PRIMARY HEALTH CARE REFORM PROGRAM

(PR-0028)

EXECUTIVE SUMMARY

BORROWER:	Republic of Paraguay		
EXECUTING AGENCY:	Ministry of Public Health and Welfare (MSPBS)		
AMOUNT AND SOURCE:	IDB/OC: (Single Currency Facility)	US$39 million 1/	84%
	Local counterpart funding:	US$ 7.6 million	16%
	Total:	US$46.6 million	100%
FINANCIAL TERMS AND CONDITIONS:	Amortization period:	20 years	
	Disbursement period:	5 years	
	Physical initiation of works:	4 years	
	Interest rate:	variable	
	Grace period:	5 years	
	Inspection and supervision:	1%	
	Credit fee:	0.75% of undisbursed balance	
	Currency of the loan:	Single Currency Facility: 50% in U.S. dollars 25% in yen 25% in deutsche marks	

OBJECTIVES: The program's general objective is to support the gradual process of health sector modernization and reform, while seeking to provide quality services to the Paraguayan population efficiently and equitably. The program, viewed as the first phase in support of the sector reform process, provides incentives and mechanisms to implement in primary health care to address one of the population's main health problems: maternal and perinatal mortality.

The specific objectives are: (i) to strengthen regional autonomy by, among other things, identifying and coordinating the sector-related responsibilities of the various agents (Regional Health Directorates, Departmental Health Secretariats, and other regional and local agencies); (ii) to strengthen the regulatory and policy-setting role of the Ministry of Health through technical assistance, the

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1/ Resources of the Intermediate Financing Facility (IFF) account may be used to pay part of the interest on up to US$32 million of the loan.

establishment of interagency cooperation agreements, the provision of a regulatory framework for the private sector, and the setup of the Office of the Health Superintendent as the agency responsible for health care sector regulation; (iii) to develop a system for distribution of MSPBS and departmental budget resources to the health care sector, to decrease regional inequity and adjust allocations to each region's poverty levels, existing service supply, and health indicators; (iv) to introduce mechanisms for improving regional and local management, making the health care regions and the departments responsible for health management performance; and (v) to provide a package of quality basic primary health care services, which implies actions to improve care by promoting active private-sector participation and the gradual integration of the various agents in the delivery of health care services (public sector, private sector, and the Social Welfare Agency).

DESCRIPTION: The program is comprised of two components:

1. Component I – modernization of the sector's organizational structure (US$4.2 million), including the regulatory and planning capacity of the MSPBS. This component provides funding for: (i) technical assistance to strengthen regional autonomy; (ii) the "outstanding professional" initiative; and (iii) improved vital statistics.

2. Component II – improvement of primary health care (US$37.8 million) through: (i) human resource development and training; (ii) improved procurement and distribution of medicines and inputs; (iii) rehabilitation of infrastructure and equipment; (iv) strengthening of the patient referral and cross-referral system; and (v) information, education, and dissemination projects.

ENVIRONMENTAL CLASSIFICATION: The Environment Committee, at its meeting of June 27, 1995, classified this as a Category II operation. The environmental profile was submitted to the PIC on September 25, 1996.

BENEFITS: The main benefits of the project are associated with reducing maternal and infant mortality, primarily among low-income groups, through increased coverage and improved quality of care. This will be achieved by identifying minimum care protocols, providing technical training for health care personnel and establishing professional requirements based on the

level of care, implementing sector regulations, and investing in equipment and infrastructure rehabilitation at the MSPBS's health posts and centers. The program will make the regional distribution of financial and human resources more equitable and will improve internal efficiency and resource allocation. By strengthening regional autonomy, the program will benefit the sector through health care policy planning that is consistent with overall available resources and local needs. Coordination among the public and private sectors and the social security system will allow the public sector to offer health care services without having to expand its payroll or infrastructure unnecessarily.

RISKS: One of the risks in the way of program success would be a shift towards centralism in decision-making, financing and allocation of resources, and policy-setting for the sector. The mechanisms to improve management, regional interagency participation agreements and agreements with other agents in the sector, and activities to improve the administrative and financial planning capacity included in the project would no longer make sense if a change in the reform agenda were to occur. To offset this risk, the project team conducted a detailed study of the deconcentration process in the health care sector and pursued a number of activities involving discussion and dissemination of the findings at the departmental and regional levels and with various authorities at the central level. The program activities were primarily designed to reduce the risks of undertaking a speedy decentralization process like the one that the MSPBS was promoting, without first identifying the responsibilities of the various agents, assessing the costs of the process, and promoting dialogue and discussion at the regional, local, and national levels. These activities will be conducted through the technical assistance to be provided under the program's Component I.

POVERTY TARGETING: Pursuant to the provisions of the Eighth Replenishment document (AB-1704, paragraph 2.15), and in view of the fact that the improved maternal and child health care activities to be provided by the public sector essentially target low-income population groups, it has been determined that the proposed program meets the characteristics of a program targeting low-income groups. In accordance with paragraph 2.13 of the aforementioned document, this program falls under the social equity and poverty reduction category.

THE BANK'S COUNTRY AND SECTOR STRATEGY:

The program design is consistent with the Bank's social sector strategy and with the Eighth Replenishment guidelines. The program focusses on actions that are compatible with the health care strategy set forth in Paraguay's 1994 country paper, in which the Bank proposed to support improved quality and coverage of decentralized services, the availability of qualified human resources, improved planning and coordination in the sector, and increased service coverage. The program also is in line with the Bank's general strategy for the social sectors, which emphasizes: (i) clear identification of objectives; (ii) a careful approach to decentralization; (iii) the evaluation of the level of preparedness of institutions to undertake sector reforms and follow-up on the phases or steps taken during the process; and (iv) introduction of incentives to make the sector more efficient.

SPECIAL CONTRACTUAL CONDITIONS: 2/

1. The following conditions precedent to the first disbursement – to be met to the Bank's satisfaction – will be stipulated: (i) establishment of the central coordinating unit and at least two departmental coordinating units, with a structure, functions, and resources to enable them to carry out the program (see paragraph 3.2); (ii) entry into force of the operations manual (see paragraph 3.8); (iii) creation and regulation of the "outstanding professional" initiative and the related technical committee and publication of the first call for applications (see paragraphs 3.14 and 3.15); and (iv) formulation of departmental strategies and the investment plan for the year one (see paragraphs 3.28 and 3.29).

2. During execution, as a means of instituting the program follow-up and review mechanism, the contract will set forth conditions to ensure that activities are planned and that proper follow-up and evaluation are conducted, as agreed upon with the country and as indicated in paragraphs 2.18 and 3.47 through 3.49.

3. PPF resources will be used to carry out activities to launch the program. These activities will make it possible to consolidate the program

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2/ The draft contract is available for consultation in the Legal Department.

and quickly fulfill the conditions precedent (see paragraph 3.49).

CONTRACTING OF CONSULTING SERVICES AND PROCUREMENT OF GOODS AND SERVICES:

The contracting of consulting services and procurement of goods and related services and awarding contracts for the construction of works will be undertaken in accordance with the Bank's procedures. International competitive bidding will be required for construction work involving amounts in excess of US$2 million and for goods and related services involving amounts in excess of US$250,000. Competitive bidding involving amounts below the aforementioned thresholds will be conducted in accordance with national legislation (see paragraph 3.40).

EXCEPTIONS TO BANK POLICY:

Management training will be carried out by the Association of University Programs in Health Administration (AUPHA) and the reproductive health management training will be provided by the United Nations Population Fund (UNFPA). Justification for direct contracting of these agencies without issuing a call for bids is provided in paragraph 3.21. Based on their vast experience in Paraguay's health care sector and their excellent track record, the direct contracting of these agencies is proposed as an exception to the Bank's hiring policies.

I. FRAME OF REFERENCE

A. Demographic and health indicators

1.1 The total population of Paraguay in 1995 was estimated at 4.9 million, with 53% living in urban areas and 47% in rural areas. The population is young, with 15% below age five and 40% below age 15. Paraguay's total fertility rate (TFR) for the 1990 to 1995 period was 4.5 children per woman, well above the Latin American average of 3.2 children per woman. However, there are noticeable differences between the rural and urban areas, where the TFR was 5.8 and 3.3, respectively over the same period. Despite the progress achieved in terms of health, the maternal mortality rate is still 380 per 100,000 live births, one of the highest in Latin America. 1/ Teenage pregnancy is very frequent and there is a very high abortion rate. Of even greater concern is that the causes of maternal mortality – such as hemorrhage, toxemia, and abortion complications – could be reduced relatively easily. Infant mortality in 1994 was 42 per 1,000 live births, twice the rate for Panama and three times the rate for Chile; perinatal complications and contagious diseases are the main causes of infant mortality.

B. The health care sector

1.2 Paraguay's health care sector is comprised of: the public subsector, which has responsibility for providing services to 73% of the population, most of which is low-income; social security services comprised primarily of the Instituto de Previsión Social [Social Welfare Agency] (IPS) and other smaller social security agencies, which cover 17% of the population; and private insurance, covering some 10% of the population. The following agencies are responsible for public health care service delivery: Ministry of Public Health and Welfare (MSPBS); Military Health Services, Police Health Services (attached to the Ministry of the Interior); the National University of Asunción (general hospital and neuro-psychiatric hospital), the municipalities, and the recently created departmental governments. The private sector plays a significant role in providing health care services in Paraguay through a growing market of private insurance and private doctor's offices and clinics, whose services are frequently used by consumers.

1/ For comparison: Bolivia, 247 in 1988; Peru, 240 in 1989; Colombia, 140 in 1991; Chile, 41 in 1990; Ecuador, 120 in 1992; Brazil, 140 in 1985; Honduras, 220 in 1992; United States, 8 in 1993. The average rate for Latin America and the Caribbean was 169 in 1988.

1. Funding

1.3 In Paraguay, as in other Latin American countries, the share of direct taxes in the government's budget is relatively small, while indirect taxes contribute significantly to it. The value added tax (VAT) contributes twice as much to the nation's budget as the revenues generated by income taxes. In 1995, total public spending came to US$1.663 billion, which represents 23.4% of gross domestic product (GDP). The central government accounts for 93% of spending, while the municipalities and departments account for 6.3% and 1.1%, respectively. 2/ In addition, total public spending on health care in 1995 was US$180 million (2.5% of GDP), of which the MSPBS was responsible for US$92 million.

1.4 Total spending on health care, not including out-of-pocket expenses, 3/ which means that these figures are underestimated, was US$207 million in 1995 (2.9% of GDP), equivalent to an annual per capita average of US$43. Without taking into account out-of-pocket payments, the private sector generates earnings of US$27 million (insurance companies and prepaid plans) i.e., over 10% of total spending on health care. Since 1993, the health care budget (not including the private sector) was increased by 26% and the allocation for the MSPBS was raised by 38%, but per capita public spending on health care remains very low. Per capita public spending on health care was US$37 in 1995, while the private sector 4/ spent US$114 per capita, i.e., almost three times the public sector figure.

2. Source of funding and budget developments

1.5 For 1996, 62.5% of MSPBS resources came from the National Treasury, 4.7% from special funds, 14.2% from Itaipú royalties, 6% from own funds, and 13% from other sources. The national budget for the central government shrank in 1993 and 1994, then recovered in 1995; however, public spending on health care was not cut during that period. Moreover, public resources allocated to health care outpaced total public spending growth, reflecting the priority that the government has given the sector (Graph 1). Between 1990 and 1995, the MSPBS budget (and its performance) swelled over 300% in real terms, and growth of 32% is projected from 1995 to 1996.

2/ The departmental governments were created in 1994 and their spending levels have increased from US$7 million in 1994 to US$18.4 million in 1995; the amount budgeted for 1996 is US$22.2 million. In 1995, an average of 3% of the departmental budgets was spent on health care and that figure is expected to increase to 4.4% in 1996. For the five departments targeted under this project, the departments allocated 7.3% of their budgets to health care in 1995.

3/ Nonreimbursed direct payments to service providers for health care services.

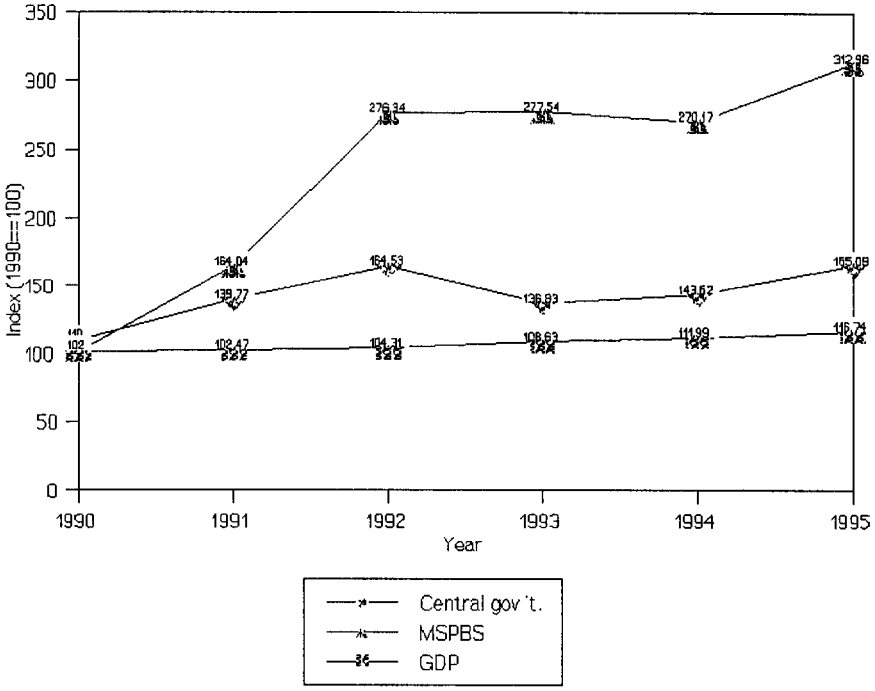
4/ Estimated solely on the basis of prepaid systems.

