



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

Appraisal Stage | Date Prepared/Updated: 16-Nov-2016 | Report No: PIDISDSA18236



BASIC INFORMATION

A. Basic Project Data

Country Guatemala	Project ID P159213	Project Name Crecer Sano: Guatemala Nutrition and Health Project	Parent Project ID (if any)
Region LATIN AMERICA AND CARIBBEAN	Estimated Appraisal Date 16-Nov-2016	Estimated Board Date 17-Jan-2017	Practice Area (Lead) Health, Nutrition & Population
Lending Instrument Investment Project Financing	Borrower(s) Ministry of Finance	Implementing Agency Social Development Fund/ Ministry of Social Development (MIDES)	

Financing (in USD Million)

Financing Source	Amount
International Bank for Reconstruction and Development	100.00
Total Project Cost	100.00

Environmental Assessment Category

B - Partial Assessment

Decision

The review did authorize the preparation to continue

Other Decision (as needed)

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B. Introduction and Context

Country Context

Guatemala is among the countries with the highest poverty rate in Latin America and Caribbean (LAC), and income growth among the bottom 40 percent of the population has been negligible in recent years. From 2000 to 2014, the poverty rate (US\$4 per day poverty line) increased from 55 to 60 percent, in striking contrast to the decline in poverty in LAC. The change in shared prosperity, as measured by the average income growth of the bottom 40 percent of the population, was negligible between 2006 and 2014, again in contrast to most LAC countries. High poverty is also reflected in the country's social indicators, such as stunting rates for children under-five, affecting in particular the poor (66 percent), rural dwellers (59 percent, and Indigenous groups (61 percent).



The country's stable macroeconomic framework has not translated into high growth. Since 1990, economic volatility was less than half the regional average, and Guatemala experienced less of an economic decline during the 2009 recession than most of LAC. Much of its relative stability can be attributed to prudent macroeconomic policies that have kept inflation and public debt manageable, while avoiding fiscal imbalances. Nonetheless, economic growth has been modest (averaging 3.4 percent between 2000 and 2015), and per capita income growth even more modest (1.2 percent). Rather than catching up with richer countries, it appears that Guatemala has diverged: its GDP per capita is now 6.7 percent of U.S. GDP per capita (current), compared to 8.4 percent in 1960.

Guatemala has one of the lowest tax revenues in LAC, and the lowest per capita spending on social sectors. At 10.2 percent of GDP in 2015, Guatemala's tax-to-GDP ratio is well below the LAC average of 21 percent. While other countries with low tax-to-GDP ratios have significant non-tax revenue sources, Guatemala does not. As a result, total Central Government revenues have been below 13 percent of GDP in the past decade (and are currently below 10 percent). Public social spending as a share of GDP increased in the last decade, but has stagnated in recent years. At just 8.1 percent of GDP in 2014, it is the lowest in Central America, notably behind countries with lower GDP per capita, such as Nicaragua and Honduras, where it was higher than 13 percent.

The new Administration that took office in January 2016 has placed health, education, stronger economic growth, and increased transparency at the center of its policy agenda. Recognizing the important role that human capital development plays in contributing to economic growth (and vice versa), the Government's 2016-2020 Plan¹ emphasizes the need for improvements in health, an increased focus on education, and reduction of chronic malnutrition. In February 2016, the Government established the Commission to Reduce Chronic Malnutrition and, in March 2016, the President officially launched the National Strategy to Reduce Chronic Malnutrition 2016-2020. The Government also recently updated its Primary Health Care (PHC) Model, adopting a multidimensional (individual-family-community) approach and integrating complementary aspects of traditional Indigenous health beliefs and practices. The Government has also expressed its commitment to improving transparency and accountability by institutionalizing management for results in the public administration and promoting social audits and other mechanisms to enhance citizen participation, among other institutional reforms.

