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

Appraisal Stage | Date Prepared/Updated: 21-Mar-2019 | Report No: PIDISDSA26165
## BASIC INFORMATION

### A. Basic Project Data

<table>
<thead>
<tr>
<th>Country</th>
<th>Project ID</th>
<th>Project Name</th>
<th>Parent Project ID (if any)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paraguay</td>
<td>P167996</td>
<td>Paraguay Public Health Sector Strengthening</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Region</th>
<th>Estimated Appraisal Date</th>
<th>Estimated Board Date</th>
<th>Practice Area (Lead)</th>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Financing Instrument</th>
<th>Borrower(s)</th>
<th>Implementing Agency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Investment Project Financing</td>
<td>The Republic of Paraguay</td>
<td>Ministry of Health and Social Welfare</td>
</tr>
</tbody>
</table>

### Proposed Development Objective(s)

The objectives of this Project are to: (i) strengthen the primary health care network; and (ii) expand access to quality primary health care services for the population covered by the Ministry of Public Health and Social Welfare.

### Components

- Investments to strengthen the service delivery capacity of Health Care Micro Networks
- Improvements in the access to quality health services through priority Integrated Care Sets
- Project Administration and Implementation Support

## PROJECT FINANCING DATA (US$, Millions)

### SUMMARY

<table>
<thead>
<tr>
<th>Total Project Cost</th>
<th>115.00</th>
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<tbody>
<tr>
<td>Total Financing</td>
<td>115.00</td>
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<tr>
<td>of which IBRD/IDA</td>
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<tr>
<td>Financing Gap</td>
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### DETAILS

**World Bank Group Financing**

| International Bank for Reconstruction and Development (IBRD) | 115.00 |
B-Partial Assessment

Decision
The review did authorize the team to appraise and negotiate

Other Decision (as needed)

B. Introduction and Context

Country Context

1. **Paraguay has experienced an average growth rates of 4.7 percent over the last decade and is an upper middle-income country since 2016.** This sustained growth has been accompanied by sizeable reductions in poverty – between 2003 and 2017, moderate and extreme poverty decreased by 6.6 and 12.6 percentage points respectively. 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. **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 the 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.

3. **To sustain the growth trends experienced in the last two decades, there is a need to address several structural challenges.** As the recent Systematic Country Diagnostic (SCD) highlighted, the current rate of depletion of natural resources (mainly deforestation) is unsustainable. Moreover, in part due to the poor job creation by the labor market, the contribution to the demographic dividend to poverty reduction is fading. This is further exacerbated by the poor quality of human capital, and the fact that social expenditures are directed more towards the elderly than the young. To put Paraguay on a

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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.
sustainable growth path, improving the quality of public services and increasing human capital is essential.

### Sectoral and Institutional Context

4. **Fragmentation is inherent to the Paraguayan health care system, as the Ministry of Public Health and Social Welfare and the Social Security Institute (IPS) operate independent service delivery networks.** The Ministry of Public Health and Social Welfare (*Ministerio de Salud Pública y Bienestar Social, MSPBS*) is responsible for health sector stewardship and regulation, but also has the mandate to provide health services free of charge to the entire population that are financed by general taxation. The IPS provides insurance coverage to the formally employed and is mainly financed by a payroll tax\(^2\). As a result, both entities operate separate service delivery networks that are uncoordinated and create duplications (any given provider can also deliver services for both the MSPBS and the IPS\(^3\). Combined, the two provision schemes cover 90 percent of the population. The remaining population is covered by private insurance, the police's and military's separate provision networks, and the University of Asuncion Hospital. While the percentage of people covered by the IPS increased from 10.3 percent in 2003 to 18.5 percent in 2016, 74 percent of the population still lacks insurance and relies primarily on the MSPBS facilities for their health needs.