While the GDP and the government budget has grown very little since 1990, the budget allocated to the MSPBS as a proportion of the central government's budget doubled from 3.5% in 1990 to 7% in 1995.

GRAPH 1

MSPBS BUDGET, CENTRAL GOVERNMENT BUDGET, AND GDP PATTERNS

Paraguay 1990-1995



Source: Central Bank of Paraguay, Ministry of Finance, and MSPBS

1.6 The MSPBS has made an effort to allocate spending more efficiently. With payroll remaining the largest expenditure, its relative weight has decreased from 77% of the budget in 1992 to around 50% in 1995. In addition, as a result of measures taken by the MSPBS to improve its management, the administrative budget, which does not include health care service delivery personnel or inputs, dropped from 32% in 1992-1993 to 12.5% in 1995. Some 32% of the resources allocated to the MSPBS are earmarked for general medical care and represent resources transferred to the 18 health care regions for service delivery, which seems minimal considering that the "National Medical Center" (level IV hospital) alone consumes 11% of the budget.

1.7 In summary, although health care spending has increased over the last few years, even in the face of total public spending cuts, and the MSPBS, through efforts to improve its management, has reduced its personnel and administrative costs, public spending on health

care and per capita budget allocations for health care are still very meager and display significant regional differences.

3. Public-private partnership

1.8 It is important to note that MSPBS transfers to the private sector – usually in the form of payment to nongovernmental organizations (NGOs) for carrying out programs and activities where the MSPBS is unable to deliver services effectively – while representing a tiny item in the budget, have increased almost ninefold since 1993. This indicates the increased development of the private-public partnership in health care service delivery in some areas and the recognition on the part of the MSPBS of the private contribution in the face of public sector limitations.

4. Regional budgets

1.9 Budget allocations and transfers to the health care regions are made on the basis of the budgets submitted by the respective Regional Health Directorate. The average per capita expenditure on health care in the regions has ranged between US$5.69 and US$9.85 from 1993 to 1996 (Table 1). Public spending per capita on health care varies significantly from region to region, which has equity-related implications. For example, while the department of Central received a per capita transfer of only US$2.50 in 1995, Cordillera received US$10.40. In the 1996 budget, the largest per capita allocation went to Alto Paraguay, at US$95, while the smallest went to Central, with US$3.70. It is unclear what mechanism is used to allocate resources among the regions since, according to the MSPBS, the allocations are based on the budgets consolidated by the Regional Health Directorates. Moreover, the MSPBS seems to apply a redistributional criteria implicitly, allocating more resources to the poorest regions. Such regions, however, are those with the lowest population density and with perhaps less developed public infrastructure, so that allocating a much higher proportion of resources per capita may disproportionately penalize regions that have higher recurrent health care costs because of larger populations and more extensive public infrastructure.

TABLE 1
REGIONAL BREAKDOWN OF MSPBS TRANSFERS 1995-1996

REGION	% OF RESOURCES		% OF POPULATION		PER CAPITA FIGURES	
	1995	1996	1995	1996	1995	1996
Concepción	6.17	6.11	3.75	3.70	9.95	16.41
San Pedro	5.33	5.67	6.51	6.53	4.95	8.61
Cordillera	7.64	6.57	4.46	4.35	10.36	15.00
Guaira	5.43	5.34	3.57	3.49	9.20	15.19
Caaguazú	6.82	6.53	8.88	8.79	4.65	7.38
Caazapa	3.66	4.13	2.90	2.84	7.66	14.43
Itapua	8.44	7.88	8.93	8.94	5.71	8.75
Misiones	4.73	4.44	2.01	1.98	14.20	22.30
Paraguari	6.21	4.57	5.13	5.00	7.33	9.07
Alto Paraná	7.89	8.36	10.99	11.35	4.34	7.32
Central	9.36	8.51	22.30	22.69	2.54	3.72
Neembucu	3.35	4.05	1.78	1.75	11.39	23.02
Amambay	3.50	4.11	2.50	2.50	8.48	16.35
Canindeyu	2.68	3.36	2.59	2.60	6.25	12.82
Pte. Hayes	4.31	4.27	1.52	1.52	17.18	27.94
Capital	12.02	9.95	11.22	11.02	6.49	8.96
Alto Paraguay	1.21	2.62	0.27	0.27	26.54	95.23
Boqueron	1.30	2.77	0.69	0.69	11.46	39.83
TOTAL	100.03	99.25	100.00	100.00	6.05	9.85
The project's five regions	35.46	31.53	44.34	44.32	4.84	7.06

Sources: MSPBS; Technical Planning Secretariat, General Statistics, Surveys, and Censuses Directorate.
NOTES: In 1995 United States dollars
The five regions on which the Bank will focus its efforts under the project are shaded.

C. Main characteristics of the sector

1.10 The health sector experiences structural problems resulting in inefficiency, inequity, and low-quality service delivery. These problems are described briefly below.

1. Fragmentation

1.11 The health care provider system in Paraguay is highly fragmented, which has resulted in complete lack of coordination among the various subsectors: public, private, and social security. The sector is characterized not only by duplication of efforts involving particular population groups – such as those with private insurance who are also covered by the social security system – but also by the huge group of low-income people who must turn to the MSPBS for their health care needs, since they have no other options, and receive low-quality and delayed treatment. Sector fragmentation makes the process of planning and consistent allocation of resources in order to meet national health goals very difficult or almost impossible to carry out.

2. Lack of institutional coordination

1.12 The consequence of the lack of institutional coordination is overlapping of responsibilities and regulatory and administrative confusion. Regional health care planning was the responsibility of the MSPBS through its Regional Health Directorates. Since 1992, however, under the new Constitution, departments that geographically coincide with the MSPBS's Regional Health Directorates were created. The office in charge of the health sector within each department (Departmental Health Secretariat) constitutes another institutional level. Although until now the Departmental Health Secretariats have had a much smaller volume of resources than that allocated to the Regional Health Directorates, the two agencies work separately, creating inefficiencies in the use of resources and regulatory chaos.

3. Human resources

1.13 The MSPBS has 11,000 employees nationwide. On the basis of the "1995 census of human resources in the health care sector" conducted in the five departments in which over half the population lives and where there is the largest concentration of public health care infrastructure and human resources, it was found that 67% of the employees assigned to those departments provided health care services directly. 5/ The geographical distribution of human resources is mixed and there are differences in the quality and timeliness of service delivery in the various departments. For example, while there are 2.92 doctors per 10,000 inhabitants in Cordillera, Caaguazú has only 0.98. In addition, human resources in the sector have mediocre technical skills; only 52% of the staff have degrees or certificates, 30% have neither, and there is no information either at the central, regional, or local level, on the remaining 18%.

1.14 A large share of the human resources in the sector have no more than incomplete primary level training and many of them have been certified "suitable" in their field by third parties. In addition, human resource allocation from the central level, as was done until 1995, created enormous difficulties in terms of remaining consistent with specific local needs. As a result, many health establishments were understaffed or had unqualified staff for the level of care involved. The current Minister of Health has emphasized regional autonomy and has made the Regional Health Directorates responsible for assigning human resources to meet the needs of the establishments in their respective jurisdictions. It

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5/ Including dentistry and laboratory services. Of the remaining employees, 23% are in administrative or general services positions, while the functions of the other 10% are unknown.

is now easier to begin the process of matching human resources to each establishment's particular level of care and to regional needs.

1.15 In the public sector, the status of existing human resources is a structural problem for the health care sector: (i) the permanent status of public servants is also reflected in the unchanging budget allocation in the region that originally hired them. This means that although an employee may later be transferred to another region, the financial resources for his or her salary continue to be allocated and transferred to the region in which he or she was originally hired. As a result, there are many irregularities in the process of hiring new employees and it becomes difficult to budget for the payroll since the amount budgeted for payroll does not match that actually paid out in a given region; (ii) until only a few months ago, the salary structure did not include a geographical differential, and there was therefore no incentive for employees to move to the more remote regions; (iii) there is no professional certification system in the country or incentives for professional development and improvement. The country needs a clear professional and technical development system for health care workers approved by the Ministries of Health and Education. Degrees should only be awarded by structured training programs that have been approved and recognized by the authority in the field.

1.16 In addition, the infrastructure and equipment of the public health care establishments are in an advanced state of disrepair 6/ and have difficulties providing medicines and inputs on a timely basis. As a result, the quality of service delivery is very unreliable.

4. Financial resources

1.17 The rigid public sector budget constitutes another structural problem in the health care sector. Restrictions on the use of own resources by the health care establishments not only generate high administrative costs but also make planning difficult for the establishments' directors and regional directors. This constraint promotes lack of responsibility for resource management and for setting and reaching goals. The allocation of resources to the sector by both the MSPBS and the departmental governments is not correcting the inequity in the per capita allocation of resources that exists today (see Table 1). Budgeting is based on past budgets and, with no evaluation and monitoring systems, it is easy to carry budget disparities over from year to year.

6/ The "1996 CAC/IDB infrastructure survey" found that there are 225 public establishments in the program's regions and that between 19% and 59% of them are in a critical and/or serious state of disrepair.

1.18 As a result of these problems, the quality of the services delivered is poor, there are no control systems or regulatory mechanisms, and inequalities among regions are considerable.

D. Cost-recovery in public health care services and out-of-pocket spending

1.19 MSPBS establishments recover costs for child and adult curative care, medicines provided at the establishment, diagnostic examinations, childbirth, prenatal consultations, and hospitalization. These resources must be sent to a common fund at the Ministry of Finance every 24 hours.

1.20 According to the figures that the establishments report to the Ministry of Finance as "own resources", the five program regions and Asunción will have recovered slightly under US$1 million in 1996. The household survey showed that the charges collected for the various services, as can be seen in Table 2, represent a much higher amount – US$11.5 million – which is 12.6% of the MSPBS budget in 1995. Moreover, if that figure is projected nationally, it is estimated that the MSPBS recovers approximately US$15 million annually, a considerable amount inasmuch as the total MSPBS budget for 1995 was US$91 million.

TABLE 2
COST RECOVERY IN PUBLIC HEALTH CARE ESTABLISHMENTS – 1996

	US$ millions
Curative care for children under age five	1.2
Curative care for patients over age five	7.4
Obstetric care	2.6
Hospital care	0.3
Annual total	11.5

Source: Estimates from the "Household survey on the use and perception of health care services, MSPBS/IDB 1996".

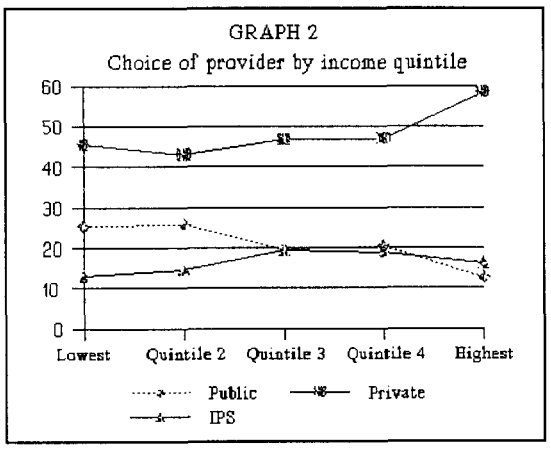
1.21 The following conclusions can be drawn from the estimates: (i) people pay a considerable amount out-of-pocket and it is important to note that a proportionately larger number of these patients are from low-income groups, who use public sector services more than do people with higher incomes; (ii) the system for daily income reporting and regional distribution through the Ministry of Finance provides a strong incentive to underreport such income, which creates high administrative expenses for the MSPBS and discourages service delivery at the establishment level; (iii) with no improved management mechanism tied to the generation and use of own resources, individual establishments are under no obligation to ensure efficient use of such resources.

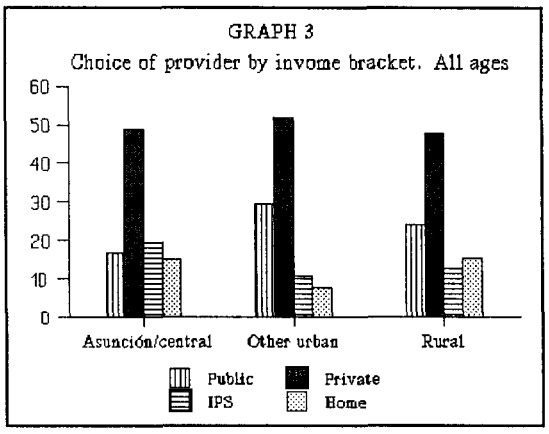
1.22 During the preparation of this program, an agreement was reached with the country under which, at the start of the program, the public establishments will be allowed to handle their own resources according to improved management mechanisms agreed upon with the respective Regional Health Directorate.