Sectoral and Institutional Context

Over the past 25 years, Guatemala has made significant progress on several health indicators, but maternal mortality and chronic malnutrition remain high, with the latter posing a serious development problem for the country. Life expectancy has increased from 62 years in 1990 to 72 years in 2013. During the same period, under-five mortality declined steeply from 81 to 31 deaths per 1,000 live births, while infant mortality declined from 60 to 26 deaths per 1,000 live births. Neonatal mortality decreased from 29 deaths per 1,000 live births in 1990 to 14 in 2014. Although the maternal mortality ratio declined between 1990 and 2014, at 93 deaths per 100,000 live births in 2014, it remains higher

¹ Política General del Gobierno 2016-2020. SEGEPLAN. National Development Plan *K'atun Nuestra Guatemala 2032*.



than the LAC average of 71 deaths per 100,000.² Moreover, according to National Maternal and Child Health Surveys (*Encuesta Nacional de Salud Materno Infantil, ENSMI*), although chronic malnutrition decreased from 55 percent in 1995 to 46.5 percent in 2014/15, it is the highest in LAC and among the highest in the world, exceeding rates of countries with significantly lower per capita incomes such as Bangladesh, Ethiopia, and Vietnam. Guatemala's high chronic malnutrition affects the quality of its human capital and, as a consequence, its growth and development potential. Studies show that malnutrition contributes to higher mortality and incidence of non-communicable diseases, and lowers learning potential and work productivity. Moreover, it is estimated that the cost of malnutrition in 2004 represented 11.4 percent of GDP in Guatemala.³

Major drivers of chronic malnutrition (maternal health, poor child feeding practices, and limited access to safe water, sanitation, and quality health services that integrate cultural norms and traditional medicine in rural areas) are interlinked. The Causes of Malnutrition Framework developed by UNICEF (1990) underscores the role that childcare practices, dietary quality, access to water, and adequate sanitation and health care play in affecting malnutrition rates. Maternal stature and nutrition are important predictors of intrauterine growth retardation and size at birth,⁴ the effects of which are not confined to one generation, but extend to the next.⁵ Complementary feeding, growth promotion, and immunization are critical for the seven to 24-month age group along with other interventions, such as deworming and administering anthelmintics to reduce the incidence of parasite and bacterial infections among pregnant women, infants, and children.⁶ Sanitation and hygiene also plays an important role in the prevention of diarrheal morbidity and mortality. Data from the 2014/15 ENSMI shows that only 53.2 percent of children zero to five months are exclusively breastfed, and 50 percent of children six to 23 months are adequately fed. In terms of primary health services, only 51.7 percent of children 12 to 23 months of age in the lowest income quintile received all of their required vaccinations, compared to 62.4 percent of children in the highest income quintile.⁷ Moreover, less than half of the population has access to primary health services, partly due to the Government's 2015 decision to discontinue the Expansion of Coverage Program (*Programa de Extensión de Cobertura, PEC*), which provided primary health and nutrition services through nongovernmental organizations, and progressively replace it with health services provided by the Ministry of Public Health and Social Assistance (*Ministerio de Salud Pública y Asistencia Social, MSPAS*). Finally, in 2015, only 71 percent of rural areas had access to piped water (compared to 97 percent of urban areas) and 49 percent to improved sanitation (compared to 78 percent of urban areas).⁸

Quality of care also remains an issue, with the sector facing a shortage of health professionals and medical inputs. Based on the findings of the social-cultural assessment carried out during the Project preparation, inadequate access to quality health care is exacerbated by discriminatory practices and lack of sufficient recognition of traditional systems and medicinal practices that have served as the primary

² World Development Indicators 2015.

³ Martinez and Fernandez 2008; UNICEF/Central American Institute for Fiscal Studies 2011

⁴ Ozaltin et al. 2010.

⁵ Ramakrishnan et al. 1999.

⁶ Horton et al. 2008a, also see Horton et al. 2008b.

⁷ ENSMI 2014/15.

⁸ Water, Sanitation and Hygiene Team Presentation, World Bank 2016.



source of health care for Mayan Indigenous populations in Guatemala for centuries. Many public health care providers do not adequately take into account cultural norms related to touch and diet, or the role of midwives and key actors in family health decision-making processes. This has generated fear and distrust, especially among Indigenous women and their communities, reducing incentives to seek official medical services when available, making public medical services a “last resort” option.