5. **The effective implementation of the National Health Law (1.032/96) has been slow.** In 2008, the National Health Law entered effectiveness and created the National Health System with a National Health Council as well as Regional and Local Health Councils (*Consejos Regionales y Locales de Salud, RHCs and LHCs*) as the political and administrative basis for the harmonization of the public, the social insurance and the private subsectors. One of the purposes of the reform was to decentralize health provision and encourage citizen participation (Law 3007) by establishing the RHCs and LHCs. However, the actual implementation of the law has been slow, and the National Health Council had actually never developed a National Health Plan.

6. **During the recent election campaign, the finally elected President called for a revolution of health care provision in the country to ensure access to quality health services for all communities of the country.** To deliver on this agenda, the Government of Paraguay (GoP) has announced a revision and full implementation of the National Health Law to improve the coordination between regional and local authorities and recently adopted the National Health Policy 2017-2030 with a focus on quality of care\(^4\). Health sector improvement is central to the Government’s agenda, and it has identified the strengthening of community-oriented PHC and the delivery of maternal, infant and child health services as key areas for improvement. The future development of the health sector in Paraguay has been amply debated in recent years\(^5\). Apart from the proposed Project, the World Bank is supporting

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\(^2\) Employers pay 14% and employees 9% of employer-reported salaries.

\(^3\) World Bank (2016).

\(^4\) The six strategic pillars of this plan are: (a) institutional strengthening, (b) quality of care based on best practices, (c) systematic and permanent improvement of quality of care, (d) patient security, (e) community involvement in monitoring of health care quality, and (f) development of operating manual for the evaluation of health care quality (MSPBS, 2018).

the GoP’s reform agenda through an Reimbursable Advisory Services (RAS) that provide analytical inputs for a broader eventual future harmonization of the Paraguayan health sector.

7. **Over the last 15 years, the GoP has made significant investments in the public health sector to increase service coverage and utilization.** To make progress towards Universal Health Coverage (UHC), the GoP started implementing an ambitious primary health care strategy in 2008, which entailed the construction of Family Health Care Centers (Unidades de Salud Familiares, FHCCs) and the abolishment of user fees in the public health system. In 2009, the MSPBS adopted a List of Essential Medicines to prioritize the procurement and availability of these listed medicines. The MSPBS has also begun to transfer financial resources to LHCs, but without establishing health care-related targets for LHCs. These reforms led to an increase in service coverage and utilization. The fraction of people reporting that they accessed health care services in the last three months increased from 16.4 percent in 2003 to 28.6 percent in 2016. During the same period, the share of the population that reported not accessing health care due to unaffordability fell from 16.6 to 3.9 percent.

8. **Despite significant improvements in the last two decades, there are still challenges ahead.** Paraguay continues to perform worse than other countries in the region for key health indicators and substantial regional inequalities within the country persist. Paraguay had better maternal and child health outcomes than the LAC average in 1990 but has since fallen behind the region’s average. 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 for 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 for MMR, and 14th for IMR and U5MR. Some of the challenges ahead are:

   a) While the burden of disease shifts towards chronic and non-communicable diseases (NCDs), Maternal and Child Health (MCH) issues and communicable and vector-borne diseases remain a concern.

   b) Total Health Expenditure accounts for 9.9% of GDP, while public health expenditure reached 4.4% of GDP in 2016, after almost doubling over the previous decade but without translating into substantially improved health outcomes. Out-of-pocket (OOP) expenditures account for more

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6 Data are from the *Encuesta Permanente de Hogares*, EPH. The survey asks respondents about their health care needs and utilization behavior in the three months prior to the survey.

7 As an example, in 2014, per capita health expenditure in Paraguay ($872) was in between the levels for Peru ($656) and Colombia ($962) but infant mortality rate was much higher in Paraguay (18.1 per 1,000 live births) compared to Peru (13.6 per 1,000 live births) and Colombia (14.1 per 1,000 live births). Trends in life expectancy, a much broader indicator, also illustrates this point: Paraguay’s life expectancy of 63.8 years in 1960 was among the highest in the region. By 2014, at 72.9 years, life expectancy was the third lowest in Latin America.
than half of total health spending, signaling weak financial protection from significant health expenditures, in particular for the poor and vulnerable population. c) The strengthening of the primary health care sector has been identified as a short-term priority. d) Allocations to public health care providers continue to be based on historical budgets and do not reflect current health care needs and health outcomes. e) Provider payment mechanisms generate few incentives for good provider performance.