E. Use of services

1.23 Because the use of services in the various subsectors – the MSPBS, private services, and those provided by the IPS – was not clearly established, the MSPBS, with financing from the Bank, conducted a household survey to determine the patterns of service use. At the same time, a survey was conducted among providers and a module was added to the national reproductive health survey, CEPEP/CDC. The data provided below comes from these sources.

1.24 As shown in Table 3 and the graphs below, taking into account all the health care services combined, use of private services in Paraguay is proportionately greater than use of public sector services, the IPS, or any other type of health care service (for additional details, see Annex I-2). With the exception of obstetric care, in which the MSPBS plays a very important role, one out of two people who sought treatment for a health care problem chose the private sector in both rural and urban areas (Graph 3). According to the "Household survey on the use and perception of health care services, MSPBS/IDB 1996", this occurs for both outpatient visits and hospital stays, for all age groups, and for all income brackets (Graph 2).





Source: "Household survey on the use and perception of health care services, MSPBS/IDB 1996".

TABLE 3

Source of treatment (curative care, all ages)	Proportion of the total who sought care
Folk healer	9.6%
MSPBS	20.4%
IPS	9.2%
Private doctors' offices and clinics	49.3%
House calls	4.6%
Pharmacy	6.9%

Source: "Household survey on the use and perception of health care services, MSPBS/IDB 1996".

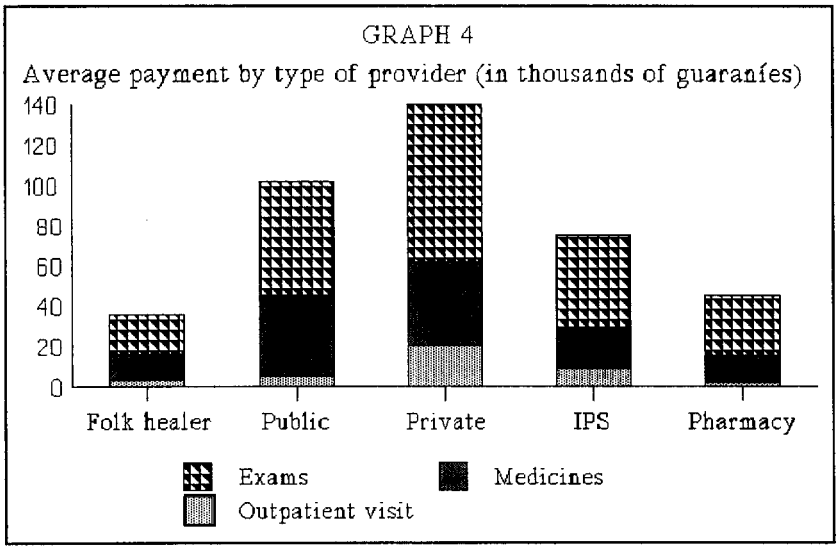
1.25 Although private sector health care is more expensive (Graph 4), a large percentage of people use it, perhaps in part because in the private sector, patients wait four times less to be seen than in the public sector and an office visit lasts almost twice as long as one would in a public establishment (Table 4).

TABLE 4

AVERAGE WAITING TIME AND DURATION OF OFFICE VISIT (minutes)			
	Public sector	**Private sector**	**IPS**
Waiting	48	12	58
Being seen	4.5	8.7	4.2

Source: Survey of health care establishments, MSPBS/IDB 1995.

GRAPH 4

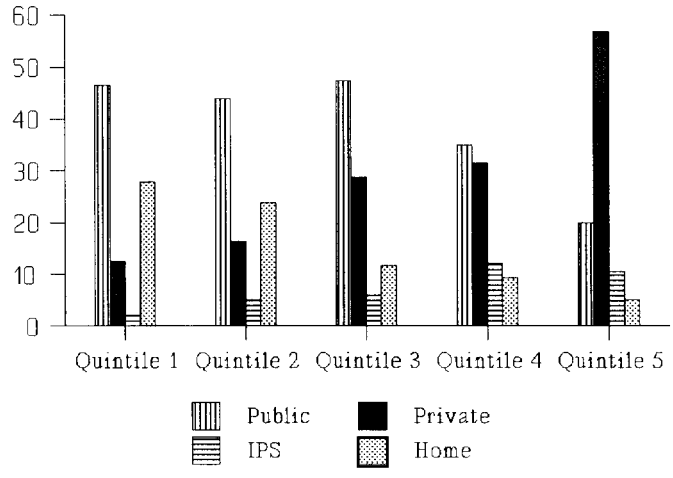


Source: "Household survey on the use and perception of health care services, MSPBS/IDB 1996".

1.26 Obstetric care is a special case since, with the exception of Asunción, in the five most populated regions of the country where 73% of births take place in institutional settings, public establishments account for 42% of total births, despite the low-quality service and the state of disrepair of the facilities. Graph 5 shows the importance of the public sector to low-income groups, particularly for maternal and child health care. The extremely high maternal and perinatal mortality rates, one of the most serious health care problems facing the country, makes improvement of maternal and child health care in MSPBS establishments perhaps the most worthwhile and important investment for the public sector and for low-income groups.

GRAPH 5

Place of birthing care by income quintile



1.27 Most people pay out-of-pocket for health care in both the private and public sectors. Of low-income women, 82% pay out-of-pocket for care, while only 63% of women with higher incomes do so. And while the former pay one third of their per capita income for childbirth expenses, the latter pay only 20%.

F. Recent changes in the sector: decentralization and the sector reform bill

1.28 The health care sector is currently one of the government sectors in which the decentralization process has played a significant role in the political agenda. A first phase (1989-1994) to fine tune an earlier deconcentration effort was undertaken, designed to strengthen the health care regions through a redefinition of their organization, functions, and resources. In 1993, the MSPBS redrew the health care regions so that they would coincide geographically with the recently created departmental governments, in order to coordinate the government's two sector prongs, and redefined the responsibilities of the regional directors.

1.29 A second phase of the process began in 1995, when the MSPBS adopted a reform strategy for the health care sector involving a gradual move towards a decentralized model that incorporates the recently created departmental governments as administrative agencies instead of the Regional Health Directorates. Currently, the MSPBS is the sole institution in the central government that has established

systems for coordination with the departmental governments (Departmental Health Councils) and, in some cases, with the municipalities (District Health Councils). As a result, it has been possible to undertake actions aimed at defining the functions of the Departmental Health Secretariats and health care regions more adequately, establishing cooperation agreements between the ministry, the departments, and the municipalities, and involving the Departmental Health Secretariats in the process of preparing, executing, and evaluating the health care regions' budgets.

1.30 The bill establishing the National Health System was passed by the Chamber of Deputies in December 1995 and is currently at the second stage of consideration by the Senate. An organizational framework will be established to carry out the sector deconcentration process, with a new policy-setting, managerial, and regulatory role defined for the MSPBS, and a national health system will be created by integrating public and private providers and the social security system, to provide services that are consistent with departmental and local health care plans. The bill proposes that the gradual participation of departmental and local governments be sought to finance the services and creates various entities for integration at the national, regional, and local levels of the different agents in the sector, through Departmental and District Health Councils and the National Health Council. The bill also provides for a quality control system for health care services and intersector integration for health sector planning, through the setup of an executive committee comprised of the MSPBS, the Ministry of Finance, the IPS, and the private providers. Separate entities would be set up to take charge of health care service delivery (National Medical Directorate), financing (National Health Fund), and sector regulation (Health Superintendent).

1.31 Despite progress in coordinating with departmental and municipal governments, the MSPBS is still not in a position to transfer responsibilities entirely to the regional and local health authorities, which is the ultimate objective of the process. The preparation process for the program proposed herein involved the regional and departmental governments in discussions with the central government and the Bank on the course charted for the sector, in order to evaluate the progressive phases needed to meet the goals proposed by the MSPBS. As a result, in view of the institutional weakness at the central, departmental, and local levels, the process-related costs and requirements, the current shortcomings of the budgeting and allocation processes, and the consensus-building necessary, emphasis was placed on the need to reinforce regional autonomy in the short term and in coordination with departmental governments for consistent sector policies and resource generation and administration. The country will thus continue to make progress in its general sector reform strategy, by identifying alternatives for remedying current constraints on the process and advancing in the negotiations towards enactment of the bill and in the drafting of its regulatory provisions.

1.32 The sector reform bill (see paragraph 1.30) constitutes the first big step towards improving the sector's organizational structure, in that it seeks to make spending more efficient and resource allocation more equitable. The proposed program (see chapter II) has been designed in this context, to support the ministry's initiative to turn over responsibilities to the regional level and involve the departmental governments in the process, in particular in the areas of planning, budgeting, and allocation of health expenditures. However, the program's actions would be perfectly sustainable even if the National Health System bill were not passed, since this is not a requirement for introducing the changes proposed. In addition, if the bill were passed and the National Health System were created, the proposed actions under the program would be fully consistent with the sector's needs during the bill's implementation.

G. Justification and scope of the program's actions

1.33 Given the current state of institutional change in Paraguay's health sector, the budget increases for health care over the last few years (see paragraphs 1.5 and 1.6), the inefficient use and allocation of public resources, and the sector's institutional weakness, it would be prudent to take measures to improve the sector's organizational structure and health care delivery prior to introducing new financing facilities for the sector or making drastic changes in the procedures for paying providers. All these changes, while necessary, should be introduced once the sector is better prepared to assimilate them successfully with less risk of failure. This program contributes to the first phase of the sector reform process, and may be followed by future operations.

1.34 The successful introduction of new payment systems such as capitation requires information systems that are somewhat more sophisticated than the current ones and, even more important, an acceptable level of quality in service delivery and a control and supervision system not yet set up in the country. In addition, and given how much the private sector's services are used, in the complete absence of regulation, introducing payment systems such as capitation under current conditions could make service delivery even more inequitable. The poorest and sickest people could receive lower-quality or less care without a control system. For this reason, it is also essential to begin with the private sector regulatory process, for which purpose it is necessary to strengthen the MSPBS's regulatory capacity, design an appropriate regulatory framework that is consistent with the characteristics of the private sector, and set up the Office of the Health Superintendent.

1.35 Although, compared with other countries, few public resources are earmarked for the health care sector, these still need to be used and allocated more efficiently before the amount of spending in absolute terms is increased. The financial innovations introduced by the program aim to: (i) encourage local governments to take on

a growing share of the budget for the dual purpose of increasing the MSPBS's scarce health care resources in each department and promoting local participation in decision-making and planning in health care activities; the coordination of actions between the various levels of government will lead to more efficient resource allocation by avoiding duplication of efforts; (ii) introduce mechanisms to make the use of existing resources more efficient, for example by improving the system for procurement and distribution of medicines and inputs and increasing the capacity of health centers to provide adequate health care for mothers and children, which today absorbs the capacity and resources of hospital care; and (iii) introduce improved management mechanisms connected to the retention and use by health care establishments of internally-generated resources, a mechanism that will be used in the health care sector exclusively, as agreed with the Bank and the Ministry of Finance.

1.36 The process that the sector has undergone since the 1992 Constitution to increase regional autonomy and local responsibility has generated new institutional relationships and entities responsible for sector financing and planning. At the same time, however, institutional coordination has been undermined as a result of the new government institutions that have been established with the departments and are superimposed on the old institutional ties with a centralized government. The program addresses this situation with technical assistance in the form of a detailed analysis of the responsibilities of each institutional level, with a view to establishing consistency in the new relationships while the policy-making and regulatory role of the MSPBS is more clearly identified, and information and consensus-building activities are carried out.

H. The Bank's social strategy and country strategy

1. Consistency with the Bank's country strategy and social sector policy

1.37 The program is consistent with the Bank's country strategy, which recommends focusing efforts on: (i) the development of the social sectors, in particular the delivery of basic services to the population's vulnerable groups in order to reduce poverty, with emphasis on improving the quality and coverage of social services and programs; and (ii) support for institutional strengthening and modernization of the State. The program is also consistent with the Bank's social sector strategy and with the guidelines of the Eighth Replenishment and stresses actions compatible with the health care sector strategy described in the 1994 country paper, in which the Bank proposed to support improving the quality and coverage of decentralized services, increasing the availability of qualified human resources, improving planning and coordination in the sector, and increasing service coverage. The Bank's general strategy for the social sectors emphasizes: (i) clear identification of objectives; (ii) a careful approach to decentralization;

(iii) evaluation of the degree of preparedness of institutions to undertake sector reforms and monitoring of the phases or steps taken during the process; and (iv) introduction of incentives to make the sector more efficient. The project activities fit into this framework of action as described in chapter II (see paragraph 2.22).

2. The Bank's experience in the sector and lessons learned

1.38 Loan 694/SF-PR: stage II of the program to expand rural public health services was approved in 1982, completed in 1992, and recently evaluated. The program provided 15 health care regions with infrastructure and equipment. The program evaluation and studies conducted to prepare this project indicate the existence of infrastructure that has been fully equipped but is currently closed and abandoned owing to a lack of trained human resources in the area or establishments in an advanced state of disrepair for lack of maintenance. There are two types of lessons: (i) alternative mechanisms need to be devised so that, along with infrastructure construction and equipping, the availability of the human resources necessary to run the establishment can be ensured; and (ii) sufficient resources need to be earmarked for maintenance, together with improved management so that the establishment's professional staff will take responsibility for reinvesting internally generated resources in preventive maintenance of the facilities.