Budget constraints, funding flow bottlenecks, and inefficient spending limit the coverage and quality of health and nutrition services, as well as other critical social protection programs. While public health expenditures increased from 1.8 percent of GDP in 2007 to 2.2 percent in 2014, this is still lower than the LAC average of 3.76 percent.⁹ Despite the 2008 Government policy mandating free-of-charge provision of health services in public facilities, private spending as a share of total health expenditures has been consistently almost twice as large as the public share (63 percent vs. 37 percent respectively). Budget allocations to the health sector are inadequate to address the significant coverage gaps and quality issues related to staffing and availability of essential inputs. Funding delays and inefficient resource management, such as poor targeting and lack of coordination, also hamper implementation.¹⁰ Budget constraints and delayed release of funds also affect the Government’s Conditional Cash Transfer (CCT) Program,¹¹ forcing cash transfers or benefit payments to be rationed. As a result, the majority of intended CCT beneficiaries do not receive the full annual benefit they are entitled to, nor do they receive transfers in a timely manner, weakening the link between transfers and fulfillment of co-responsibilities and limiting the program’s potential to support the poor’s increased access and utilization of health services.

The previous Government’s Zero Hunger Program yielded mixed results, but provided useful lessons. Launched in March 2012, the Program targeted 166 municipalities (out of 340) with the highest prevalence of chronic malnutrition, using a multisectoral approach involving several ministries, as well as private sector and civil society organizations. In 2012, the Ministry of Finance (*Ministerio de Finanzas Públicas*, MINFIN) and the MSPAS signed a results-based budgeting agreement to track progress made in implementing the First 1,000 Days of Life Initiative under the Program. Evaluations indicate mixed results: chronic malnutrition for children ages three to 59 months decreased by only 1.7 percentage points in Program areas, from 60.1 percent in 2012 to 58.4 percent in 2013, while stunting increased for children under one year old.¹² The evaluations highlighted the need for a multisectoral approach in providing a prioritized package of services, while intensifying better-coordinated efforts with fewer institutions in fewer prioritized areas. Qualitative research carried out under the proposed Project’s social assessment noted that the Program’s shortcomings could partly be attributed to insufficient understanding of cultural dietary practices and preferences, and lack of proper communication, for example, on the benefits of nutritional supplements and how to integrate them into local diets.

⁹ World Bank Social Sector Expenditure and Institutional Review 2016.

¹⁰ World Bank Health System Functional Review 2016.

¹¹ Guatemala’s CCT targets families with children between 0-15 years. It promotes regular health visits for children aged 0-6 years and pregnant women, and school attendance for children aged 6 to 15. Annex I provides more information.

¹² SESAN-International Food Policy Research Institute 2014.



Nevertheless, some promising PHC interventions have shown results in reducing chronic malnutrition in Guatemala. Preliminary results show that in four districts where the Inclusive Health Model (*Modelo Incluyente de Salud*, MIS) was piloted by MSPAS, the prevalence of chronic malnutrition in children 24 to 27 months declined, on average, by two percentage points per year from 2013 to 2016. The MIS combines essential traditional Indigenous health beliefs and practices with public health services.

Given the magnitude of chronic malnutrition in Guatemala, the Government requested World Bank Group (WBG) support for the implementation of its National Strategy to Reduce Chronic Malnutrition 2016-2020. This multisectoral strategy seeks to address the main risk factors associated with chronic malnutrition, by increasing its target population's access to improved PHC, water and sanitation services, as *well* as information and additional resources to promote and support healthy behaviors. The WBG program features complementary instruments, including: (i) the proposed Project to target needed investments and interventions in priority areas; (ii) a Development Policy Financing to support needed policy reforms; (iii) technical assistance to support evaluation of the national strategy; (iv) support for South-South dialogue (e.g., with Peru); and (v) the potential buy down of the interest rates on the Project loan through the Global Financing Facility (GFF), which will free up resources from interest rate payments that the government will match and reinvest in the CCT program that benefits children under two years old. WBG-funded interventions will complement ongoing assistance in health and nutrition of other development partners, such as the Belgian Fund (BF), Canadian Government (CG), Inter-American Development Bank (IADB), United States Agency for International Development (USAID), Pan American Health Organization (PAHO), European Union (EU), United Nations Children's Fund (UNICEF), Spanish Cooperation, Spanish Agency for International Development Cooperation (SAIDC), Swiss Cooperation (SC), and World Food Program (WFP).