9. The MSPBS has started to implement information systems to improve its stewardship over the sector and that can facilitate a reform to prepare the service delivery network for its new challenges. In order to address these challenges, the GoP request WB financing and technical support to develop a Project to expand population access to quality health services and to contribute to the realignment of the service delivery system with priority disease areas.

C. Proposed Development Objective(s)

Development Objective(s) (From PAD)

10. The objectives of this Project are to: (i) strengthen the primary health care network; and (ii) expand access to quality primary health care services for the population covered by the Ministry of Public Health and Social Welfare.

11. The primary health care services cover maternal and child care and the following prevalent diseases: (i) Non-communicable diseases: Diabetes, hypertension, cervical and breast cancer; and (ii) Communicable diseases: HIV, sexually transmitted diseases (STDs) and TB.

Key Results

(i) Strengthening the primary health care network:
- Number of new health care micro-networks established that report performance through the SIG
- Number of FHCCs operating according to the national standard

(ii) Expanding access for the population covered by the MSPBS:
- Percentage of population covered by the MSPBS with access to PHC through the FHCCs
- Number of children immunized

(iii) Expanding quality primary health care services:
- Percentage of pregnant women with early prenatal checkups
- Percentage of hypertension patients correctly diagnosed
- Rate of TB cases (new and relapsed)

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8 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).
D. Project Description

12. The Project will have three components:

13. **Component 1: Investments to strengthen the service delivery capacity of Health Care Micro-Networks (US$95.1M).** This Component will finance activities for the strengthening of HCMNs so they can provide quality health care services to people under different ICS. The component will finance the following activities:

   (i) Construction of new FHCCs, rehabilitation of infrastructure in district hospitals and existing FHCCs, and the conversion of health posts to FHCCs through Civil Works (US$50.3M).
   (ii) Provision of medical equipment, furniture, information and communication technology (ICT) (US$28.3M) for the newly constructed, rehabilitated and converted FHCCs will be needed to improve the quality of primary health care services.
   (iii) Capacity building of MSPBS staff with distinct roles and from different organizational levels (US$4M).
   (iv) Specific support services (US$12.5M) for the: (i) institutional strengthening to improve the performance of HCMNs at central and local level; (ii) design of a mass communication and social media strategy to promote the population’s behavioral change (i.e. generating awareness regarding health promotion and self-care on ICS; and, (iii) establishment of efficient procurement and logistic mechanisms for medicines and medical supplies.

14. **Component 2: Improvements in the access to quality health services through priority Integrated Care Sets (US$15M)** The objective of this component is to expand population access to quality health care services for the following health ICS: (i) maternal and child health; (ii) highly prevalent NCDs (i.e. hypertension and diabetes) and cancers prevalent among women (i.e. cervical-uterine and breast cancer); and, (iii) infectious diseases (i.e. tuberculosis, sexually transmitted diseases (STDs)) such as syphilis and HIV.

15. **This component will finance capitation payments for the provision of ICS under a Results-based Financing (RBF) scheme.** Resources will be transferred to Local Health Councils based on population reached and the outcomes related to the following health functions: (i) regulation; and (ii) service delivery. In terms of regulation, the Project will promote results linked to: stewardship, governance and HCMN performance monitoring (Result Area 1). Under the second function, the Project will promote: health Promotion (Result Area 2) and health outcomes (Result Area 3).

16. **Component 3: Project Administration and Implementation Support (US$4.6M).** This component will support and finance the Project implementation and supervision efforts, including Project management, fiduciary tasks, the management of environmental and social risks, monitoring and evaluation (M&E) and the financial audit through consulting, non-consulting services and operating costs.

