level performance. Providers can hold multiple contracts and work in both MSPBS and IPS facilities (World Bank, 2006). Experiences from other countries tying a small portion of resources to outcomes have found large positive health impacts.[12] Strengthening the primary care sector and redesigning provider payment mechanisms could help improve efficiency.

12. **The GoP is committed to providing affordable and quality health services to its population and recently adopted the National Health Policy 2017-2030.** The six strategic areas of this plan are: (a) institutional strengthening, (b) quality of care based on best practices in health, (c) systematic and permanent improvement of quality of care, (d) patient security, (e) community participation in monitoring of health care quality, and (f) development of operating manual for execution and evaluation of health care quality (MSPBS, 2018). In the past, in 2008, the GoP also undertook reforms to decentralize health provision and encourage citizen participation (Law 3007) by establishing the Consejos Regionales y Locales de Salud (Regional and Local Health Commissions). In the same year, to ensure availability of medicines and to improve accountability, it adopted the List of Essential Medicines for the first time and established the Automated Information and Inventory Control System ("Sistema de Informacion y Control de Inventarios Automatizado del Paraguay, SICIAP"). It has also recently started publishing the list of facilities, doctors' schedules and medicines' availability through an Open Data Portal.

13. **The new administration considers health central in its program agenda and has established it as a priority for the early years of the term.** The GoP administration's election campaign called for a revolution in health sector management so that every community had access to quality health services. It also recognized strengthening of the community-oriented primary health sector and delivering maternal, infant and child health as key areas for improvement. In the election campaign, the President also called for revision and full implementation of the National Health Law (1032/96) to encourage effective coordination between the regional and local authorities. To deliver on this agenda, the GoP has sought the World Bank's support through an Investment Project Financing (IPF) and a Reimbursable Advisory Service (RAS). The present IPF address aims to strengthen the primary health care sector to improve access and quality of health care services available to the poor and vulnerable populations. The RAS will take a longer-term view to produce background research and analytical inputs to support the Government towards future broader health care reform.

Relationship to CPF

14. **The proposed project is in line with the World Bank's twin goal of eliminating extreme poverty and boosting shared prosperity.** Within the health sector, the World Bank's strategy to achieve the twin goals is through assisting countries to accelerate progress toward the achievement of Universal Health Coverage (UHC) as noted in the Priority Directions for the Health, Nutrition and Population Global Practice 2016-2020. In addition, the proposed project is aligned with the World Bank's Human Capital Project, which calls for countries to make greater investments in health and education to improve the productive capacities of their populations.

[12] As for example, see Celhay et al. (2018) for an evaluation of Argentina's Plan NACER program.

15. **The proposed project addresses two of the four main priority areas identified in the Systematic Country Diagnostic (SCD) and the Country Partnership Framework (CPF), FY19-FY23 and partially addresses a third one.** The CPF highlights four policy priority areas for Paraguay: (i) Rule of law, accountable institutions and business environment, (ii) Natural wealth management, (iii) Quality of public services, and (iv) Human capital. The Project is directly aligned to the third priority area as it seeks to improve the quality of health services and indirectly contributes to the first priority area by increasing the capacity and accountability of MSPBS. Within the fourth priority area, the Project makes direct contributions as health is a productive input in human capital. There are also indirect links to human capital as health augments the accumulation of education, which is another key input of human capital.

16. **The proposed project builds upon previous analytical work in the country.** The recently concluded Human Development Public Expenditure Review (HD PER, Report No. AUS0000223) by the Bank identified system fragmentation as the main driver of inefficiency in the health sector and inequity in outcomes. It recognized that integration was a longer-term goal while proposing strengthening of the primary health care sector as one of the shorter-term goals. A stronger and quality public health sector also facilitates the eventual integration of the MSPBS network with other health care networks such as IPS and the private sector.

C. Proposed Development Objective(s)

17. The objectives of this project are to: (i) expand access to health services (prevention, diagnosis and care) for maternal and child care and prevalent health problems to the poor and vulnerable populations in the national territory; (ii) strengthen the primary health care network in priority area; and (iii) improve the efficiency of public expenditures in health.