C. Proposed Development Objective(s)

Development Objective(s) (From PAD)

The Project Development Objective (PDO) is to improve selected practices, services and behaviors known to be key determinants of chronic malnutrition (with an emphasis on the first 1,000 days of life) in the intervention areas.

Key Results

To monitor progress toward the PDO, a core set of indicators will be used:

- Percentage of children six months old with exclusive breastfeeding in the intervention areas;
- Coverage of growth promotion for children under 24-months old in the intervention areas;
- Number of families being served by new or rehabilitated water systems in the intervention areas; and
- Proportion of municipalities where integrated interventions were implemented.

In addition, the Project will include the following disbursement-linked indicators (DLIs):

- DLI 1. Increased coverage of prenatal care with at least four visits;
- DLI 2. The Unique Registry of Beneficiaries receiving individual level data on health system usage;



- DLI 3. Increased percentage of children six months old with exclusive breastfeeding; and
- DLI 4. Increased percentage of children under two years old who are beneficiaries of the CCT Program receiving transfers based on compliance with the full verification cycle of health co-responsibilities in the intervention areas.

D. Project Description

Component Name	Cost (USD Million)	Comments
Intersectoral package of services to address main risk factors of chronic malnutrition	81.00	This Component will support provision of a package of nutrition and health services to mothers and children; promotion of behavioral change interventions targeted to families and communities; improving access to safe drinking water and sanitation; and enhancing coordination across sectors. The Component will finance works for health posts, small water supply and sanitation systems, and select community centers, as well as equipment, medical and nonmedical supplies, health promotion activities, technical assistance, studies and training. The Environmental Assessment instruments will incorporate the WB Environmental Health and Safety Guidelines in relation to works relating to the health care facilities and water/sanitation infrastructure.
Moving the focus towards results	15.00	This Component will introduce results-based financing and use DLIs to: (i) promote use of health services (timely prenatal care) and behavioral change, such as exclusive breastfeeding; and (ii) strengthen the CCT program in target geographic areas.
Project Management, Monitoring and Evaluation	4.00	This Component will support the Social Development Fund (Fondo de Desarrollo Social, FODES) and the Project Implementation Unit (PIU) to ensure day-to-day management; monitoring of results; and coordination with relevant multi-sectoral partners. The Component will finance non-government staff, consulting services, office equipment, training, and operational costs as well as an external entity to verify achievement of the DLIs.

Component Name:
 Providing an inter-sectoral package of services to address chronic malnutrition risk factors



Comments (optional)

Component Name:

Moving the focus towards results

Comments (optional)

Result based financed

Component Name:

Supporting project management, monitoring and evaluation

Comments (optional)

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

The Project will finance investments and activities in an estimated 138 municipalities in seven prioritized departments. The first phase will include 81 municipalities from Alta Verapaz (17 municipalities), Huehuetenango (32 municipalities), Quiché (21 municipalities), and Chiquimula (11 municipalities). The second phase, estimated to start during year two of implementation, will include: San Marcos (30 municipalities), Totonicapán (8 municipalities), and Sololá (19 municipalities). The PHC package will be offered simultaneously in all of the seven departments.

All of the targeted municipalities have Indigenous populations that meet the four criteria of OP/BP 4.10, and four of the seven have the largest percentage of Indigenous populations in the country, i.e., Totonicapán (97.8%), Sololá (96.5%), Alta Verapaz (89.7%), and Quiché (88.6%). The Indigenous populations of the other beneficiary departments are: Huehuetenango 57.5%, San Marcos 30.3%, and Chiquimula 7.10%.

