



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

Concept Stage | Date Prepared/Updated: 15-Nov-2016 | Report No: PIDISDSC17327



BASIC INFORMATION

A. Basic Project Data

Country Guatemala	Project ID P159213	Parent Project ID (if any)	Project Name Crecer Sano: Guatemala Nutrition and Health Project (P159213)
Region LATIN AMERICA AND CARIBBEAN	Estimated Appraisal Date Nov 16, 2016	Estimated Board Date Jan 17, 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

Concept Review Decision

Track II-The review did authorize the preparation to continue

Other Decision (as needed)

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B. Introduction and Context

Country Context

Guatemala has a rich cultural heritage and considerable economic potential, but a challenging history of conflict and exclusion. The country has made progress in consolidating democratic institutions since the end of the 36 year civil war in the mid-1990s. More recently, the country successfully resolved a difficult political transition and a new administration is in place after a peaceful election. However, economic and social challenges remain, including achieving higher and more equitable growth. With 60 percent of its population living in poverty in 2014, Guatemala urgently needs to accelerate growth and ensure that it is more inclusive.

Guatemala’s stable macroeconomic framework has not translated into high growth or poverty reduction. The country is the largest economy in Central America with a GDP of US\$53 billion (2013). Since 1990, economic volatility



was less than half the regional average, and the country experienced less of an economic decline during the recent crisis. Much of Guatemala's relative stability can be attributed to prudent macroeconomic policies that have kept inflation and public debt manageable, while avoiding fiscal imbalances that have affected much of the region. Fiscal discipline has been achieved despite Guatemala having one of the lowest tax burdens in the world (about 10.8 percent of GDP in 2014). Nonetheless economic growth has been modest (averaging 3.4 percent between 2000 and 2015) and per capita growth has been weak. Aggregate economic indicators dynamics suggest that rather than catching up with richer countries, Guatemala has diverged. Guatemala's GDP per capita is now 6.7 percent of the U.S. GDP per capita (current) when in 1960 it was 8.4 percent. Today, Guatemala is the fifth poorest economy in terms of GDP per capita in the Latin America Region.

Guatemala is among the countries with the highest poverty rate in Latin America, and income growth among the bottom forty percent of the population has been negligible in recent years. The poverty rate (US\$4 per day poverty line) increased from 55 percent in 2000 to 60 percent in 2014. This implies that the number of Guatemalans living below the poverty line increased from 6.8 million to 9.6 million during the same period. This trend is in striking contrast to the overall strong decline in poverty in both Latin American as a whole and most of Central America. Shared prosperity, as measured by the average growth of the incomes of the bottom forty percent of the population, was negligible in Guatemala between 2006 and 2014, again in direct contrast to most Latin American countries.

The low level of revenue mobilization has constrained the ability of the state to steer development and social policy. Guatemala has one of the lowest tax revenues in the region, and the lowest per capita spending on social sectors. At around 11 percent of GDP, Guatemala's tax-to-GDP ratio is well below the Central American average of 13.3 percent, and far lower than the 19.2 percent average for all of Latin America. While other countries with low tax-to-GDP ratios, including Mexico and Panama, 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. Social public spending's share of GDP increased in the last decade but has stagnated in recent years and – at 8.2 percent of GDP in 2013 – it is the lowest in the Central American region, notably behind countries with lower GDP per capita such as Nicaragua and El Salvador, where social public spending as percentage of GDP is greater than 12 percent.

The new administration, which assumed office in January 2016, has placed health, education, stronger economic growth and increased transparency at the center of its policy agenda. The new Government's plan emphasizes improvements in health, prioritizing the reduction of chronic malnutrition and education –recognizing the important role that the social sectors play in contributing to economic growth and vice versa. It also expressed its commitment to improving transparency and accountability.