Key Results (From PCN)

I. Integrated Care[13] Set (ICS) based on quality and effective services for maternal and child care and prevalent problems formally adopted and reviewed on a biannual basis
II. Number of clinical guidelines developed for each ICS
III. Increase in primary health care utilization rates, disaggregated by gender
IV. Reductions in maternal, infant and child mortality rates
V. Reductions in the incidence of infectious diseases such as Tuberculosis, HIV/AIDS and other STDs
VI. Increase in the number of patients receiving preventative and early treatment services for diabetes and hypertension
VII. Number of primary health care facilities fully equipped to provide the services for defined ICS
VIII. Number of providers trained to provide the services of the ICS

[13] Following Lewis et al., the project will promote three of the four possible types of integration: **functional, service and clinical**. Functional integration means integration of non-clinical and back-office functions through, for example, shared electronic patient records. Service integration refers to integration of different clinical services at an organizational level by, for example, establishing multidisciplinary teams. Clinical integration is integration of care into a single and coherent process within/or across professions by means of, among others, using shared guidelines and protocols. The fourth possible integration type, is the **organizational**, and refers to coordination of provider networks between separate organizations brokered by purchaser, so it does not apply to the case. (Lewis R, Rosen R, Goodwin N, Dixon J. Where next for integrated care organizations in the English NHS? London: The King's Fund; 2010, in: Satylganova, Altynai. (2016). Integrated care models: an overview. Copenhagen: WHO Regional Office for Europe; 2016.)

D. Concept Description

18. **Given the shift in the burden of diseases towards NCDs, high rates of maternal and child mortality, and a service delivery system unable to meet population needs efficiently and equitably, there has been a push for health sector reform in the country.** As discussed above, Paraguay achieves poor health outcomes in relation to its spending. System fragmentation creates differences in access and quality of services across sub-groups of the population. Furthermore, because of changing demographic and epidemiological profile, the health system is unable to meet the changing needs of the population. The proposed project aims to reorient the health system to tackle priority diseases through the design and implementation of ICS in a cost-effective, equitable and sustainable manner. It envisions to do so by strengthening the USFs to increase the poor and vulnerable population's access to high-quality care for prevalent diseases: hypertension, diabetes, HIV, sexually transmitted diseases (STDs), TB, breast cancer, cervical cancer and maternal and child conditions.

19. **The proposed project will support efforts towards making the service delivery model sustainable.** To make the health care delivery model sustainable, the project emphasizes prevention and early control of the abovementioned diseases. To deliver corresponding services of highest quality in an efficient manner, the protocols and care pathways will need to be reviewed and/or defined. Mechanisms will need to be developed for referrals to and counter-referrals from the higher levels of care to ensure effective integration of care through different levels. To ensure that facilities are able to provide services, they will need to be adequately equipped and/or reequipped with clinical infrastructure, and physical infrastructure may need to be rehabilitated. To ensure that MSPBS has the capacity to deliver the project, its implementation capacity will need to be strengthened.

20. **The proposed project will have four components as described below:**

Component 1: Improving the quality of health services for the poor and vulnerable populations at the national level

21. This component would include the creation, review and implementation of selected ICS to be prioritized and provided to the target population. This plan will include cost-effective services that correspond to the epidemiological needs of the poor and vulnerable population. Some services that will be included are Maternal and Child Health (MCH) services, prevention and control of Communicable Diseases (CDs) like HIV/AIDS, Tuberculosis and STDs, and the more prevalent Non-Communicable Diseases (NCDs) like hypertension, diabetes and cervical and breast cancer.[14]

22. *Subcomponent 1.1: Implementation of the ICS*. Proposed activities under this subcomponent include: (i) Enrollment of the target population to be covered; (ii) Phased rollout of the benefits plan in the intervention areas; (iii) Assessments and investments in information systems for the administration of benefits plan; (iv) Communication campaign to generate awareness about the benefits plan; (v) Implementation of the performance-based financing (provider incentives) scheme and implementation of purchaser provider agreements; (vi) Review and implementation of financial control mechanisms and technical audits.

23. *Subcomponent 1.2: Establishment and implementation of a referral and counter-referral system.* This subcomponent will help MSPBS build capacity and protocols to implement referral recommendations as defined by care pathways for the selected ICS. Specific activities will include: (i) periodic review of the selected ICS to be provided and national clinical guidelines for proper case management of all services included (this will be anchored

[14] The exact list of services is yet to be determined.

in international and national guidelines); (ii) Development of clear protocols and mechanisms for referrals and counter-referrals; (iii) Mapping of optimal referral pathways between USFs and higher-level care facilities; (iv) Formulation of implementation tools to ensure proper referrals and counter-referrals; (v) Development and implementation of audits and monitoring mechanisms to ensure proper functioning of the referral system; (vi) Strengthening of IT systems to implement, track, measure and monitor adherence to referral recommendations.