The Social Cultural Assessment documented important differences between departments and linguistic families in regards to capacity to communicate in native languages and Spanish, literacy, extreme poverty, fertility rates, and maternal mortality that should be taken into account when designing project interventions. For example, only 56% of Indigenous women are literate in Spanish compared to 77.7% of Indigenous men. Women's education levels and chronic malnutrition appear to have a strong correlation as 69.3% of illiterate women are chronically malnourished whereas that rate drops to only 20.1% among women with secondary education. In regards to linguistic and literacy tendencies, in Alta Verapaz 51.8% of Q'eqchi' are monolingual in their native language and literacy rates in Q'eqchi' are 28.5% whereas only 17.3% of Mam are monolingual (and thus a significant portion also speak Spanish) and literacy rates in this native language fall to 6.9%. These differences are important to take into account when designing communications tools and strategies to ensure the most effective use of linguistic and written materials. It was also found that being Indigenous is not necessarily a determining factor for fertility rates, as both Alta Verapaz and Chiquimula have fertility rates of 3.9 vs. the 3.7 average for rural Guatemala, despite the fact that Alta Verapaz is predominantly Indigenous and Chiquimula has a small Indigenous population.



F. Environmental and Social Safeguards Specialists on the Team

Gunars H. Platais, Dianna M. Pizarro

IMPLEMENTATION

MIDES, through FODES and its technical and fiduciary units, will be responsible for implementation and oversight of the proposed Project, with support of additional fiduciary, social and technical consultants. FODES will be responsible for day-to-day management, coordination, and supervision of Project activities through its various line units (complemented by additional technical and fiduciary staff as needed, and its Director will be the General Project Director, entrusted with overall strategic oversight of the Project. Since FODES would house the Implementing Unit for the Project, and the Unit is fully integrated within the structure of FODES, the Project documents will refer to it as FODES/PIU. FODES was selected because of its ability to operate with greater independence than other agencies, which is critical given the multisectoral nature of the Project, and because it has the authority to enter into agreements with other institutions. Other entities involved in Project implementation include MSPAS, SESAN, the Commission to Reduce Chronic Malnutrition,¹³ and municipalities in the targeted areas. FODES/PIU will sign institutional agreements with MSPAS and SESAN to guarantee their assistance in implementing the Project. All reporting and oversight relationships will be defined in the Project Operations Manual, to be adopted before Project effectiveness.

FODES/PIU will coordinate with local- and community-level actors to strengthen buy-in to and relevance of the Project. FODES/PIU and other participating institutions will coordinate with Community Development Councils (*Consejos Comunitarios de Desarrollo*, COCODES) and Municipal Development Councils (*Consejos Municipales de Desarrollo*, COMUDES) to increase ownership of activities and adjust the interventions to the specific needs of targeted areas. When needed, additional Indigenous leaders and relevant organizations will be invited to participate in key Project decisions according to specific procedures included in the Project's Operations Manual. In the identification of health, and water and sanitation infrastructure, FODES/PIU will seek the agreement of COCODES on the works to be financed under the Project, and confirm their commitment to maintain them.

Multisectoral coordination will be overseen by a Steering Committee. The Steering Committee will provide multisectoral policy oversight and stewardship of the Project, and ensure working-level coordination between the relevant Government agencies, regional authorities and Indigenous representatives from the participating departments. The Steering Committee will be chaired by the Commissioner for Reducing Chronic Malnutrition and made up of representatives of MSPAS, SESAN, MINFIN, MIDES, and FODES/PIU. These officials would remain fully accountable for implementation progress of their respective subcomponents. Representatives of other institutions, Indigenous authorities and Government agencies will be invited to join the Steering Committee as needed. The Steering Committee will meet at least on a bimonthly basis to review implementation progress and take decisions. Given that this is a new institutional arrangement, a stocktaking by Project stakeholders and

¹³ The President of Guatemala appointed the Commissioner for Reducing Chronic Malnutrition to coordinate the Commission to Reduce Chronic Malnutrition, which was officially established in February 2016.



the WBG will be conducted after the first six months of implementation to make any necessary adjustments.