Sectoral and Institutional Context

Guatemala has made progress with regard to several of its health indicators but maternal mortality and chronic malnutrition remain high. Life expectancy rates have increased from 62 years in 1990 to 72 years in 2013. In addition, under-five mortality rate has declined from 81 per 1,000 live births in 1990 to 31 in 2013, and infant mortality rates have also decreased from 60 to 26 per 1,000 live births. However, although Guatemala's maternal mortality rate (MMR) has declined from 1990 to 2005, it has remained stagnant at 140 deaths per 100,000 live births since 2005. It is also among the highest in the LAC region which has a regional average MMR of 87 per 100,000 live births in 2013 (WDI 2014). Moreover, although chronic malnutrition rate decreased from 55 percent in 1995 to 46.5 percent in 2014/15 (series of National Maternal and Child Health Surveys or ENSMIs), Guatemala's stunting rate is the highest in the LAC region and among the highest in the world—exceeding stunting rates of countries with significantly lower per



capita incomes such as Bangladesh, Ethiopia, and Vietnam.

Major drivers of chronic malnutrition are interlinked: *poor child feeding practices and limited access to safe water, sanitation and quality health services in rural areas.* The UNICEF framework (1990) underscores the role that child care practices, dietary quality, access to water and adequate sanitation and health care play in affecting malnutrition rates. Data from the 2014/15 ENSMI shows that only 53.2% of children 0-5 months are exclusively breastfed (in rural areas, babies risk ingesting unsafe weaning foods) and 50% of children 6-23 months, adequately fed. In terms of basic health services, only 51.7% of children 12-23 months of age in the lowest income quintile have received all their required vaccinations compared to 62.4% of children in the highest income quintile (ESNMI). Moreover, less than half of the population have access to primary health services due to the Government's decision to discontinue the Extension of Coverage Program (PEC), which provided basic health and nutrition services through NGOs, and progressively replace it with health care services provided by Ministry of Health staff. Quality of care also remains an issue with the sector facing a shortage of health professionals and medical inputs. Guatemala's health personnel to population ratio in 2013 was only half of the World Health Organization's standard. There have also been frequent alerts of shortages in drugs and medical inputs in all facilities. Finally, only 71% of rural areas have access to piped water compared to 97% of urban areas, while only 49% of rural areas have access to improved sanitation facilities compared to 78% of urban areas in 2015.

Insufficient funds, funding flow bottlenecks, and inefficient spending limit the coverage and quality of health and nutrition services. Guatemala's public spending share on health of GDP increased from 1.8 percent in 2007 to 2.2 percent in 2013. However, it is lower than the LAC average (3.76 percent) and is the lowest in Central America (WB SSEIR 2016). The budget assigned to the health sector has been frequently cited as inadequate to address the significant coverage gaps and quality issues related to staffing and availability of essential inputs. While there is a need to increase the public resources allocated to health, delays in funding would also need to be addressed. There are also reports of inefficient management of resources including poor targeting, contract awards that do not meet technical standards and procurement guidelines, and uncoordinated efforts among key institutions within the health sector and across sectors. (WB SSEIR 2016).

The previous Government's Zero Hunger Program yielded mixed results, providing useful lessons. Launched in March 2012, the Zero Hunger Program (ZHP) targeted 166 municipalities with the highest prevalence of chronic malnutrition, using a multi-sectoral approach involving several ministries, as well as private sector and civil society organizations. The Ministry of Finance (MOF) and MOH also signed a results-based budgeting agreement in 2012 to track progress made in implementing the First 1000 Days of Life Initiative under the ZHP. Evaluations of the ZHP indicate mixed results. For example, chronic malnutrition for children 3 to 59 months only decreased from 60.1 percent in 2012 to 58.4 percent in ZHP areas in 2013 and stunting rates increased for children under 1 year old (SESAN-IFPRI 2014). There are also a number of ZHP targets that have not been met by a large margin. For example, the MOH's 2015 report shows that only 38.2 percent of children younger than 1 year were vaccinated based on the required scheme for their age and only 30.8 percent of pregnant women received timely prenatal care. The ZHP evaluations suggest the need to continue with the multi-sectorial approach, intensifying better coordinated efforts with fewer institutions in fewer prioritized areas.