Component 2: Improving the service delivery capacity of Family Health Centers (Unidades de Salud Familiares, USFs) in priority areas

24. This component would finance rehabilitation and refurbishment of USFs to increase service provision capacity. To ensure that facilities are adequately equipped to provide services and meet national norms, the availability and quality of current clinical and physical infrastructure will be assessed, and based on the results, rehabilitation and improvement activities will be undertaken, including provision and repair of clinical infrastructure and improvements in physical infrastructure. Specific activities will include: (i) Review of current health services provided at USFs and evaluation of service provision capacity, including clinical infrastructure and human resources, (ii) Refurbishment of medical equipment and infrastructure to ensure facilities meet national norms; (iii) Improvements in physical infrastructure to ensure facilities meet national norms; and (iv) Assessment of IT services and equipment availability and strengthening needs.

Component 3: Institutional strengthening of MSPBS

25. *Subcomponent 3.1: Strengthening the pharmaceuticals and medical devices procurement process to improve efficiency and quality*. This component will support the ministry to increase efficiency of expenditures for pharmaceuticals and medical devices through pooled procurement. Specific activities include: (i) Strengthening the national pharmaceutical procurement agency; (ii) Review and development of the agency's constitution/charter and the scope of work; (iii) Review and revision of the current list of essential medicines with a focus on cost-effective generic medicines; (iv) Introduction of standardized nomenclature of medicines; (v) Support for the development and implementation of advance procurement plans, including design and implementation of multi-year framework agreements; (vi) Development and implementation of a real-time stock management system; and (vii) Development and enforcement of quality control mechanisms on medicine stocks.

26. *Subcomponent 3.2: Development of a national strategy for the prevention and control of NCDs.* Specific activities under this subcomponent will include: (i) Analytical study of the historical, current and future burden of diseases with an emphasis on the contribution of NCDs; (ii) Assessment of current policies and regulation for the control of consumption of salt, trans-fat, alcohol and tobacco; (iii) Development of policies and a national strategy for the control of consumption of salt, trans-fat, alcohol and tobacco; and (iv) Design of mass communication and social media strategy for behavioral change.

Component 4: Project management and coordination unit

27. This component will support and finance the project implementation and supervision efforts, including project management, fiduciary tasks, environmental and social risk management, and monitoring and evaluation (M&E). The project will be managed by a stand-along Project Implementation Unit (PIU) that will be housed within the MSPBS. This design will contribute to a more effective launching and implementation of the project, permitting a progressive transfer of activities and capabilities to the structures of the MSPBS.

SAFEGUARDS

A. Project location and salient physical characteristics relevant to the safeguard analysis (if known)

The project activities will have partly a national coverage and partly address priority areas that remain to be selected as project preparation proceeds. Indigenous peoples are present nationwide. At least at Concept Stage, the planned project activities do not relate with physical characteristics in terms of environmental safeguards that would require attention.

B. Borrower's Institutional Capacity for Safeguard Policies

The Ministry of Public Health and Social Welfare (MSPBS) will have the overall responsibility for project implementation, and a new Project Implementation Unit (PIU) will be established and physically located within the MSPBS. The PIU will carry out the main project management tasks, including environmental and social risk management. The MSPBS has no prior experience on implementing a Bank-financed project and the Government administration recently changed in mid-August 2018. As the project preparation proceeds, the Bank will conduct a capacity assessment of safeguards implementation within the MSPBS to determine the respective needs for institutional strengthening through the PIU composition and/or other means to provide and secure sufficient capacity for social and environmental management of the project activities. It is probable that the MSPBS will hire consultants to prepare the necessary safeguards instruments by project Appraisal.

C. Environmental and Social Safeguards Specialists on the Team

Graciela Sanchez Martinez, Social Specialist
Tuuli Johanna Bernardini, Environmental Specialist

D. Policies that might apply

Safeguard Policies	Triggered?	Explanation (Optional)
Environmental Assessment OP/BP 4.01	Yes	The project aims to reorient the national health system to improve addressing of priority diseases through strengthening of the Family Health Clinics ("Unidades de Salud Familiares", USFs) and access to high-quality care for prevalent diseases, such as hypertension, diabetes, HIV/AIDS, sexually transmitted diseases (STDs), tuberculosis, breast and cervical cancer, as well as maternal and child health particularly by the poor and vulnerable population. The project triggers OP/BP 4.01 and is considered Category B in terms of environmental risks and impacts as Component 2 will finance medical equipment and minor scale rehabilitation and improvement of physical health care infrastructure, and Component 3 will improve procurement and