E. Implementation
Institutional and Implementation Arrangements

17. The Project will be implemented by the MSPBS through the Project Implementation Unit (PIU) established within the MSPBS. The PIU will depend on the Minister of Public Health and Social Welfare. The PIU will be responsible for working with MSPBS Directorates and the Regional and Local Health Councils to implement the Project in a timely manner, conforming to agreed-upon quality standards. The PIU will work closely with the MSPBS teams institutionally responsible for the health programs implementing the priority LoCs such as Maternal and Child, Immunizations, Sexual and Reproductive Health, Adolescent Health, Diabetes, Hypertension, HIV, ITS, TB, cervix and breast cancer and the additional teams such as the DINASAPI and the others included to work together in the Healthy municipalities Strategy: School Health and Tobacco Control. In addition, the PIU would have the primary responsibility for tracking progress related to Project activities, outcomes and results.

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

The Project activities will have a national coverage except for civil works under Component 1 that will be mainly focused on four prioritized departments: Central, Paraguarí, Cordillera and Amambay. New Family Health Care Centers (FHCCs, Unidades de Salud Familiares) will be constructed, infrastructure rehabilitated in existing FHCCs and some district hospitals, and small health centers and sanitary posts converted into FHCCs in prioritized departments. None of these activities will impact natural habitats, forests or physical cultural assets, nor cause any type of involuntary resettlement. The specific locations of the proposed interventions will be defined during Project implementation. Indigenous Peoples (IP) are present in 14 out of the 18 departments of the country (excluding Cordillera, Paraguarí, Misiones and Ñeembucú).

G. Environmental and Social Safeguards Specialists on the Team

Graciela Sanchez Martinez, Social Specialist
Tuuli Johanna Bernardini, Environmental Specialist
Marcelo Roman Morandi, Environmental Specialist
Francisco Jose Garcia Faure, Social Specialist

<table>
<thead>
<tr>
<th>SAFEGUARD POLICIES THAT MIGHT APPLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguard Policies</td>
</tr>
<tr>
<td>Environmenta l Assessment OP/BP 4.01</td>
</tr>
</tbody>
</table>
and impacts, taken Component 1 will finance, among other things, medical equipment and civil works to construct new Family Health Care Centers, rehabilitate district hospitals and existing FHCCs, and convert health posts to FHCCs. The construction of new FHCCs and the rehabilitation of existing infrastructure of district hospitals will be initially limited to four prioritized departments (Central, Paraguari, Cordillera and Amambay). New FHCCs will be built according to a standardized model that includes an energy-efficient design in terms of indoor climate control. The Project will also 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 Appraisal Stage.

Environmental and social risk management will be needed to prevent, minimize and mitigate any negative impact of the civil works and the handling of pharmaceuticals. Particularly, the Project will identify and address the need for improved management of health care waste (HCW), including other hazardous waste that can be expected to increase in volume and challenge the existing management capacity. Addressing HCW with Project support is expected to cause positive environmental and social impacts compared with the baseline situation. Regarding execution of civil works, monitoring the related institutional articulation between the Ministry of Environment, DIGESA, contractors and their inspectors will require attention to incorporate adequate risk prevention and mitigation measures.

Since specific physical interventions will not be determined before Appraisal, the MSPBS/PIU prepared and consulted an Environmental and Social Management Framework (ESMF). The ESMF, which was acceptable to the Bank, was disclosed in the MSPBS's website and in the World Bank external website on March 20, 2019. The ESMF guides identification of environmental and social risks and impacts and adoption of good practices and measures to prevent, minimize and mitigate them.
as well as to maximize environmental and social value added. The ESMF focuses on HCW management, worker and community health and safety, communication, grievance redress management, and stakeholder engagement in improving health care infrastructure, equipment and services. It also guides and orients planning, execution and monitoring of civil works to construct and remodel FHCC.