The Government's new chronic malnutrition reduction strategy builds on lessons learned from Guatemala and Peru. The new Government recently launched its National Strategy to Reduce Chronic Malnutrition, taking into account lessons learnt from (a) Guatemala (ZHP & the World Bank Maternal and Child Health & Nutrition Project): (i) prioritize an integrated package of interventions in fewer areas & with fewer implementing agencies; (ii) improve monitoring and supervision; and (iii) strengthen financial flows to support flow of funds to implement the National



Strategy; and (b) from Peru: (i) ensure strong Government commitment: the President of Guatemala has endorsed the new National Strategy to Reduce Chronic Malnutrition and publicly declared reducing chronic malnutrition has one of his Government's top priorities; (ii) support multi-sectoral efforts targeting the determinants/risk factors of malnutrition; (iii) promote strong advocacy and communication for behavioral change; (iv) implement financing for results and target communities with greater needs; and (iv) strengthen local involvement in reducing chronic malnutrition.

Relationship to CPF

The recently completed Systematic Country Diagnosis for Guatemala underscores chronic malnutrition and access to basic social services as important areas of focus to promote human capital development and shared growth in Guatemala. The Country Partnership Strategy (CPS) currently under preparation would include a bundled package of instruments comprised of a Nutrition and Health Project, Development Policy Financing, and technical assistance to support the Government of Guatemala in addressing the key drivers of chronic malnutrition while at the same time also contributing to strengthening governance and accountability mechanisms and results-orientation at central, municipal and community levels.

C. Proposed Development Objective(s)

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 (From PCN)

Preliminary results indicators include the following:

- i. Reduce by 10 percent the prevalence of chronic malnutrition (stunting) among children 24 months old in the intervention areas
- ii. Increase by 70 percent coverage of growth promotion for children under 24-months
- iii. Increase by 25 percentage points of families with access to safe drinking water and sanitation in the intervention areas
- iv. Increase by 70 percentage points the number of municipalities where integral interventions were implemented (Water and sanitation; PHC and behavioral change promotion)

D. Concept Description

To achieve these objectives over a five-year period, the proposed operation would support the new Government Nutrition Strategy ("Estrategia Nacional para la reducción de la desnutrición crónica 2016-2020") to reduce chronic



malnutrition with special emphasis on the first 1,000 days of life with intensified actions in prioritized municipalities. Intervention areas were selected based on high rates of stunting, and maternal and child mortality, large numbers of children under five, and high proportion of rural and indigenous population (mainly in the Highlands). The Project would focus on three main interventions, (a) increasing access and strengthening the quality of primary health care services; (b) support health and nutrition promotion and behavioral change at the community level; (c) improve access to safe drinking water and sanitation, ensuring that these are delivered as a package in specific target areas to maximize synergies. The Project would also support the National Strategy by improving governance, cross sectorial coordination and comprehensive interventions. The proposed Project would also implement a result-based financing component based on fulfillment of targets using a weighted performance average of intermediate/process and outcome indicators in the intervention areas to support the implementation of the entire Nutrition Strategy.

Component 1. Inter-sectoral package of services to address main of chronic malnutrition (US\$ 95M). This component would have four subcomponents:

Subcomponent 1. Strengthening Primary Health Care services in the intervention areas. This subcomponent aims at providing primary health care services in areas affected by the elimination of the Extension of Coverage Program (PEC), which used to provide basic health and nutrition services through NGOs contracted by the MOHSA and increase access and quality to PHC services. The subcomponent would support the provision of nutrition and health services to mother and children with special emphasis in first 1000 days. The basic package of services would include prenatal care, immunization, growth monitoring, counseling, family planning, etc. Each health center would develop a census of houses and families in their areas and create a system for monitoring the demand/utilization of health services. The subcomponent would finance: works to rehabilitate and build some new health posts (“puestos de salud”) as well as rehabilitate few community centers; medical equipment; medical and non-medical supplies; technical assistance, and training. This subcomponent would also support some equipment for secondary level health facilities that would contribute to build health networks.