I. Studies conducted during project preparation and findings

1.39 During preparation of this operation, the Bank supported the country in laying the groundwork for the following activities: (i) study on the epidemiological profile; (ii) survey of the physical infrastructure, equipment, and road system at public sector establishments; (iii) 1995 census of human resources in the public health care sector; (iv) 1996 household survey on the use and perception of health care services; (v) 1995 survey of establishments; (vi) module on access to maternal and child health care services in the "1996 CEPEP-CDC national survey on reproductive health"; (vii) analysis of the decentralization of health care services in Paraguay; and (viii) review of health sector earnings and expenditures.

1.40 The last three of the above-mentioned activities were national while the others focused on the departments of Central, Caaguazú, Paraguarí, Guairá, and Cordillera. The MSPBS derived significant benefits from the activities in that it obtained a great deal of reliable data on the state of the sector and developed mechanisms to use such data as an instrument for planning. The findings of the various studies have been discussed at the departmental level, with the Regional Health Directors, and the Departmental

Secretaries of Health, which generated much interest around the country in updating knowledge about the sector and the use of data as an instrument for planning.

1.41 The study on the epidemiological profile not only revealed the high incidence of miscarriages or abortions in Paraguay but was also of interest to health care establishments for evaluating their services and their effects on maternal and child health by developing instruments for assessing the establishments and holding regionwide discussion fora on findings. A list of generic medicines for mother and child health was prepared. The public infrastructure survey work identified on site the exact layout of existing establishments and clarified rehabilitation and equipment needs through direct observation. At the same time, architectural and equipment standards were identified based on the level of care. The human resource census gathered not only quantitative but also qualitative information on the sector's human resources, and found discrepancies between the payrolls managed at the regional and central levels and the human resources actually working at the establishments. The census achieved a level of detail in the data never before available to the MSPBS, which will provide the information it needs to carry out its planning functions. The analysis of decentralization in the sector made it possible for central and local authorities to hold various meetings to discuss the health-care-related benefits, costs, and risks of decentralization, for the purpose of clarifying the important steps that would need to be taken prior to implementing a constitutional mandate on decentralization. The household survey on the use and perception of health care services and the survey on establishments allowed the MSPBS to gain experience in the design and preparation of surveys. At the same time, the findings of the surveys have updated the country's view of the sector and can serve as baseline data with which to compare information of the same type to be gathered after the program proposed below is implemented.

II. THE PROGRAM

A. Objective

1. General objective of the program

2.1 The program's general objective is to support the gradual process of health sector modernization and reform, while seeking to provide quality services to the Paraguayan population efficiently and equitably. The program, viewed as the first phase in support of the sector reform process, provides incentives and mechanisms to implement in primary health care to address one of the population's main health problems: maternal and perinatal mortality.

2. Specific objectives

2.2 The specific objectives are: (i) to strengthen regional autonomy by, among other things, identifying and coordinating the sector-related responsibilities of the various agents (Regional Health Directorates, Departmental Health Secretariats, and other regional and local agencies); (ii) to strengthen the regulatory and policy-setting role of the Ministry of Health through technical assistance, the establishment of interagency cooperation agreements, the provision of a regulatory framework for the private sector, and the setup of the Office of the Health Superintendent as the agency responsible for health care sector regulation; (iii) to develop a system for distribution of MSPBS and departmental budget resources to the health care sector, in order to decrease regional inequity and adjust allocations to each region's poverty levels, existing service supply, and health indicators; (iv) to introduce mechanisms for improving regional and local management, making the health care regions and the departments responsible for health management performance; and (v) to provide a package of quality basic primary health care services, which implies actions to improve care by promoting active private-sector participation and the gradual integration of the various agents in the delivery of health care services (public sector, private sector, and the IPS).

2.3 The sector reforms introduced under the program would be applied nationally by the Ministry of Health, while the actions to improve health care and the implementation of incentives to improve management will focus on five of the country's 17 departments, in which some 50% of Paraguay's total population lives (Central, Caaguazú, Cordillera, Paraguarí, and Guairá). The World Bank recently approved US$31 million in financing for an operation to support the improvement of maternal and child health in another six departments, covering 27% of the population; the operation has a component that includes Asunción, to support child development. Although both operations aim to improve mother and child health, the Bank's program is unique in that it falls within the framework

of the sector modernization process and supports the actions necessary to carry this process through at the national level. It is not a vertical program for the improvement of mother and child health. Other donors, such as the GTZ, JICA, and the Spanish government, are funding specific operations throughout Paraguay's other regions.

2.4 The rationale for involving this program in the sector modernization process over the long term is set forth in Annex II-1, which is supplemented with the monitoring and follow-up indicators in Annexes II-2A and II-2B.

B. Description 7/

1. Component I: modernization of the sector's organizational structure (US$4.2 million)

2.5 The goal of this component is to strengthen the regional autonomy and regulatory and planning capacity of the MSPBS, as the sector's governing body. The component depends on legislative processes for the implementation of the changes discussed below and is comprised of three subcomponents:

a. Subcomponent 1: strengthening of regional autonomy (US$940,000)

2.6 This subcomponent will finance technical assistance for:

(i) Analyzing and delimiting the areas of responsibility of the various institutional structures currently in existence, to make activities within the current structure of the MSPBS 8/ consistent with the new entities created as a result of the 1992 Constitution, which was the source of emerging departmental participation in the delivery and financing of regional health care services. 9/ Once these responsibilities have been identified and agreed upon, they will be instituted by ministerial resolution.

(ii) Developing and implementing the legal framework of general cooperation agreements between the departmental governments and the Regional Health Directorates. Service agreements between public providers, social security, and the private sector will also be supported.

7/ Details on the methods of execution of each component under the program appear in chapter III.

8/ Ministry of Health at the central level, and Regional Health Directorates.

9/ Departmental Health Secretariats, Departmental and District Health Councils.

(iii) Enabling the National Health Council to fulfill its role of integrating the system, including issuing regulations for the National Health System Act if it passes.

(iv) Fine-tuning the design of a formula for the regional distribution of MSPBS budget resources and departmental resources to be earmarked for health care and implementing it through a ministerial resolution. The formula will be based on criteria related to poverty level, existing supply indicators, and epidemiological and demographic indicators.

(v) Designing and implementing improved management mechanisms to promote local responsibility, the achievement of goals, and the efficient use of own resources and establishing clear responsibilities regarding infrastructure and equipment maintenance, solid waste management, and appropriate management of human resources working in health care. The Ministry of Finance will actively participate in the formulation of improved management mechanisms and regulatory frameworks providing general guidelines for financial management of own resources and for proper spending oversight. The program will begin in year one with improved management arrangements with the regional directors and directors of the regional hospitals, on whose evaluations the exercise of managerial responsibilities would depend. Subsequently, and depending on the results of the evaluation, it would be extended to cover a broader group of providers.

2.7 This subcomponent includes activities for the regions to share experiences with each other and build a consensus around the sector reform process, through seminars, workshops, etc.

b. Subcomponent 2: the "outstanding professional" initiative (US$2.7 million)

2.8 A competitive system for selecting candidates and assigning doctors and nurses to geographical areas will be created. The "outstanding professional" initiative sets up a merit and incentives system for obtaining and assigning positions at the health centers and stations that, based on the 1995 census, have a human resources deficit. Those participating in the "outstanding professional" program will receive a special honorable mention from the Ministry of Health, medical circles, and Paraguay's School of Medicine. The initiative is designed to help recruit recently graduated professionals with excellent technical skills. The conditions for eligibility are described in chapter III (see paragraph 3.14).

c. Subcomponent 3: improvement of vital statistics (US$560,000)

2.9 The purpose of this subcomponent is to find a way to improve the existing birth registry system, by adding specific data related to mothers and maternal and perinatal mortality. It will include the implementation of the improved system and its formal recognition, as well as training for those who collect and analyze the data.

2. Component II: improvement of primary health care (US$37.86 million)

2.10 The purpose is to improve the quality of services delivered in accordance with accepted technical standards for a minimum supply of infrastructure, equipment, and qualified human resources, the timely delivery of inputs, and participation of the private sector and the social security system in service delivery. In this way, a basic package of primary health care services will be available to mothers and children. The component is comprised of five subcomponents:

a. Subcomponent 1: human resource development (US$2.04 million)

2.11 The objective is to improve the technical skills of health care staff, with special emphasis on the delivery of services related to child and maternal health care and reproductive health, and management capacity at the various levels of health care. Training will be provided at the establishment when the service is delivered, so that health care workers will not have to be removed from their jobs or daily activities. The training will be aimed at resolving the problems that arise at the establishment and in the professionals' current response capacity. The following types of training will be provided: (i) on-site technical training in health care, aimed at correcting problems in prenatal care, childbirth and postpartum care, reproductive health and family planning, neonatal care, and well child and sick child care; (ii) management training for managerial and executive staff of the Regional Health Directorates and for staff at the health care establishments and training in reproductive health; (iii) training for traditional birth attendants, with emphasis on normal childbirth care, reproductive health, and early risk detection. Incentives would be introduced to connect birth attendants to the sector for the purpose of referring high-risk cases; (iv) training for management of the referral and cross-referral system involving health care establishment staff, which consists of proper management of communications and transportation systems; (v) training in the management of medicine and medical input inventories for primary health care, which consists of the proper management of the inventory control (INVEC) system. The training activities will

involve private sector institutions, universities, medical and scientific associations, specialized agencies, and certain entities attached to the MSPBS (see chapter III, section 2a).

b. Subcomponent 2: improved medicine and input procurement and distribution system (US$10.1 million)

2.12 The objective of this component is to implement an efficient system for procurement, storage, and timely distribution of medicines, by establishing a connection with the private sector, which would perform these functions and distribute inputs directly to the health care establishments. The MSPBS would then be able to focus its efforts on the planning, monitoring, and control responsibilities that would allow it to fine-tune the process of estimating pharmaceutical and other input needs and to delegate its current purchasing, storage, and distribution activities to a company (laboratory) hired for this purpose. The MSPBS and the project team prepared a methodology to estimate pharmaceutical needs for primary care in each department. Under this subcomponent, the supply and distribution of inputs for maternal and child health care consistent with the needs established by department will be financed. In addition, a data and inventory control system will be set up and staff will be trained to run and oversee it (see paragraph 2.11). The activities of this subcomponent will be monitored through an audit and supervision system (see paragraph 3.26).

c. Subcomponent 3: infrastructure rehabilitation and equipment (US$22 million)

2.13 The goal is to rehabilitate the infrastructure and equipment of health posts and centers and regional hospitals providing basic health care, in order to improve the quality of care provided by the health units. In particular, the five regional hospitals and approximately 24 health centers will be upgraded and turned into centers providing higher quality of care, thereby creating a network of high-performing maternal and child health care centers.

d. Subcomponent 4: strengthening the patient referral and cross-referral system (US$1.92 million)

2.14 The communications and transportation network that connects the various types of establishments would be improved to make it easier to refer patients to the closest medical center with the proper capacity to respond to the health problem in question. A network of establishments connected by means of radio equipment or telephone is planned, including means of transportation, and simple portable radio equipment will be provided to trained traditional birth attendants. In addition, necessary training will be provided

to health care workers on risk factors and referral protocols and to communications and transportation system operators, as described in paragraphs 2.11 and 3.25.

e. Subcomponent 5: information, education, and dissemination (US$1.8 million)

2.15 The program proposes to use the mass media, health fairs, and simple plays to improve the population's knowledge about self-care, disease prevention, teenage pregnancy prevention, birth spacing, and the proper use of health care services. These activities would be tailored to the local culture.

C. Linkage between components

2.16 Enhancing the quality of primary health care, through the actions described in Component II of the program, without making progress in the sector reform process to correct the sector's structural problems will not contribute over the long run to improving the sector or the health of the population. For the effects of the health care improvement activities to be lasting and effective, the sector has to be headed by institutions that are connected with each other and have common purposes and requires clear resource allocation methods. Interconnections among the various government levels and financial cooperation are essential to the sustainability of the activities to improve health care and develop sector policy. The drafting of regulations for the private sector, the monitoring of health standards in service delivery, and the establishment of cooperation agreements are necessary to interconnect the actions in the sector and guarantee improved health care quality in all the subsectors.

2.17 Execution of the two components will be closely connected, since investments to improve maternal and child health care in each department (Component II) will be subject to the existence and annual updating of cooperation agreements between the Ministry of Health and the departmental governments. Annual investments will be tied to fulfillment of the commitments made annually by the departmental governments and Regional Health Directorates in the context of the cooperation agreements (see paragraph 2.6(ii)), which will be spelled out annually in a document that identifies the specific commitments to be fulfilled during the year in each department.