<table>
<thead>
<tr>
<th>Performance Standards for Private Sector Activities OP/BP 4.03</th>
<th>No</th>
<th>OP 4.03 is not triggered as none of the planned Project activities finance private sector activities.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Natural Habitats OP/BP 4.04</td>
<td>No</td>
<td>OP 4.04 is not triggered as none of the planned Project activities imply impacts on natural habitats of any type.</td>
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<tr>
<td>Forests OP/BP 4.36</td>
<td>No</td>
<td>OP 4.36 is not triggered as none of the planned Project activities imply impacts on forests or communities whose livelihoods depend on forests.</td>
</tr>
<tr>
<td>Pest Management OP 4.09</td>
<td>No</td>
<td>OP 4.09 is not triggered as the Project will not finance the procurement of pesticides nor will it support activities which lead to the increased use of pesticides or other hazardous chemicals</td>
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<tr>
<td>Physical Cultural Resources OP/BP 4.11</td>
<td>No</td>
<td>Project implementation is not expected to have any negative impact on identified physical cultural resources.</td>
</tr>
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</table>

OP/BP 4.10 has been triggered since there are Indigenous Peoples (IP) in the Project area due to its nationwide nature in all components, except for civil works under Component 1. In Paraguay there are around 118,000 IP (1.8 percent of the total population) that belong to 19 ethnic groups and 5 linguistic families. The need for a differentiated approach for IP health has been recognized by the GoP through the National Policy on IP Health (2008) and the Law of IP Health (2015). Since Project activities and their geographic scope will be determined during Project implementation, the Directorate of Indigenous Peoples Health of the MSPBS (DINASAPI, for its acronym in Spanish) prepared and consulted an Indigenous Peoples Planning Framework (IPPF) as part of the Environmental and Social Management Framework (ESMF) based on the above referred national regulations and the OP/BP 4.10.
Th IPPF includes provisions to extend Project benefits to IPs present in the Project area in a culturally adequate manner through Indigenous Peoples Plans (IPPs). During Project implementation, IPPs will be designed by the MSPBS as part of annual objective setting and planning of activities to ensure that adequate cultural adaptations or complementary activities be carried out for Project activities as pertinent. IPPs will include activities at two levels: training, monitoring, research, consulting and communication at the national level and intercultural health care and registration of ethnic variable in health information systems by Family Health Care Centers (in charge of IP communities at the local level). The IPPF will be implemented by the areas of the MSPBS involved with the Project. Activities foreseen in the IPPF will be included in the Annual Performance Agreements signed between the MSPBS and LHCs.

The IPPF includes a specific grievance redress mechanism (GRM) for IP, which respects indigenous peoples’ culture by considering participation of the Indigenous Peoples’ Health Council, the use of indigenous language, and the adoption of their own conflict resolution mechanisms when needed, among others.

Culturally adequate consultations on the IPPF with the Indigenous Peoples Health Council and relevant indigenous leaders from Central Department were carried out on January 4, 2019, and with relevant Amambay IP leaders on January 22, 2019. The final version of the IPPF which was found acceptable to the Bank was disclosed in the MSPBS web page on March 6, 2019 and in the World Bank external website on March 7, 2019.

Involuntary Resettlement OP/BP 4.12 No

OP 4.12 is not triggered as none of the planned Project activities will generate physical or economic displacement of people. Civil works will only be financed in those health facilities whose land ownership right is under rule and belongs to the MSPBS or those that have a Usufruct Agreement signed between the MSPBS and another state institution or between the MSPBS and Indigenous Communities. The Project will not finance civil works
that require land purchase or expropriation or generate physical or economic displacement of people. The Operational Manual will include the provisions to ensure the compliance with these criteria.

<table>
<thead>
<tr>
<th>Safety of Dams OP/BP 4.37</th>
<th>No</th>
<th>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.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Projects on International Waterways OP/BP 7.50</td>
<td>No</td>
<td>OP 7.50 is not triggered as the planned Project activities will not be conducted in or influence international waterways.</td>
</tr>
<tr>
<td>Projects in Disputed Areas OP/BP 7.60</td>
<td>No</td>
<td>OP 7.60 is not triggered as the Project will not finance activities in disputed areas as defined in the policy.</td>
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**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:

   No large, significant and/or irreversible impacts or other major safeguards issues are expected associated with the Project activities.