Subcomponent 2. Promoting behavioral change. This subcomponent would support a set of inter-sectoral interventions aiming to reduce several behavioral related risk factors for chronic malnutrition (increase exclusive breast feeding, improve feeding practices for children above 6 months, improving hygiene practices, increase the demand of PHC, iron/folate supplementation, etc.).

This subcomponent would finance health promotion (workshops), interpersonal communication, culturally appropriate local communication strategies (including several innovative communication mechanisms), sub-projects to be designed and implemented by the communities, and incentives for communities achieving results in reducing risk factors and prevalence of chronic malnutrition. This subcomponent would support links with the CCT program (including revision of targeting, conditionalities, communication protocols and outreach strategies) and the development of monitoring dashboard at municipal level.

Subcomponent 3. Improving Access to safe drinking water and sanitation. This subcomponent would finance or co-finance the design and implementation of water supply and sanitation subprojects in rural communities in the prioritized areas. The project would coordinate with local municipalities to identify potential water and sanitation subprojects. These subprojects would be co-financed with local municipalities (the amount of co-financing would depend on each municipality’s income) but full financing could be considered if the communities achieve specific results in reducing other risk factors (i.e. participation in the growth promotion and the immunization programs).

Subcomponent 4. Improving governance and cross sectorial coordination. This subcomponent would support coordination across sectors to implement the Government strategy. The subcomponent would finance a set of tools



for monitoring progress in implementing the strategy, promote links among user/beneficiary registries in different sectors, finance studies to better understand the causes and roles of risk factors in the development of chronic malnutrition, evaluate specific interventions, and finance a nationwide communication strategy for health and social workers, stakeholders and general population.

Component 2. Moving the focus towards results (WB: US\$ 50M;). This component would increase the focus on results by introducing a result-based financing mechanism. While Component 1 would finance several inputs needed, significant proportion of resources to implementation of the proposed strategy would come from the Government budget. These budget resources would be needed to finance salaries, operational costs and inputs not covered by Component 1. This component would co-finance the Government strategy through disbursements linked to eligible expenditures and specific results defined in relation to results chain (Disbursement-linked Indicators – DLI). At present the Government is in the process of costing its nutrition strategy and the line items costs will be defined in late April/May. The results matrix would also include some intermediate outcomes to allow program implementation and to incentivize the achievement of results. To trigger disbursements the Government would submit to the Bank evidence of achieving the result/s and proof that Eligible Expenditures were executed to finance the Strategy.

Potential DLIs to be included:

- Increased % of prenatal care
- Increased % of institutional deliveries
- % of families receiving information and having access to family planning services
- % immunization coverage among 12-month-old children
- % children 5 month old with exclusive breast feeding
- Increased coverage of the rural population having regular access to safe drinking water.
- % of prioritized areas with health institutional teams (“*equipos institucionales de salud*” - EIS)
- % of health posts in prioritized municipalities with updated houses and families census and monitoring system operational
- Surveillance system for safe drinking water in place, and reporting as defined in the protocols.
- % of municipalities that are implementing monitoring dashboard for chronic malnutrition.
- Unique registry of users/beneficiaries in place
- Operational Plan and Procurement Plan for the first 18 months of project implementation approved by the Government and WB which could be considered as retroactive financing to support the GoG to facilitate Project implementation as soon as it becomes effective

Component 3. Project Management, Monitoring and Evaluation (US\$ 5M). This component aims to support the Project Implementation Unit to provide day-to-day project management, including the fiduciary tasks of the Project and Monitoring and Evaluation.

SAFEGUARDS

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



The Project will finance two phases of 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).

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%.

Some of the beneficiary communities may include Chixoy-affected communities in the departments of Alta Verapaz and Quiché. A specific outreach and consultation measures would be designed to take into account the historical legacies of the Bank with these communities.