SAFEGUARD POLICIES THAT MIGHT APPLY

Safeguard Policies	Triggered?	Explanation (Optional)
Environmental Assessment OP/BP 4.01	Yes	<p>The Project is classified as Category B. The specific individual works to be financed under the Project will not be known until after Project approval. The potential environmental impacts associated with the type and size of works are expected to be relatively minor to moderate, and will not involve significant impacts, and the potential negative impacts would be managed appropriately. An Environmental and Social Management Framework (ESMF) was prepared to manage the potential associated environmental impacts and risks related to the types of works to be financed under Project Sub-component 1 (works to rehabilitate and build some new health posts (“puestos de salud”) as well as rehabilitate a few community centers; medical equipment; medical and non-medical supplies; technical assistance and training; some equipment for secondary level health facilities that would contribute to build health networks), Sub-component 3 (design and implementation of water supply and sanitation subprojects in rural communities in the prioritized areas), and Component 2 (co-finance the Government strategy through disbursements linked eligible expenditures and specific results defined in relation to results chain (Disbursement-linked Indicators – DLI)).</p> <p>The Project will be highly participatory in nature, building on the successes of the Inclusive Health Model that supports complementarity between traditional and official health systems, intervening at individual, family and community levels. The ESMF includes a grievance redress mechanism to ensure adequate and reiterative information, communication channels and a system to address complaints in a transparent, efficient, and confidential manner. The ESMF will also include screening criteria to identify and avoid any potential cases of land acquisition that would generate involuntary resettlement impacts per</p>



		OP/BP 4.12.
Natural Habitats OP/BP 4.04	No	The Project does not contemplate rehabilitation or new works in areas of natural habitats or that would significantly impact natural habitats.
Forests OP/BP 4.36	No	The Project will not finance activities in forests or that could potentially affect forest resources or their management.
Pest Management OP 4.09	No	The project will not finance activities involving the use of pesticides nor will it promote and is not expected to lead to an increase in the use of pesticides (e.g. for mosquito control).
Physical Cultural Resources OP/BP 4.11	Yes	Due to project scope in water and sanitation projects in rural areas, there might be a possibility of chance findings that will be managed via the ESMF
Indigenous Peoples OP/BP 4.10	Yes	The Project will finance activities and investments that benefit, almost in the majority, Indigenous communities that meet the four criteria of OP/BP 4.10. Given this, the Project is considered an Indigenous Peoples project and all requirements of this Policy will be complied with through project preparation and implementation, guided by the PAD and Project Operations Manual. A sociocultural assessment was carried out to inform project design that included consultation processes at a departmental and national level. Based on the results of the sociocultural assessment and consultation process, specific project actions and provisions for community level participation and to ensure broad community support in relevant project decisions have been incorporated into the Operations Manual. The Inclusive Health delivery model works directly with communities to diagnose and treat health issues and attend to community concerns and priorities. The entire project will engage at the community level to increase knowledge and awareness among expected beneficiaries and promote access to services through the COMCODES and COMUDES. Project related grievances will be handled in accordance with the GRM outlined in the ESMF.
Involuntary Resettlement OP/BP 4.12	No	During Project preparation it was determined that no investments will be supported that could introduce involuntary resettlement impacts per this Policy. The ESMF will include screening criteria to avoid the involuntary taking of land and that if usage or acquisition rights are attained for health posts or WSS infrastructure, these are fully voluntary in nature by



		the individual or community granting or transferring the rights.
Safety of Dams OP/BP 4.37	No	The Project will neither support the construction or rehabilitation of dams nor will it support other investments which rely on services of existing dams.
Projects on International Waterways OP/BP 7.50	Yes	Given the limited amounts of water to be abstracted and the localized nature of the sources, the Task Team has concluded that while the activities financed under project consist of additions or alterations of the ongoing scheme, they: (i) will not adversely change the quality or quantity of water flows to the other riparian; and (ii) will not be adversely affected by the other riparian possible water use. An exception to the riparian notification requirement was granted on November 7, 2016, on the basis that while the activities financed under the Project consists of additions and alterations to an ongoing scheme, they will not affect point i and ii mentioned above.
Projects in Disputed Areas OP/BP 7.60	No	The Project will not finance activities in disputed areas as defined in the policy.