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

   Negative indirect and/or long-term potential negative impacts are not expected due to anticipated activities in the Project area. Benefits and positive impacts due to the institutional strengthening and articulation between different areas of the MSPBS and DIGESA are expected in terms of HCW management at the targeted FHCCs and related disposal sites.

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

   N/A

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.

   Institutional responsibilities on Project-related environmental and social risk management include citizen engagement and are aligned to the institutional arrangements and implementation agreements within the MSPBS, that will create a PIU. The PIU will be the main interlocutor with the Bank, while operative units responsible for technical work will be responsible for safeguards implementation.

   To implement OP 4.10, the PIU will coordinate activities with the DINASAPI. To design IPPs, the DINASAPI and PIU will work with the General Directorate of Planning (GDoPE) that is in charge of defining Project’s annual goals. IPP implementation will be performed by the different MSPBS areas involved in the Project at the national level and at the
local level by the MSPBS through the FHCCs. Monitoring of compliance with OP 4.10 will be done by the PIU and DINASAPI in coordination with the Directorate of Health Networks and Services (DHNS), which will receive monitoring and progress information through the SIG and will be in charge of assessing the level of performance on Project’s annual goals. Free, prior and informed consultations with IPs will be conducted by the DINASAPI or the implied LHC, depending on the level of the activities consulted (national or local), following the directives of a new consultation protocol recently approved by the GoP. The General Directorate of Environmental Health (DIGESA) of the MSPBS will be responsible for implementing the ESMF. DIGESA has a solid experience in the management of HCW and it applies hospital waste management procedures in interaction with hospitals, clinics and FHCCs.

The Ministry of Environment and Sustainable Development (MADES) will be responsible for providing Environmental Licenses for the Project-financed civil works, thus ensuring compliance with national environmental regulations and administrative procedures during the construction of works. MADES will also contribute for DIGESA to comply with the World Bank environmental and social safeguards. MADES has relevant experience, since in 2016 it developed and applied a Generic Environmental Management Plan for civil works that were executed as part of the Early Child Development Program (PR-L1051) financed by the Interamerican Development Bank (IDB) and executed by the MSPBS. Following this example, a model Generic Environmental and Social Management Plan for the Project-financed civil works was included in the ESMF as Annex 10. Social management of the civil works include a Communication Program, Grievance Redress Management Program and Community Safety Program. Supported by DIGESA and an environmental and social consultant that the MSPBS will contract for the Project, the PIU will be responsible for including these previsions in bidding documents and monitoring their implementation. To develop a training plan for the staff of the new FHCCs, DIGESA will articulate with the National Strategic Directorate of Human Resources in Health that has experience in preparing and offering training through virtual courses associated with the Pan American Health Organization (PAHO). There will also be periodic training for the FHCC staff that manages health care waste (HCW) to prevent negative impacts of potential increase in generation of HCW.

Borrower Capacity. Currently the DINASAPI has extensive experience working with IPs’ health and conducting free, prior and informed consultations with IP leaders, but it does not have experience with the Bank’s safeguards and lacks enough human and physical resources to ensure adequate implementation of the IPPF. Thus, strengthening measures were established in the IPPF, including: a) adequate number and expertise of skilled staffing for the DINASAPI; b) provisions to cover logistic expenses for consultation activities; and c) training on World Bank safeguard policies and Project’s administrative schemes. Regarding environmental risk management, health teams in the FHCCs will be trained in intercultural health throughout the Project implementation period.

Prior Review. All environmental and social activities, including terms of reference, assessments, reports and plans will be prior reviewed and no-objected by the Bank team to secure compliance with the ESMF as established in the Operational Manual.