B. Borrower's Institutional Capacity for Safeguard Policies

Proposed institutional arrangement would be kept simple by having a single Project Implementation Unit (PIU) within the Ministry of Health to implement the entire Project. A new Government law requires that PIU Coordinator, Financial Management and Procurement Specialists must be Government staff to promote accountability. The PIU would also include consultants to support this core team. A multi-sectoral steering committee with participation of all relevant sectors (e.g. Secretariat of Food Security and Nutrition, MOHSA, Ministry of Social Development (MIDES, etc.) will provide guidance to the PIU, monitor progress towards Project objectives and facilitate dialogue with the participating sectors to deal with bottlenecks.

During project preparation, the Bank will assess the needs and capacities of relevant entities to manage environmental and social safeguards and to effectively engage Indigenous Peoples and incorporate their unique cultural vision and needs within investment design and service delivery. During preparation, the project team will support the client with safeguards training and identify the necessary human and financial resources, inter-institutional arrangements, and specific actions necessary for environmental and social management. The necessary resources, actions and procedures will be included in the Project Component 1.4 (Improving governance and cross sectorial coordination) and Component 3 (Project Management and Monitoring and Evaluation); outlined in the Project's Environmental and Social Management Framework (ESMF), Indigenous Peoples Policy Framework (IPPF), Resettlement Policy Framework (RPF)- if deemed necessary; and integrated into the Project Operational Manual.

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.

C. Environmental and Social Safeguards Specialists on the Team



Gunars H. Platais, Dianna M. Pizarro

D. Policies that might apply

Safeguard Policies	Triggered?	Explanation (Optional)
Environmental Assessment OP/BP 4.01	Yes	<p>The Project is proposed to be 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 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. Specific sub-projects and activities are not yet defined, an Environmental and Social Management Framework (ESMF) will be developed 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 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 to eligible expenditures and specific results defined in relation to results chain (Disbursement-linked Indicators – DLI)).</p> <p>The ESMF will also incorporate the World Bank’s Environmental Health Safety Guidelines for works relating to health care facilities and water/sanitation infrastructure.</p>
Natural Habitats OP/BP 4.04	TBD	<p>The Project does not contemplate rehabilitation or new works in areas of natural habitats or that would significantly impact natural habitats. However the type and scale of Subcomponent 3 (design and implementation of water supply and sanitation subprojects in rural communities in the prioritized areas) will be assessed during preparation to confirm whether this policy should be triggered.</p>



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. A social assessment will be carried out during project preparation, that will include consultation and with Indigenous peoples and organizations at a departmental level and at a national level with key Indigenous stakeholders to inform project design. An Indigenous Peoples Planning Framework (IPPF) will be prepared, consulted and disclosed prior to appraisal outlining the actions and procedures to prepare Indigenous Peoples Plans (IPPs) during implementation. The IPPs will describe the specific actions, budgets, and indicators for each type of investment or activity supported by the project, taking into account the cultural differences and actors for each department and ethnicity. The Inclusive Health delivery model, that would be supported by the Project, 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	TBD	Early in Project preparation, based on an initial training on OP/BP for the Client, the Team will determine whether to trigger this Policy and prepare a Resettlement Policy Framework (RPF) or exclude all subprojects with potential involuntary land taking. If the latter is chosen, the ESMF will include specific screening and assessment procedures to identify and exclude subprojects that could cause impacts covered by this Policy.



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	No	The Project will not finance activities involving the use or potential pollution of international waterways.
Projects in Disputed Areas OP/BP 7.60	No	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

Aug 01, 2016

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

An Social Assessment (SA), Environmental and Social Management Framework (ESMF), Indigenous Peoples Planning Framework (IPPF) and possibly Resettlement Policy Frameworks (RPF) would be needed.

Timeframe for these studies is:

April: draft Terms with Client and hire consultant(s) for SA

May/June: carry out SA and prepare IPPF

July: validate IPPF and incorporate comments

August: disclose and appraise

Feasibility studies for health facility renovations and new health posts and water and sanitation facilities will be carried out during the first two years of the Project implementation

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APPROVAL

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