		management of pharmaceuticals and medical devices at the national level. The project's Environmental and Social Risk is considered Moderate at the Concept Stage as the initial project design does not include any mayor civil works or other aspects that could lead to mayor environmental risks or impacts. Environmental risk management will be needed to prevent, minimize and mitigate any negative impacts of the minor civil works and handling of pharmaceuticals, medical devices and potentially chemicals to combat vector-borne diseases. Particularly, the project will identify and address needs for improving management of healthcare waste (HCW), including chemical and other hazardous waste that can be expected to increase in volume and challenge the existing management capacity. Addressing HCW is expected to cause positive environmental impacts compared with the baseline situation. Since specific physical interventions will not be determined before Appraisal, the MSPBS/PIU will prepare, consult and disclose, and the Bank will guide the preparation of, review, no-object and disclose an Environmental and Social Management Framework (ESMF). The ESMF will guide identification of environmental and social risks and impacts and adoption of good practices and measures to mitigate them, as well as to maximize environmental and social value added. The ESMF will focus on HCW management, worker and community health and safety, and stakeholder engagement in improving health care infrastructure, equipment and services. The ESMF will also establish a Grievance Redress Mechanism at the project level. Additional to national legislation and the Bank Safeguards Policies, the ESMF will reference the relevant sections of the World Bank Group General Environmental, Health and Safety (EHS) Guidelines as well the Indigenous Peoples Planning Framework (IPPF) and as defined the Resettlement Policy Framework (RPF),
Performance Standards for Private Sector Activities OP/BP 4.03	No	OP 4.03 is not triggered as none of the planned project activities finance private sector activities.

Natural Habitats OP/BP 4.04	No	OP 4.04 is not triggered as none of the planned project activities imply impacts on natural habitats of any type.
Forests OP/BP 4.36	No	OP 4.36 is not triggered as none of the planned project activities imply impacts on forests or communities whose livelihoods depend on forests.
Pest Management OP 4.09	TBD	OP 4.09 might be triggered for precautionary purposes to facilitate potential management of chemicals used to control vector-borne diseases.
Physical Cultural Resources OP/BP 4.11	TBD	Project implementation is not expected to have any negative impact on identified physical cultural resources. However, OP/BP 4.11 might be triggered for precautionary purposes.
Indigenous Peoples OP/BP 4.10	Yes	Indigenous Peoples (OP/BP 4.10) has been triggered since there are indigenous peoples in the Project's area due its nationwide nature in at least one of its components. Therefore, an Indigenous Peoples Planning Framework (IPPF) will be prepared by the MSPBS in public and culturally adequate consultations with relevant indigenous organizations. Specific measures respectful to indigenous people's culture such as the use of indigenous language, adoption of their own conflict resolution mechanisms, cultural particularities need of the health services for maternal and child care, among others, will be included in the TORs for the IPPF.
Involuntary Resettlement OP/BP 4.12	TBD	Involuntary Resettlement OP/BP 4.12 triggers and will be confirmed during preparation proceeds. The Bank team will conduct due diligence to assess the status of land tenure related with the small civil works of rehabilitation or repair of existing health infrastructure that would be financed. As needed a tailored Resettlement Policy Framework (RPF), which will include a Guidelines to Land Regularization of Infrastructure will be prepared by the MSPBS.
Safety of Dams OP/BP 4.37	No	OP 4.37 is not triggered as the planned project activities do not include construction/rehabilitation of dams nor other interventions which rely on the performance of existing dams.
Projects on International Waterways OP/BP 7.50	No	OP 7.50 is not triggered as the planned project activities will not be conducted in or influence international waterways.
Projects in Disputed Areas OP/BP 7.60	No	OP 7.60 is not triggered as the project will not finance activities in disputed areas as defined in the policy.

E. Safeguard Preparation Plan

Tentative target date for preparing the Appraisal Stage PID/ISDS

Nov 19, 2018

Time frame for launching and completing the safeguard-related studies that may be needed. The specific studies and their timing should be specified in the Appraisal Stage PID/ISDS

Taken the March 2019 target date for Board approval of the project, preparation of the ESMF, the IPPF and the RPF (as confirmed) need to get started as promptly as possible. To comply with the Concept Stage preparation schedule for Appraisal, the advanced draft of the ESMF, the IPPF and IRF (as defined) will need to be disclosed and consulted around November 19, 2018.

CONTACT POINT

World Bank

Luis Orlando Perez, Daniela Paula Romero
Sr Public Health Spec.

Borrower/Client/Recipient

The Republic of Paraguay

Implementing Agencies

Ministry of Health and Social Welfare
Carolina Careres
Project Coordinator
carolina.lucey@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

Practice Manager/Manager:	Daniel Dulitzky	01-Oct-2018
Country Director:	Renato Nardello	04-Oct-2018