2.18 In addition, on the basis of the results of an interim evaluation (see paragraph 3.45), the actions to be undertaken will be identified. If the evaluation reflects negative results in terms of the progress of the program, a decision will be made as to whether to cancel the financing of activities in Component I and rescale Component II; this means that under such circumstances and given the size of the investments needed to deliver maternal and child health care services, it is important to redefine the size of

Component II according to the following criteria: (i) make the investments involving resources already committed as of the time of the evaluation; and (ii) only make the minimum investments that will not result in a reduced rate of return on investments that have already been made or committed. Since this program is the first phase of the sector reform process (see paragraphs 1.33 and 2.1), which could be supplemented with simultaneous or phased operations to undertake the actions described in paragraph 1.34, if the interim evaluation shows that the agreements reached with the Bank on the sector modernization activities set forth under Component I are not being fulfilled, support for the sector reform and modernization process with simultaneous or phased operations will not be considered.

D. Program costs and financing

1. Cost of the program

2.19 The total cost of the program is US$46.6 million equivalent. A breakdown of the costs of each component is provided below:

TABLE OF COSTS
(in thousands of U.S. dollars)

CATEGORY		SOURCE OF FUNDING		
		IDB/OC	LOCAL	TOTAL
1.	**Administration and supervision 1/**	**2,500**		**2,500**
2.	**Component I: Modernization of the sector's organizational structure**	**2,100**	**2,100**	**4,200**
	2.1 Strengthening of regional autonomy	940		940
	2.2 "Outstanding professional" initiative	600	2,100	2,700
	2.3 Improvement of vital statistics	560		560
3.	**Component II: Improvement of primary health care**	**32,360**	**5,500**	**37,860**
	3.1 Human resource development	1,400	640	2,040
	3.2 Improvement of the INVEC input and medicine procurement and distribution system	5,240	4,860	10,100
	3.3 Rehabilitation of infrastructure and equipment	22,000		22,000
	3.4 Strengthening of the patient referral and cross-referral system	1,920		1,920
	3.5 Information, education, and dissemination	1,800		1,800
4.	**Project Preparation Facility (PPF)**	**400**		**400**
5.	**Associated costs**	**1,250**		**1,250**
	5.1 Audit of input supply system	1,000		1,000
	5.2 Evaluation	250		250
6.	**Inspection and supervision**	**390**		**390**
	TOTAL	39,000	7,600	46,600
	PERCENTAGE	84	16	100,0

1/ Includes financing costs for project coordination unit (PCU) (incremental staff salaries (see paragraph 3.4), international advisor's compensation and benefits, and miscellaneous services), the contracting of supervisory services for works and identification of maintenance needs for the design of maintenance plans.

2.20 The following terms and conditions are proposed for the Bank's prospective loan:

TERMS AND CONDITIONS OF THE LOAN

Amount of the loan	US$39 million
Amortization period	20 years
Grace period	5 years
Disbursement period	5 years
Interest rate	variable
Inspection and supervision	1%
Credit fee	0.75% of undisbursed amount
IFF	US$32 million

USE OF THE SINGLE CURRENCY FACILITY 1/
TYPE OF CURRENCY
(in thousands)

U.S. DOLLARS	DEUTSCHE MARKS	YEN
19,500	16,285	1,195,350
50%	25%	25%

1/ The exchange rate used was the one published in the June 4, 1997, *Wall Street Journal*'s official list.

2.21 In accordance with the Bank's regulations, the country expressed the desire to use the Single Currency Facility according to the breakdown provided above.

E. Consistency of the program with the Bank's strategy and with problems in the sector

2.22 The design of the program is consistent with the Bank's social sector strategy, as described in chapter I (see paragraph 1.37), through the following activities:

a. The program will strengthen the MSPBS's policy-making and regulatory capacity, help to define the roles of the various government entities as well as financing entities and health care service users, improve coordination among the various providers, and include specific actions to improve the quality of health care. The program would be the first phase of a reform process that the country is undertaking and that could be supported by the Bank through future operations.

b. To make resource allocation more efficient, incentives will be developed such as: (i) the "outstanding professional" initiative; (ii) improved medicine and input procurement and distribution system; (iii) priority assigned to delivering a number of highly cost-effective health care services, which will be addressed through physical investments, equipment, the purchase of inputs, and human resource development; and (iv) the methodology for allocating regional budgets according to poverty levels, current supply, and other sociodemographic indicators.

c. Private sector participation in the delivery of health care services will be encouraged through the development of cooperation agreements, the introduction of a new human resource development system (training and a competitive

recruitment process), and the creation and implementation of an appropriate regulatory framework for the sector will be initiated.

d. The program focuses on the definition and clarification of responsibilities and interagency connections in the sector for the purpose of averting the risks that would arise from embarking on a hasty decentralization process and of making the existing deconcentration process more efficient.

III. PROGRAM EXECUTION

A. Organizational structure for program execution

3.1 The MSPBS, through the Oficina de Proyectos de Cooperación Internacional [Office of International Cooperation Projects] (OPCI), will be the executing agency for the program. The OPCI's general directorate is assisted by several units that coordinate activities involving projects being provided with external support. One of these units is the IDB Program Coordinating Unit (IDB/PCU), another is the World Bank Program Coordinating Unit (IBRD/PCU), and a third is in charge of coordinating other projects (JICA, GTZ, KfW, etc.). The general directorate will be responsible for maintaining a direct link with the Ministry of Health for general program guidance and policies, advising the different units attached to it on technical aspects of the projects, ensuring consistency among the projects, and coordinating execution of the activities together with the ministry's other general directorates.

B. IDB/PCU

3.2 The IDB/PCU, in the person of its director, will be responsible for ensuring effective and timely program execution, by guiding the planning and implementation of its technical, financial, and administrative facets and coordinating all its activities with the MSPBS's Regional Directorates covered by the program, through departmental PCUs (DPCUs). To carry out his functions, the director of the PCU will have support from an international technical advisor, a legal advisor, and four area coordinators: administration and finance, sector modernization, infrastructure and equipment, and human resource development and information, education, and dissemination activities (IED). As a condition precedent to the first disbursement, the MSPBS will submit evidence to the Bank that the central PCU and DPCUs have been set up with the agreed upon structures and functions set forth in the program's operations manual.

3.3 The sector modernization and human resource development and IED coordinators will have a technical assistant while the administration and finance coordinator will have two procurement and contracts officers, an accounting assistant and a medicines and inputs assistant. The infrastructure coordinator will have the support of a specialized architectural firm to be hired on the basis of a noncontinuous services contract with resources from the program. This architectural firm will also undertake the technical strengthening of the MSPBS's Infrastructure Directorate.

3.4 Some of the PCU staff will be MSPBS employees. The director's technical advisor will be an international consultant. Taking into account MSPBS employees' four-hour workday and the amount of work

that project execution will require, program resources will be used to pay the PCU staff a supplement to work a full day. The incremental cost resulting from the extra wages to be paid to these employees, which will be covered from the loan proceeds, accounts for some 1.5% of the total cost of the project; this is justified because of the need for full-time staff, the importance of keeping properly motivated and committed staff in the PCU who participated in project preparation, and the desirability of having the ministry's own staff take advantage of the experience and know-how that will come out of project execution.

3.5 To carry out his functions, the PCU's director will have the support of the Competitive Bids Committee, comprised of the OPCI's director, the IDB/PCU's director, the administrative-financial coordinator, the coordinator of the subcomponent concerned with procurement, a representative of the Regional Health Directorate, and a representative from the Health Secretariat of the department in question. The committee will be involved in both local and international calls for bids and its main function will be to ensure that the activities involved in preparing the competitive bidding procedures are consistent with the guidelines agreed upon with the Bank, to witness the official bid opening ceremonies, and to evaluate the bids received in accordance with established evaluation criteria, while ensuring equitable and transparent procedures.

3.6 The organizational and functional structure of the PCU will be expanded regionally through the creation of the DPCUs in the Regional Directorates of the departments covered by the program and in close coordination with the Departmental Health Secretariats. Each DPCU will have a technical coordinator and an administrative assistant whose main functions will be to support the Regional Directorate in carrying out, coordinating, monitoring, overseeing, and evaluating execution of the program's various activities in its respective department, always in coordination with the central IDB/PCU.

3.7 Each health care region involved in the program will have the support of a Regional Advisory Committee, comprised of the departmental secretary of health, the regional director, and a member of the departmental health council. For the purposes of departmental coordination, cooperation agreements (policy frameworks, priority-setting, coordination in budget allocation) have been concluded between the Regional Directorates and the departmental governments to ensure that the allocated resources are properly administered and used, that each department's health care policy is consistent, and that local financial resources are used to guarantee that the program is executed properly and on a timely basis and is sustainable.

C. Operations framework

3.8 Program execution will abide by an operations manual agreed upon by the borrower and the Bank. The entry into force of this manual will be a condition precedent to the first disbursement. Each component of the program has its own operating guidelines, which are described below.

3.9 The following investment categories may be financed with proceeds from the loan: training, input supply and distribution, infrastructure rehabilitation, overhauling, and outfitting, communications and transportation equipment, technical assistance and activities such as seminars and regional meetings, and information, education, and dissemination.

1. Component I: modernization of the sector's organizational structure

a. Subcomponent 1: strengthening of regional autonomy

3.10 The technical assistance activities to analyze institutional capacity will begin with the hiring, through a call for offers, of a group of consultants who would conduct studies according to the terms of reference and schedule agreed upon with the Bank. When these studies are completed, a seminar will be conducted to disseminate, analyze, and build a consensus around the outcomes, to be attended by the various institutional levels involved, the MSPBS, the recently created "Decentralization Council" headed by the Minister of Finance, and representatives from social security and the private sector.

3.11 The legal framework for the cooperation agreements among the various agents in the system and the institutions involved has been prepared and copies of the agreements concluded will be submitted during negotiations. Similarly, the Regional Directorates and departmental governments will annually update and identify the activities to be conducted under the agreement framework. Approval of the annual investment plan for each department will be subject to the parties' fulfilling these agreements (see paragraphs 3.47 and 3.48). Once a study on the classification of private sector health care services has been completed and the appropriate regulatory framework has been designed, a regional consensus-building seminar will be conducted to begin the legislation approval process. Once the legislation has been passed, meetings will be held periodically with the National Health Council to design control and supervision mechanisms to ensure compliance with the regulations issues in the course of the program. The mechanisms will remain in place as one of the functions of the National Health Council.

3.12 In order to reduce inequity by improving the budget resource distribution process of both the MSPBS and the departmental

governments, a simple formula for redistribution of budget resources will begin to be implemented gradually that will involve the population and poverty indicators such as unmet basic needs. This formula will be ready in time for the negotiations and will be adjusted and improved during program execution. A group of consultants will be hired to fine-tune the formula to accommodate regional epidemiological indicators and health care services supply and demand figures in all the departments in the country. To gather this information, the household survey that was conducted in five departments during program preparation will be expanded under the program to cover all the departments. Once this study has been conducted in accordance with the timetable established with the Bank, the findings will be applied with support from an MSPBS ministerial resolution and with the agreement of the Ministry of Finance. The system will continue to be applied during the life of the program and will be subject to revisions and updates in the future.

3.13 The program's Component I also provides for the drafting of regulations to implement the National Health System Act, if passed, and in particular for the functions of the already established and operating National Health Council. The component includes regular interregional consensus-building activities to be conducted throughout the course of the program and opportunities will be provided to discuss new regional and local experiences and processes of change in the sector with the central government and the various agents in the sector. The goal is to disseminate across the nation the experiences that are successful at the local level but unknown at other levels, so that they can be replicated, and to encourage discussion and achieve consensus around the changes that the MSPBS wishes to make in the sector.

b. Subcomponent 2: the "outstanding professional" initiative

3.14 This initiative will be established by means of a ministerial resolution and a public awards ceremony. On the basis of the studies underlying the program (infrastructure and networks, human resources, and regional epidemiological profile), the IDB/PCU, in conjunction with the Departmental Health Secretariats and the Regional Health Directorates, will annually publish a list of establishments in which the "outstanding professional" program will be implemented. The MSPBS will issue a call for applications annually and the Technical Advisory Committee 10/ will select the applicants based on eligibility criteria agreed upon with the

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10/ The Technical Advisory Committee membership will be comprised of a representative of the Minister of Health, the Regional Departmental Director, a representative of Universidad Nacional de Asunción's School of Medicine, a representative from medical and scientific associations, and a representative from the Departmental Health Secretariat.

Bank. The application period will last 45 days and recently graduated professionals will be encouraged to participate and work in the public sector. Efforts will be made to avoid creating distortions in the current employment market for civil servants or any type of future obligation for the MSPBS in terms of benefits for the persons hired. The legal framework that currently covers Paraguay's civil servants (Law 200), the specific characteristics of human resources in the public health sector in Paraguay (see paragraphs 1.15 and 1.16), and similar experiences in other countries point out the serous risk that the MSPBS would run if it allowed current public servants to participate in the initiative. To offset this risk, it has been agreed that civil servants will not be eligible. The IDB/PCU will receive documents submitted by applicants and the Technical Advisory Committee will have 15 days to review and evaluate applications and make its selection.