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:



Environment: Guatemala's environmental and health legislation and associated regulatory instruments are quite extensive. More than sufficient to cover the needs of the World Bank's Safeguard Policies. The government's capacity to enforce compliance however, is limited. Weak institutional capacity will require project support to strengthen implementation.

The potential environmental impacts associated with the type and size of works are anticipated to be relatively minor to moderate, and will not involve significant impacts, and with appropriate standard mitigation measures the potential negative impacts would be managed appropriately.

Social: The majority of the Project's beneficiaries are Indigenous peoples. Given this, and the fact that the Primary Health Care (PHC) Inclusive Health Model to be supported by the Project builds fully on Indigenous health systems and community driven models, for the purpose of OP/BP 4.10, the Project is considered an Indigenous Peoples Project. The Project does not introduce any potential large scale, significant and/or irreversible impacts. Potential social safeguards risks for this project include the exclusion of Indigenous populations, the delivery of health care systems that are culturally insensitive or undermine traditional beliefs and practices, and/or discrimination or poor treatment of Indigenous populations in health posts or centers supported by the Project. Whereas historically, all of these risks have been present in the delivery of PHC in Guatemala, in the case of this Project, indigenous populations will be among the predominant beneficiaries due to the ethnic make-up of the targeted departments. At the same time, the Government's new Strategy to combat Chronic Malnutrition and the proposed PHC model for builds on a highly successful intercultural model for health care delivery. This model builds complementarity between traditional Indigenous systems and concepts of health and illness and western "official" systems, strengthening and building complimentary, mutual understanding and referral systems between official and traditional health service providers. In addition, traditional health service providers, such as midwives or "comadronas" and traditional healers and specialists are integrated into the health delivery system, fully recognizing their knowledge, importance and role within their communities and as service providers.

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

Environment: The Project's anticipated activities are relatively minor and are not expected to have any indirect and/or long term impacts. In fact, the Project's interventions are expected to improve environmental management both of health posts and rural water supply and sanitation systems through the application of Guatemala's extensive environmental legislation and regulatory instruments together with other Project supported activities such as capacity building, occupational health and safety training and environmental education.

Social: There are no potential indirect or long term impacts due to anticipated future activities in the project area that would raise safeguards concerns.

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



Environment: N/A

Social: The primary project alternative considered was the extent to which the Inclusive Health Model could be escalated and adopted within the Government's primary health care delivery model. The original proposal for project design was to only include some aspects of the Model due to budgetary limitations and compliment as necessary with the IPPF. After further consideration the Ministry of Health has decided to escalate the full model by reducing costs through eliminating some actors on the extramural teams so that the extramural service will be focused solely on the nursing assistants working integrally within the communities and with the traditional health service providers to ensure the full application of the Model. With this change it was decided that the Project could be considered an Indigenous Peoples Project as it will implement the actions requested and recommended through the Sociocultural Assessment and participatory processes. The specific decision points and key issues for implementation that were requested through the participatory processes with Indigenous leaders and representatives have now been integrated into the Project's Operations Manual and a separate IPPF or preparation of IPPs is not necessary.

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.

Environment: The government undertook an extensive review of Guatemala's environmental and health legislation and regulatory instruments as they pertain to the Project. These were found to comply if not surpass the requisites of the World Bank's safeguards policies.

Health service providers targeted under the Project will implement the MSPAS guidelines for health care waste management, storage and disposal system to adequately accommodate any additional waste that would occur as a result of the expanded coverage. Where sufficient capacity does not exist, the Project will finance activities as needed to ensure adequate disposal of all health care waste related to the project.

Equally, the government will ensure that water supply and sanitation systems supported by the project will be done in accordance with current legislation thus minimizing any potential environmental impact.

This project is considered an Indigenous Peoples project as the overwhelming majority of direct beneficiaries are Indigenous. A sociocultural assessment (SA) was carried out to inform project design that included consultation processes at a departmental and national level. Based on the results of the SA and consultation process, specific project actions and provisions for community level participation in relevant project decisions have been incorporated into the Operations Manual. FODES will hire a social specialist to supervise implementation of these actions and provisions, elaborate and implement a culturally appropriate communications strategy, and to ensure any concerns or issues that arise during project implementation at a community level are adequately addressed.