Environment and Social Records and Filing System: Detailed records to reflect the Project’s environmental and social management will be filed and maintained by the PIU. These records will be maintained for at least two years after the Project’s closing date. The records will include terms of reference, assessments, plans, management of grievances and other feedback, as well as any public notice or information related to implementing the ESMF.

Project Grievance Redress Mechanism (GRM). The Project’s GRM will be built under the current Customer Service (Servicio de Atencion al Usuario) of the MSPBS based on three principles: (i) availability for beneficiaries and stakeholders considering and respecting their socio-cultural characteristics and needs; (ii) known procedures and timeline for analyzing and resolving grievances; and (iii) affordability of grievance resolution for the claimers.
The IPPF includes a specific GRM for IPs that respects indigenous peoples’ culture considering, among other aspects, participation of the Indigenous Peoples’ Health Council, use of indigenous language, and adoption of IPs’ own conflict resolution mechanisms when needed.

All dissemination on Project’s GRM will include information on the Grievance Redress Service (GRS) of the World Bank. Prior to Project effectiveness, GRM-related details will still be revised and agreed upon between the MSPBS and Bank.

Citizen Engagement. The Project will actively engage citizens and key stakeholders by promoting broad dissemination of work plans on the targeted health care improvements and preventive care and monitor public accountability for executing said plans. The Project will also enable beneficiaries and stakeholders to provide feedback and will integrate received feedback as pertinent to improve results throughout the Project cycle. The Project’s citizen engagement system will be built on the existing User Attention Service (SAU, for its acronym in Spanish) of the MSPBS as described in further detail in the Project’s M&E system.

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

Social: Project’s key stakeholders include: (i) Direct beneficiaries; public health care users; (ii) Regional/Local Health Councils comprised of regional/local government authorities, civil society organizations and private firms that provide services or carry out activities related to health and well-being of the population; (iii) Municipalities; and (iv) Indigenous Peoples’ Health Council, IP NGOs and IP leaders.

Culturally adequate consultations on the IPPF with the Indigenous Peoples’ Health Council and with relevant indigenous leaders from Central Department were carried out on January 4 and with relevant Amambay IP leaders on January 22, 2019. The final version of the IPPF was disclosed in the MSPBS website on March 6, 2019 and in the World Bank external website on March 7, 2019.

Environmental: Key stakeholders are those responsible for adequate management of HCW at health facilities, especially the FHCCs and hospitals and/or clinics that receive the waste from the FHCCs that benefit of the Project. In addition, MADES as the national environmental authority will also be responsible for the overall environmental control in the targeted FHCCs and particularly for the environmental and social control of the Project-financed civil works.

The MSPBS/PIU prepared and consulted an Environmental and Social Management Framework (ESMF). The ESMF was disclosed in the MSPBS's website and in the World Bank external website on March 20th, 2019.

B. Disclosure Requirements

<table>
<thead>
<tr>
<th>Environmental Assessment/Audit/Management Plan/Other</th>
<th>Date of receipt by the Bank</th>
<th>Date of submission for disclosure</th>
<th>For category A projects, date of distributing the Executive Summary of the EA to the Executive Directors</th>
</tr>
</thead>
</table>
"In country" Disclosure
Paraguay
20-Mar-2019

Comments
https://www.mspbs.gov.py/dependencias/portal/adjunto/037a03-MGASFINAL19319.pdf

Indigenous Peoples Development Plan/Framework
Date of receipt by the Bank | Date of submission for disclosure
06-Mar-2019 | 07-Mar-2019

"In country" Disclosure
Paraguay
06-Mar-2019

Comments
https://www.mspbs.gov.py/portal/mppi.html

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

OP/BP/GP 4.01 - Environment Assessment

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

OP/BP 4.10 - 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
The World Bank Policy on Disclosure of Information

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

All Safeguard Policies

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

CONTACT POINT

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APPROVAL

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Approved By

Safeguards Advisor:

Practice Manager/Manager: Daniel Dulitzky 22-Mar-2019

Country Director: Renato Nardello 22-Mar-2019