3.15 Once the professionals have been selected, one-year service delivery contracts will be concluded, which may be renewed by mutual agreement between the parties, depending on the respective evaluations. The contracts will define MSPBS responsibilities to the personnel hired regarding commitments as to permanent positions and retirement or trade-union commitments. The professionals will set up permanent residence in the community in which the health establishment to which they have been assigned is located and moving to another community will be forbidden. The first year of implementation of the initiative will be financed with resources from the Bank's loan. Beginning in the second year, departmental and municipal budget allocations will participate increasingly in the financing. As a condition precedent to the first disbursement, the MSPBS will submit evidence to the Bank that: the administrative act(s) by means of which the "outstanding professional" initiative is created have been approved, along with the respective regulations; the Technical Committee has been set up and is performing its functions; and the first call for applications has been published.

c. Subcomponent 3: improvement of vital statistics

3.16 The program seeks to improve the vital statistics system through mechanisms to reduce underreporting of births, maternal deaths, and deaths of infants up to one year of age from the current 50% to at most 20%. In this context, the MSPBS will consider alternatives to eliminate the registration "tax" (which in departments in the interior can be as much as US$20) and all birth attendants will be trained not only in childbirth care (see paragraphs 2.11 and 3.23) but also in the collection of birth data. Public health care establishments will be required to report data on births, maternal deaths, and deaths of infants up to one year of age, starting with those taking place in the departments given priority under the project. This data will form the basis for the Single Register of Births and the Single Register of Deaths. To define the methodology for setting up these registration systems, a firm or

team of international consultants with experience in designing vital statistics information systems will be hired to design instruments for data collection, an information system consistent with such needs, and a method for implementing the system and training staff to manage it, in accordance with the terms of reference in the operations manual.

3.17 In order to reduce errors in recording, human resources will be trained in data collection and mechanisms will be developed to correct recording errors (feedback to the collection unit down the line and quality control of the register).

3.18 The program also proposes to promote use of the data to improve knowledge at the various decision-making levels about demographic variables relevant to health care policy design. For this purpose, existing departmental and central-level staff will be trained and basic information systems support (hardware and software) will be provided so that vital statistics of interest at the departmental level can be compiled.

2. Component II: improvement of primary health care

a. Subcomponent 1: human resource development

3.19 **Technical training - in-service training -** will be conducted by two local multidisciplinary teams in coordination with each other and assisted and evaluated by two external advisors throughout the five years of program execution. A three-week in-service training program will be conducted in each eligible establishment, with an additional week of supervision each year during program execution. It is estimated that a total of some 269 weeks of in-service training will be provided for the benefit of five regional hospitals and the type "A" health care centers. The cost of this training will be financed with proceeds from the Bank loan for the first two years. During years three and four, the Bank will finance 50% and 25% of the cost respectively. During year five and thereafter, the ministry will be responsible for funding this type of training, for which purpose it will make the respective allocation in its budget.

3.20 The multidisciplinary teams will include a pediatrician, an obstetrician/gynecologist, a surgeon, and a registered nurse. The selection of the training teams will be done through an open competition based on merit and abilities. Universities, clinics, scientific associations and teams of medical faculty will be invited to submit bids. The bids must be submitted in accordance with the terms of reference agreed upon with the Bank and will be evaluated by a selection committee comprised of the IDB/PCU training coordinator, a representative of the Faculty of Medicine, Science, and the external advisors for the component.

3.21 **Management training** will be conducted by the Association of University Programs in Health Administration (AUPHA), an international network of universities with programs in health administration, which provides nationwide training in Latin American countries and also conducts health care service management training programs at American universities belonging to the network. Training in reproductive health management will be provided by the United Nations Population Fund (UNFPA). Both these specialized agencies successfully provided this type of service to the MSPBS in 1993 and 1994. Alternatives for carrying out these activities were considered, but based on these agencies' vast experience in Paraguay's health care sector and their excellent track record, their direct hiring is proposed as an exception to the Bank's hiring policies. The hiring of these agencies without issuing a call for bids is justified as follows: knowledge of the country and its institutions, vast experience nationally and internationally, high quality of the courses conducted and positive evaluations thereof, the adjustments that they will be able to make in the courses based on past evaluations, and the reasonable cost of the courses. The total cost of hiring these two agencies is US$356,000.

3.22 Management training will be provided to some 139 professionals, comprising executives and staff assigned to establishments. It will consist of two basic courses: health care administration and reproductive health and family planning administration. The first will be organized and taught by AUPHA and will have the following four modules: (i) management skill development; (ii) information and decision-making; (iii) organization of health care services; and (iv) health care resource management. The course will last six months, and will be taught three times over the first three years of program execution. The second course will be organized and taught by UNFPA and will consist of the following modules: (i) introduction and leadership; (ii) management and negotiation; (iii) planning for reproductive health and family planning services; and (iv) evaluation of health care programs and decision-making. The duration of this course, with a participatory methodology, will be five months, and it will be taught twice, during years two and three of program execution. The project team reviewed the content of each module, the methodology used in teaching it, and the teaching materials used, and found them satisfactory.

3.23 **Training of traditional birth attendants** will be conducted in coordination with the General Directorate for Family Health, the unit through which the MSPBS carried out similar activities in 1995, such as the project entitled "Birth attendant – the child's and mother's friend". The purpose of this project is to train traditional birth attendant trainers using a technical and personal approach, in order to establish an institutional link with these workers, for training in clean deliveries, a risk focus, timely

referrals, and breast-feeding, and the inclusion of traditional birth attendants in the referral and cross-referral system. Each DPCU, in coordination with its Regional Directorate, will prepare its program prior to the beginning of the budget year and will submit it to the IDB/PCU to request the required support in the form of material, human, and financial resources.

3.24 Trainer training will be provided in each health care region by central-level staff or already trained regional staff. Some 150 trainers are expected to be trained in the course of four events (two concurrently during year one and two in year four), each lasting a day and a half. Traditional birth attendant training will be conducted by already trained regional trainers belonging to district and local health care establishments. Each health care establishment will identify the birth attendants in their service area and will invite them to participate in the training session to be carried out on its premises. Some 40 sessions lasting one and a half days will be held and will cover the various regions (40 simultaneous sessions during year one and another 40 during year four of the program), benefitting some 400 practicing birth attendants. This activity also provides for 75 one-day monitoring and evaluation sessions throughout program execution. The purpose of these sessions, to be conducted by the main health centers, will be to develop and maintain ongoing communication with the birth attendants so that effective incorporation of the techniques and procedures taught can be evaluated and to encourage them to participate in the referral and cross-referral system.

3.25 **Training in the referral and cross-referral system** will be provided at the regional level with participation by the MSPBS's Department of Transportation and Workshops and with the cooperation and advisory support of staff from Paraguay's Volunteer Fire Department, the Paraguayan Radio Club, and technical staff from the National Paramedic Emergency Service. Drivers and radiotelephone operators will be trained through 35 one-day sessions at the regional level. An annual session is also proposed for technical staff and radio-operators at the central level and two four-day specialized courses will be conducted for emergency vehicle drivers that will include defensive driving skills, legal and technical issues, emergency vehicle maintenance, communication system for emergency vehicles, rescue skills, and patient transport. This training complements the work on risk factors, patient handling, and referral methods to be done with health care workers under the health care technical training module (see paragraphs 3.19 and 3.20).

b. <u>Subcomponent 2: improved medicine and input procurement and distribution system</u>

3.26 For the supply and distribution of medicines and inputs, the program calls for contracting out to a laboratory through

international competitive bidding, which will undertake to provide and distribute necessary inputs directly to the establishment, according to a plan agreed upon with the MSPBS that includes the type of medicine, the quantity to be distributed, delivery periods, the quality of products and their expiration dates. The laboratory's initial contract will be for two years. Six months before the contract ends, a second call for bids will be issued. This system will decrease intermediation and storage costs and will make the provider responsible for the timely delivery of inputs. The human resource training subcomponent provides for instructing staff at the establishments in the inventory control (INVEC) system. The call for bids will be centralized in the IDB/PCU and the process of choosing bids will be supported by the regional units through the Competitive Bids Committee. The call for bids will be subject to technical specifications for medicines consistent with international minimum quality standards and in accordance with a list of medicines consistent with the following principles: (i) medicines must be for maternal and child health care; (ii) the use of antibiotics is limited to pathologies that cannot be treated effectively in any other way; and (iii) generic medicines will be used. A firm will be hired to conduct an external audit of the medicine and input procurement and distribution system. The terms of reference for hiring this firm were already agreed upon with the MSPBS and are included in the annexes to the operations manual.

3.27 For purposes of sustaining the activities implemented under the program, financing for the supply of inputs with local counterpart resources will increase over the course of the program. An agreement has been reached with the government so that all purchases of medicine intended for maternal and child health care in the five departments covered by the program will be made in accordance with the system described. The proceeds from the Bank loan will cover 100%, 80%, 60%, 40%, and 25% of the costs for each of the five years of the program, respectively.

c. Subcomponent 3: infrastructure rehabilitation and equipment

(i) Preparation and approval of the annual investment plan and project priority-setting

3.28 The justification for investments in infrastructure and equipment will have to be made in the context of a departmental strategy, which will be the general analytical framework for assessing the feasibility of investment projects comprehensively by department. This strategy will contain consistent elements with a dual purpose: (i) to decrease regional inequity; and (ii) to set up a network of establishments that are more responsive to maternal and child health care, based on indicators such as the current state of repair of the infrastructure, the need for rehabilitation of the infrastructure, and the need based on the number of pregnant women

per delivery room, number of childbirth beds per 10,000 women of reproductive age, and number of annual office visits.

3.29 For investments, priority will be given to regional hospitals and type "A" health care centers. The latter are existing health care establishments which require investments to improve their capacity to respond in such a way that they can handle both normal and high-risk deliveries and provide outpatient pediatric care and uncomplicated in-patient services. Investments in type "B" health care centers (establishments with a lower response capacity than type "A" centers, having adequate human resources and equipment for providing care in normal delivery situations and pediatric care) and health posts will only be made once the other investments have been completed and will be subject to availability of resources and eligibility based on agreed upon criteria. Submittal of departmental strategies and the investment plan for the first year will be a condition precedent to the first disbursement.

3.30 The DPCUs will prepare project proposal files following the guidelines set forth in the project presentation manual annexed to the operations manual. To this end, they may receive support from the MSPBS's Infrastructure Directorate or the IDB/PCU, through the infrastructure and equipment coordination unit.

3.31 Once the IDB/PCU has received the files, they will be evaluated to determine whether the projects are consistent with the agreed departmental strategies and whether the established eligibility and technical criteria are met. In order to establish priorities among equally eligible projects within a department, the project will also be subjected to a priority-setting process based on a system of relative weights given to the eligibility criteria, as described in the operations manual. For example, projects involving an adequate number of human resources and a preventive maintenance plan are given greater weight. In this connection, the IDB/PCU will review and reach a consensus with the pertinent regional advisory committee on each department's annual investment plan.

3.32 Once consensus has been reached on the departmental investment programs, the IDB/PCU will prepare an overall annual investment plan. This investment program will subsequently be reviewed by the Bank as part of the annual project follow-up exercise (see paragraph 3.47). Once approved, the projects will be subjected to a final design stage and then the IDB/PCU will issue a call for bids following the procedures agreed upon with the Bank.

(ii) Financing ceilings

3.33 The maximum amount of the projects will be the equivalent of the cost of bringing the establishment up to the functional standards agreed upon by the MSPBS and the IDB, in the case of both civil works and equipment. Such ceilings have been established specifically and in detail for each of the establishments in the

public system of the five departments covered by the program, through a needs survey performed on site. Consistency between such ceilings and the specific projects submitted will be evaluated by the IDB/PCU when it reviews the files to make up the annual investment plan.

3.34 The cost of the supervision component for each project is not to exceed 5% of its total cost. The operations manual contains an annex that sets forth terms of reference for contracting the works supervision services.

(iii) Establishment of a departmental financial ceiling

3.35 In order to narrow the gaps between regions, a financial ceiling has been established for each department based on the following formula developed with specific indicators for each department: 50% based on the target populations and another 50% based on the following indicators, weighted equally: existing infrastructure in a critical state of disrepair; need for infrastructure rehabilitation and equipment; maternal health care (number of pregnant women per delivery room); and maternal and child health care (visits per capita).

(iv) Project approval

3.36 The projects that are included in the annual investment plan whose amounts exceed US$1 million must be approved in advance by the Bank. However, the first five projects to be financed will have to be submitted for prior approval by the Bank. After that, the Bank will annually review a random sample of projects approved by the PCU in order to determine whether the criteria, guidelines, and procedures established for program execution are being met.

d. Subcomponent 4: strengthening the patient referral and cross-referral system

3.37 The activities under this subcomponent focus primarily on the procurement of radio communication equipment and emergency transport vehicles (ambulances) and will be carried out by the IDB/PCU in coordination with specialized units of the MSPBS and the Regional Health Directorates. Initially, this equipment will be provided to all the regional hospitals and priority type "A" health centers and type "B" health centers and posts given priority under the infrastructure rehabilitation and equipment subcomponent. Those health care centers and posts not rehabilitated under the program will be eligible for this component but priorities will be set according to the following criteria: (i) that a health care establishment that can deal with more complex cases exists within a 15 to 20 km radius; (ii) that it is located in the neediest regions of the departments of Caaguazú and Central; and (iii) that it lacks its own telephone system and uses public telephones located outside the establishment.

e. Subcomponent 5: information, education, and dissemination

3.38 The activities under this subcomponent will be carried out by the IDB/PCU in coordination with the MSPBS's Public Affairs and Education Directorate. The services of a specialized firm will be hired during year one of program execution to produce the IED master plan, prepare manuals and other printed matter, and produce radio spots, educational videos, and television campaigns. The Public Affairs and Education Directorate will assist by providing technical data for the production of educational and informational materials, participating in the selection of the agencies hired, giving its views on the output of the firm hired, and regulating the broadcasting, publication, and compulsory distribution of the materials. The IDB/PCU will provide technical support to the directorate in the planning of activities, product quality control, and coordination with the contracted firm and the mass media, and will supervise and monitor execution of the subcomponent. The outreach activities will begin in year two of the program when all the educational and communication materials, skit scripts, and schedule of activities for the first health fairs are ready.