The SA included: (i) a stakeholder mapping at both the national and departmental levels for the first four participating departments; (ii) interviews with key stakeholders at a national, departmental and community level, including government actors, NGOs, and Indigenous organizations; (iii) focus groups in 12 municipalities from the four departments prioritized under the first phase, with Indigenous leaders - traditional health care providers, youth and Indigenous women; and (iv) a desk analysis of barriers to access, and both unsuccessful and successful past experiences in reducing chronic malnutrition, infant mortality, maternal mortality, and increasing adoption of family planning methods. The full SA was published on the Bank's, MSPAS, MIDE, and SESAN's websites

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

Environment: The two main government counterparts are the MSPAS and the Ministry of Environment. The first as the



main recipient of project funds and the second as an important partner in guaranteeing compliance with environmental legislation.

The ESMF was disclosed on the Government’s website.

Social: Key stakeholders include beneficiary communities in the seven departments where the project will be implemented, local and Indigenous community leaders, health personnel working at health posts and centers, extramural nurse assistants, midwives, and other Mayan healers and specialists. These stakeholders participate and are represented in the Community Development Councils and Municipal Development Councils where key project decisions will be made. The MOP requires a revision of the legitimacy of these Councils and, in cases where Indigenous authorities are not adequately represented, additional measures should be taken to ensure their voice in key project decisions

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

Environmental Assessment/Audit/Management Plan/Other

Date of receipt by the Bank 15-Sep-2016	Date of submission to InfoShop 08-Nov-2016	For category A projects, date of distributing the Executive Summary of the EA to the Executive Directors
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"In country" Disclosure

Guatemala
27-Oct-2016

Comments

Indigenous Peoples Development Plan/Framework

Date of receipt by the Bank 05-Sep-2016	Date of submission to InfoShop 04-Nov-2016
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"In country" Disclosure

Guatemala
27-Oct-2016

Comments

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

OP/BP/GP 4.01 - Environment Assessment



Does the project require a stand-alone EA (including EMP) report?

No

OP/BP 4.11 - Physical Cultural Resources

Does the EA include adequate measures related to cultural property?

No

Does the credit/loan incorporate mechanisms to mitigate the potential adverse impacts on cultural property?

No

OP/BP 4.10 - Indigenous Peoples

Has a separate Indigenous Peoples Plan/Planning Framework (as appropriate) been prepared in consultation with affected Indigenous Peoples?

Yes

If yes, then did the Regional unit responsible for safeguards or Practice Manager review the plan?

Yes

If the whole project is designed to benefit IP, has the design been reviewed and approved by the Regional Social Development Unit or Practice Manager?

Yes

OP 7.50 - Projects on International Waterways

Have the other riparians been notified of the project?

No

If the project falls under one of the exceptions to the notification requirement, has this been cleared with the Legal Department, and the memo to the RVP prepared and sent?

Yes

Has the RVP approved such an exception?

Yes

The World Bank Policy on Disclosure of Information

Have relevant safeguard policies documents been sent to the World Bank's Infoshop?

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

CONTACT POINT

World Bank

Christine Lao Pena
Senior Human Development Economist

Carlos Marcelo Bortman
Lead Health Specialist

Borrower/Client/Recipient

Ministry of Finance

Implementing Agencies

Social Development Fund/ Ministry of Social Development (MIDES)
Carlos Enrique Rosenberg
Executive Director
directorejecutivo.fodes@gmail.com

FOR MORE INFORMATION CONTACT

The InfoShop
The World Bank
1818 H Street, NW
Washington, D.C. 20433
Telephone: (202) 458-4500
Fax: (202) 522-1500



Web: <http://www.worldbank.org/infoshop>

APPROVAL

Task Team Leader(s):	Christine Lao Pena Carlos Marcelo Bortman
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Approved By

Safeguards Advisor:		
Practice Manager/Manager:	Daniel Dulitzky	16-Nov-2016
Country Director:	Maryanne Sharp	16-Nov-2016