D. Infrastructure and equipment maintenance

3.39 The program provides for preventive and routine maintenance activities. The investments under Component II of the program in each department will annually be subject to budget allocations sufficient to cover maintenance and the drafting of a maintenance plan. For investment subprojects, the presentation of a preventive maintenance plan for the establishments is a condition for eligibility (see paragraph 3.31). Moreover, the improved management schemes that allow the health care establishments to use their own funds give priority to preventive maintenance financing (see paragraph 1.22). The operational maintenance of infrastructure will be contracted out to a firm that will conduct the actions identified by the works supervision contractors. The maintenance of equipment acquired through the program will be performed by the equipment supplier as established in the bidding procedures.

E. Procurement of goods and services

3.40 Goods and related services will be procured and works construction contracts awarded in accordance with the Bank's standard procedures. International competitive bidding will be compulsory for construction works costing in excess of US$2 million and for goods and related services above US$250,000. Domestic law will apply to procurement below those thresholds. Contracts for studies and consulting services called for under the program will be awarded in accordance with the Bank's standard procedures. The program's procurement plan appears in Annex III-5.

3.41 For the purposes of program execution, the IDB/PCU will be assisted by two specialists in procurement and contracts. If necessary,

these specialists will avail themselves of the structure for competitive bidding procedures already in place at the ministry's central and regional levels. As noted above, the Competitive Bids Committee will evaluate the bids and approve the signing of contracts.

F. Disbursement timetable

3.42 The program will be executed over a five-year period. The disbursement timetable based on completed programming is presented below. The period for physical initiation of works will be four years from the date of eligibility for disbursements.

DISBURSEMENT TIMETABLE
(in thousands of U.S. dollars)

SOURCE	1997	1998	1999	2000	2001	TOTAL
Bank	7,141	10,444	10,736	6,551	4,128	39,000
Local contribution	304	689	1,235	2,150	3,222	7,600
TOTAL	7,445	11,133	11,971	8,701	7,350	46,600
PERCENTAGE	16	24	25	19	16	100

G. External audit

3.43 During program execution, the borrower, through the executing agency, will annually submit the program's financial statements along with a report containing the unqualified opinion of external auditors acceptable to the Bank.

H. Follow-up and evaluation system

3.44 During program execution, the PCU will submit semiannual reports on the physical and financial progress of the program. Every year, a report on the progress of the reform measures contained in Component I (Annex II-2B) will be submitted, describing the degree of fulfillment of the activities agreed upon annually under the cooperation agreements, as well as a proposal on the cooperation activities to be included in the agreements for the following year. The PCU, members of the MSPBS, and the Bank will meet annually to review: (i) the departments' investment plans for the following year; (ii) improvements in equity in terms of the regional budget allocations; (iii) progress of reform actions contained in the report previously sent to the Bank, including fulfillment of the actions set forth in the yearly cooperation agreements between the departmental governments and Regional Health Directorates, on which approval of each department's investment plan for the following year depends; and (iv) the arrangements stipulated under the cooperation agreements for the following year. The report will

also contain an account of the progress made under the Component II activities, based on the indicators set forth in Annex II-2A.

3.45 The program evaluation process will consist of two evaluations — one interim and one final. The interim evaluation will be performed based on progress and impact indicators agreed upon with the Bank (see Annex II-2A) and on the achievements of the reform actions with respect to the contents of Annex II-2B. The interim evaluation will be conducted once 50% of the program resources have been committed, or two years into program execution, whichever occurs first. The purpose of the evaluation is to assess the status of program execution, verify the degree of fulfillment of the proposed goals, detect problems, and introduce corrective measures. If the evaluation should find that the advances achieved by the MSPBS in the execution of the program and fulfillment of the agreed commitments are deemed unsatisfactory, the Bank may cancel the resources to finance Component I and rescale Component II as explained in detail in chapter II (see paragraphs 2.17 and 2.18).

3.46 The final program evaluation will be submitted prior to the last disbursement. Its content and methodology will be the same as that of the interim evaluation. In addition, the final evaluation will show that the persons who will conduct the second survey on the use and perception of health care services and the subsequent data analysis have been selected and hired. The objective of conducting this survey is to gather data comparable to that collected during program preparation and thus make it possible to compare data that would indicate the impact of the program's activities.

I. Status of program preparation

3.47 The MSPBS, in coordination with the Regional Health Directorates and the Departmental Health Secretariats, has worked to set up an investment strategy for each department, which will be consistent with the annual investment plans for the next five years. Moreover, five files have been submitted to the Bank that identify the investments in the regional hospitals, which will be improved upon and supplemented with two files for the type "A" health care centers and will be submitted prior to negotiations on the program. The financial ceilings for investments in each department have been estimated and the departmental strategy for the next five years is designed with such ceilings in mind.

3.48 As part of the sector institutional coordination process, the Regional Health Directorates and Departmental Health Secretariats are working with the MSPBS to define the model cooperation agreement, which will be submitted officially and will enter into force during the negotiation phase. The MSPBS is also working with the Ministry of Finance to design the regulatory framework for the health care establishments' use of their own resources, which is described in the accountability mechanism.

3.49 In order to provide continuity for program activities over the period between negotiations and the start of the program, once it has been approved by the Congress, the Bank will use the project preparation facility approved for Paraguay (4/LC-PR) to finance various activities, including strengthening of the Infrastructure Directorate of the MSPBS, identification of procedures for implementing and updating the improved management mechanisms, review and update of technical specifications and quality standards for equipment, improvement of the formula for dividing budget allocations among regions, and the process of launching the program with regional and local participation. An estimated US$400,000 will be spent. As a result of these activities, the conditions precedent to the first disbursement will be fulfilled more quickly.

IV. PROGRAM BENEFITS AND RISKS

A. Economic analysis and program sustainability

4.1 The economic evaluation in this document is based on the cost-effectiveness approach, which seeks to evaluate the benefits achieved by the project vis-à-vis the expected costs, bearing in mind specific health indicators. This option has been used as an alternative to traditional cost-benefit analyses, which tend to undervalue health benefits and the impact of activities like the ones of interest in the program.

4.2 As shown in chapter I, among the members of MERCOSUR, Brazil and Paraguay are the countries with the poorest maternal and child health care conditions. For this reason, one of the objectives of the program is to expand coverage for these population segments over a five-year period, until all mothers and children without private insurance, IPS, or other types of health coverage (armed forces, police, etc.) are covered.

4.3 The main benefits of the project are associated with reducing maternal and child mortality through increased coverage and improved quality of care. By the end of the project, the following targets are expected to be reached: a net increase in coverage of 34,400 pregnant women, 240,000 children under five years of age, and 41,000 births at MSPBS establishments. A summary of project benefits appears in Table 1. Throughout project implementation, it is estimated that 2,700 deaths of children under age one and 1,600 deaths of children between the ages of one and five will have been avoided, as well as 1,100 maternal deaths. Project evaluations in countries with a social structure similar to that of Paraguay show that the project could increase spacing between pregnancies and reduce fertility rates by up to 15% through the proposed activities in the areas of reproductive health training (see paragraph 2.11), input and medicine procurement and distribution (see paragraph 2.12), and community education (IED) (see paragraph 2.15).

4.4 After project implementation, benefits will continue to accrue: it is estimated that 1,500 deaths of children under five years and 130 maternal deaths will be avoided each year in the five departments where the program will have been implemented.

TABLE 1
ESTIMATED BENEFITS

CHARACTERISTICS OF COVERAGE	BENEFITS DURING PROJECT IMPLEMENTATION (1997-2001)	BENEFITS AFTER PROJECT IMPLEMENTATION
Infant mortality (< 1 year)	2700 deaths avoided (540 per year)	900 deaths will be avoided each year
Infant mortality (1-5 years)	1600 deaths avoided (320 per year)	600 deaths will be avoided each year
Maternal mortality	1100 deaths avoided (220 per year)	130 deaths will be avoided each year
Years of healthy life (YHL)	1.3 million additional YHL	480,000 YHL will be added each year
Family planning	15% drop in fertility rates	

4.5 A significant part of the program's costs relates to activities needed to provide a package of quality maternal and child health care services (equipment and infrastructure rehabilitation, provision of inputs and materials, human resource development, and community education and outreach work). The effectiveness of such an investment can be measured by the increase in years of healthy life (YHL) – or a reduction in the current loss of YHL due to maternal and perinatal complications – resulting from increased coverage and reduced maternal and child mortality. Table 2 summarizes the effectiveness indicators associated with each US$10,000 invested during the life of the program. These benefits are even greater if the impact that the program investment will continue to have, even after the end of the program, is taken into account. In terms of deaths avoided, increased coverage, and reduced disabilities, the cost-effectiveness of providing this package of maternal and child health care services is not only high based on the results shown in Table 2, but would tend to increase in the years following program implementation.

TABLE 2
PRINCIPAL RESULTS EXPECTED FROM EACH US$10,000 INVESTED

TARGET GROUP	COVERAGE GOALS	YHL GAINED	REDUCTION IN MORTALITY
1997-2001 – PROJECT EXECUTION			
Children under one year	Additional increase in coverage of 56 children	173	0.6 deaths avoided
Children from one to five years of age			0.2 deaths avoided
Women of reproductive age, mothers, and births	Additional increase in coverage of 8 pregnant women and 10 births	137	0.1 deaths avoided
2001-2016 – AFTER EXECUTION			
Infant mortality	Increase in coverage of 891 children	957	3.2 deaths avoided
Mortality among children 1 to 5 years of age			2.1 deaths avoided
Maternal mortality	Increase in coverage of 102 pregnant women and 138 births	661	0.5 deaths avoided

4.6 The cost-effectiveness of the activities to be carried out through the program investments is higher than other alternatives considered. The analysis of alternatives considered: (i) the impact on maternal and perinatal mortality of continuing under the current system of service delivery, which is inequitable and low quality, and penalizes low-income groups more than others; (ii) the implementation of a vertical program of maternal mortality reduction that, within existing structures, finances the provision of services but does not seek to reduce inequity or make structural changes to increase the system's efficiency; the scope of these actions is not sustainable and their impact on health indicators would be limited to perpetuating the system's current inefficiencies and inequities; and (iii) the implementation of changes in the health care model, by improving the quality of care at the establishments and creating a network of maternal and child health care that adopts all the changes generated in the sector at the macro level. This option, which is the one developed by the program, has multiplier effects stemming from changes in the efficiency of service delivery and generates savings in the cost of delivering services by emphasizing the use of non-hospital establishments.

4.7 It can safely be said that this program's activities are highly cost-effective: with an investment of US$18 per beneficiary per year (women of reproductive age and children from birth to five years of age) between 1997 and 2001, 5,400 maternal and child deaths will be avoided during program execution and 8,150 additional deaths during the five years after program completion. In addition, by the year 2001, 1.3 million YHL will have been safeguarded and 480,000 YHL per year, beginning in 2002.

B. Program benefits

4.8 As shown in section E of chapter I and in Annex I-2, the project will benefit Paraguay's low-income population, in particular women of reproductive age and children under five. The program will improve the quality of primary health care services by identifying basic care protocols, providing training in health care services for health care personnel and establishing professional requirements based on the level of care, implementing sector regulations, and investing in infrastructure equipment and rehabilitation at the MSPBS's health posts and centers. Improvements in maternal and child health care, as studies performed in other Latin American countries show, is one of the investments that generates the greatest gains in health. Studies find 11/ that improved access to and quality of basic public health care services in low-income areas can save about 10% of the burden of illness measured in years of life adjusted for disability. Improvements in maternal

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11/ "Economía y Salud" ["Economy and Health"], volume 11. Mexico, D.F. Funsalud, 1994.

and child health care suggest, in the case of Mexico, that an average savings of 47 years of healthy life would accrue for every 100 beneficiaries per year, which would otherwise be lost if this type of health care was not improved. In the case of Colombia, 12/ studies suggest that in rural areas an average of 14.7 years of healthy life are lost per 1,000 inhabitants per year, from death or disability caused by maternal and perinatal illnesses, the majority of which could be prevented and/or treated with quality maternal and child health care and broad coverage.

1. Equity

4.9 The program establishes ceilings for investment resources in each department in order to reduce regional inequity in the supply of health care services; estimates the input requirements for maternal and child health care vis-à-vis the actual needs of each department; and encourages the geographic reassignment of human resources. In addition, to make the distribution of budget resources more equitable, a formula will be implemented for budget transfers to the regions based on demographic, socioeconomic, and health indicators, thereby reducing the actual discrepancies shown in Table 1 of chapter I. The timely, homogeneous provision of a quality package of maternal and child health care services will reduce the differences in care currently received by the various income groups. By the end of the program the existing difference between departments in the use of services and availability of supply is expected to have been eliminated.

2. Efficiency

4.10 The program will make resource allocation in the sector more efficient by: (i) introducing mechanisms for financial coordination and complementarity between the regional budgets of the MSPBS and those of the Departmental Health Secretariats; (ii) strengthening the regulatory, administrative, and planning capacity of the MSPBS and the departmental and regional units; and (iii) steering spending to finance the delivery of highly cost-effective maternal and child health care services.

4.11 The program will also improve the internal efficiency of the Paraguayan health care system by: (i) salvaging the installed capacity in the public sector and making it more efficient; (ii) increasing the successful treatment capacity of health care establishments, thus decreasing the number of patients referred to regional hospitals and reducing the cost of care; (iii) contributing to the financial self-sustainability of the establishments through the more efficient use of their own resources acquired through cost recovery and by tying such use to

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12/ "La Carga de la Enfermedad en Colombia" ["Burden of Disease in Colombia"]. Ministry of Health, Bogota 1994.

an improved management mechanism; and (iv) improving the sector's management capacity at the regional and local supervisory levels as well as in the establishments providing services.

3. Quality

4.12 The program will improve the quality of primary health care service delivery by: (i) providing equipment (medical equipment and communications and transport systems) and rehabilitating the existing infrastructure in the context of a service network approach; (ii) training staff to raise their technical capacity; and (iii) supplying the establishments with sufficient inputs.

4. Regional autonomy and integration with the private sector

4.13 The sector will benefit from the clarification and coordination of responsibilities of the various institutional levels (Departmental Health Secretariats and Regional Health Directorates), if health policy planning is consistent with total resources available and in line with local needs. Public sector coordination with the private sector and the social security system through service delivery agreements will allow the public sector to provide health care services without expanding its payroll or infrastructure unnecessarily.

5. Demonstration effect and replicability

4.14 The program will develop managerial and organizational capacity in the sector, which may generate experiences that could be replicated in other sectors. Moreover, the changes to be introduced in the five departments will offer significant lessons for the development of similar mechanisms in the rest of the country.

C. Risks of the program

1. Changes in the reform agenda

4.15 Paraguay is making progress in the strengthening of regional autonomy and in encouraging regional and local responsibility for the health sector. The stages to be followed in the process of change in the public sector are being discussed in the National Decentralization Committee headed by the Minister of Finance. One of the risks in the way of program success would be a shift towards centralism in decision-making, financing and allocation of resources, and policy-setting for the sector. The improved management schemes, regional interagency participation agreements and agreements with other agents in the sector, and activities to improve the administrative and financial planning capacity included in the program would no longer make sense if a change in the reform agenda were to occur. To offset this risk, the project team conducted a detailed study of the deconcentration process in the health care sector and pursued a number of activities involving

discussion and dissemination of the findings at the departmental and regional levels and with various authorities at the central level. The program activities were primarily designed to reduce the risks of undertaking a speedy decentralization process like the one that the MSPBS was promoting, without first identifying the responsibilities of the various agents, assessing the costs of the process, and promoting dialogue and discussion at the regional, local, and national levels. These activities will be conducted through the technical assistance to be provided under the program's Component I.

2. Inadequate implementation of activities to improve care

4.16 The inadequate implementation of rehabilitation and equipment subprojects, weaknesses in health care technical training, and ineffective user education and communication activities will reduce the impact of efforts to improve the use and quality of health care. To offset this risk, the program provides for implementation of: (i) infrastructure and equipment standards, designed under the program on the basis of a survey of current supply, and human resource profile standards by level of care that did not exist before and have been approved by the MSPBS, which explains why there are significant differences today in the condition and quality of health care establishments. In addition, based on a detailed study of public infrastructure, equipment, and road systems, the program designed criteria for setting priorities and granting eligibility to investment subprojects and will be outsourcing work supervision; (ii) the methodology of providing training directly at the place where services are delivered, which includes a week focused exclusively on reinforcing the training received during the year and on evaluating findings on quality of care; in turn, the trainees will evaluate the effectiveness of the group of trainers. The program introduces flexibility so that adjustments based on the findings of the ongoing evaluation procedures can be made. In addition, for technical health care training, protocols on managing maternal and child health care were designed, which the MSPBS had been lacking; (iii) IED activities will be conducted by people in the community using methodologies that fully take into account social and local issues and local language and symbols, with participation by national celebrities and important figures from the media, theater, etc., known throughout the country.

3. Slow legislative procedures

4.17 The sector modernization component depends on legislative procedures for implementing changes in the departmental and MSPBS budgeting processes, for regulating the responsibilities of the National Health Council as the sector's regulatory and integration organ, for coordinating and integrating the two levels of government (central and departmental), and for establishing the Office of the Health Superintendent and private sector regulation.

Although it is difficult to predict exactly how the legislative approval process will turn out, the MSPBS has worked with the project team on the dissemination of information on program activities at the central and departmental government levels (Ministry of Finance, Office of the Advisor to the President, Chamber of Deputies, National Health Council, Departmental Health Councils, departmental governments, etc.), which has generated discussions and consensus-building that will facilitate legislative approval in the future.

4. Slow or little implementation of health sector regulations

4.18 Once the technical assistance activities for the classification of the private sector, the drafting of regulations, and the discussion, processing, and approval of legislation have been completed during the first three years of the program, the Bank will be able to execute an operation in the sector exclusively focussed on the setup, operation, and evaluation of the effectiveness of the Office of the Superintendent of Health.

D. Beneficiaries

4.19 The direct beneficiaries of the program are users of the MSPBS's health care services, the large majority of whom are members of low-income groups. In particular, the beneficiary population is comprised of at least 44% of the women of reproductive age who have had a child and 12.3% of children under five years of age who currently go to the MSPBS when they are ill and who will receive higher quality care, with special emphasis on highly cost-effective procedures and preventive care. In time, improved care is expected to attract a much larger number of beneficiaries. The program directly benefits the poorest consumers, and women and children in particular, through: (i) improved quality of the primary health care provided by the MSPBS; (ii) the provision of adequate inputs for the delivery of highly cost-effective health care services; and (iii) health education and outreach activities at the local level.

4.20 Indirectly, health care service providers and consumers will benefit from: (i) the introduction of competitive mechanisms for selection of professionals; (ii) incentives and retraining to improve service delivery management and quality; (iii) allocation of the program's investment resources according to current sector needs in each department; (iv) strengthening of administrative responsibility at the local level; (v) narrowing of the current gaps among departments in the allocation of budget resources; (vi) improved MSPBS capacity to regulate and control the sector; and (vii) improvement of governments' administrative capacity at the regional level and strengthening of regional autonomy in terms of health care planning and achievement of the proposed outcomes.

MAIN FINDINGS – USE OF SERVICES

The main findings on the use and perception of health care services are summarized below. For further details, see RE1/SO1's sector study entitled "Study on the use and perception of health care services in Paraguay, 1996".

1. Illness constitutes a large cost since over half of the people who became ill were absent from their regular activity an average of 6.6 days.

2. Over half the people over the age of five who feel sick seek health care services. Of those who do not, one fourth cite financial reasons for not doing so and only 4% report geographical distance as a reason.

3. In rural areas, a smaller proportion of those reporting illness decide to seek health care services and people self-medicate more frequently than those living in urban areas.

4. Private-sector health care services are sought much more often than public-sector services, in both rural and urban areas at all income levels and by all age groups.

5. In the regions considered, 10% of the population has private insurance, 17% are social security beneficiaries, and the rest have no coverage.

6. Private insurance coverage increases with income level, from 1% in the poorest quintile to 20% among higher-income levels. The same is true of membership in the social security system.

7. The writing of medical prescriptions was rather generalized in the public and private sectors and in the IPS. However, only 20% of the public sector patients received the medicines where the prescription was issued, compared with 86% in the IPS.

8. A significant proportion of monthly per capita family income is spent on health care – one third in rural areas and 42% in urban areas (not counting Asunción).

9. The patients who received care in public-sector facilities paid almost as much for medicines as those who sought private-sector medical care. In both cases, the payments represented a significant proportion of the total cost of treatment.

10. Most people pay for the office visit regardless of the provider. Payments vary, with private medical care being four times costlier than office visits at public-sector facilities. The latter cost slightly under twice what a traditional healer charges.

11. Although an office visit at a public-sector facility costs almost half what it would cost in the IPS, diagnostic examinations in the public sector cost twice what they did in the IPS and only 5% less than in the private sector. In rural areas, the average payment for diagnostic exams is only 2% less than the payment in Asunción.

12. The total amount of time invested in getting health care services was decidedly lower for those who chose the private sector than for those who chose the MSPBS and/or the IPS.

13. MSPBS establishments are important providers of obstetric care. In the five project regions (without Asunción), 73% of the deliveries are "institutional" and 42% of the total take place at MSPBS establishments, while 15% of pregnant women are assisted by Chaé midwives or traditional birth attendants.

14. Not all women were cared for at the establishment they planned on using. One of the most important reasons for this was remission, which may indicate the low treatment capacity of the establishment consulted.

15. Women do not always use the establishment closest to their home, mostly because of a perception of low quality.

16. Over half the women pay out-of-pocket for prenatal care in both rural and urban areas. Among low-income women, 82% had to pay for care, while only 63% of higher-income women did. The poorest women pay almost one third of their monthly per capita income for childbirth care, while higher-income women pay less than 20%.

17. Only 72% of newborns in rural areas are registered at birth.

CONCEPTUAL FRAMEWORK
PR-0028 IN THE GENERAL CONTEXT OF PARAGUAY'S HEALTH CARE SECTOR

CTERISTICS	CONSEQUENCES	ACTIONS IN THE SECTOR		
		SHORT TERM (Actions taken by the government)	**MEDIUM TERM With the program (5 years)**	**LONG TE (10 to 15 y**
NTALIZATION OF THE SECTOR				
ation stitutions h	a.1 Overlapping of responsibilities and administrative confusion.	a.4 Incentives to establish regional autonomy.	a.6 Consistency among the central and regional levels for health care planning (cooperation agreements renewed annually).	
epartmental iats)	a.2 Lack of planning in the sector and inefficient resource allocation.	a.5 Creation of the National Health Council so that over the long term it will become a regulatory and advisory agency that can bring together the various agents in the sector and the many governmental agencies.	a.7 Cooperation of the departmental and municipal governments in the financing of MSPBS actions.	National Health Syste comprehensive netw and private providers
	a.3 Regulatory weakness at the central and regional levels.		a.8 Technical assistance for the strengthening of regional autonomy (coordination of responsibilities, related regulatory procedures, and consensus-building activities).	Departmental Health merged with MSPBS into a single institutio at the departmental l
ation among , IPS, private	b.1 Duplication of efforts.		b.4 Participation of the private sector and social security through service delivery agreements, supplementing public-sector action.	Regulatory and plann MSPBS fully operatio
	b.2 Inequity; regressive payments and significant disparities in service quality.			
	b.3 Lack of regulatory mechanisms to cover all the service providers.			
TOR				
d with many us types	a.1 Low quality service.		a.3 System for classification of the private sector.	Private sector working coordination with the Health System.
	a.2 Dispersion of providers and inequity in service delivery.		a.4 Development of an appropriate regulatory framework.	Basic standards for q training and certificati
			a.5 Creation of the Office of the National Health Superintendent or its equivalent, for implementation.	place for providers.

ICS OF THE CTOR	CONSEQUENCES	ACTIONS IN THE PUBLIC SECTOR		
		SHORT TERM (Measures already taken by the government)	MEDIUM TERM With the program (5 years)	LONG T (10 to 15
OURCES				
- life-time Law 200)	a.1 Assignment of human resources from the central level, which makes regional planning and efficient resource allocation difficult. a.2 Inadequate geographical distribution. a.3 Health care establishments lack appropriate staff.	a.4 First steps to make payroll more flexible: - Give regions responsibility for managing regional payroll although decisions must still be reported to the central government (MSPBS) (Min. Res. 373/93). Resources are transferred to the regional level based on historic payroll levels. - Payroll changes: reduce staff from 15,000 to 11,000; freeze payroll as of 1995.	a.5 Competitive system for selection of candidates and their assignment to health care establishments in areas of the country with staff shortages. (Outstanding professional program). a.6 Implementation of standards at least in the health care centers rehabilitated under the program.	Payroll manageme for meeting human at the local level. Equitable geograp distribution. Salary scale that re differences.
cal quality	b.1 Serious deficiencies in the quality of health care delivery; high rates of maternal and perinatal mortality.	b.2 Identification of standards for professional team needed by level of care. June 1996.	b.3 Technical health care training on site at the place of service delivery to improve primary health care quality (emphasis on mothers and children). b.4 Management training at various levels of government and at institutions providing health care.	Optimal technical c branches and at al

TICS OF THE ECTOR	CONSEQUENCES	ACTIONS IN THE PUBLIC SECTOR		
		SHORT TERM (Measures already taken by the government)	MEDIUM TERM With the program (5 years)	LONG TE (10 to 15 y
ND MANAGERIAL				
ource nd limited e public sector	a.1 Resources allocated do not match local needs. a.2 Final responsibility for output, inputs, and finances completely centralized in the MSPBS, far away from those who make decisions in the units.	a.3 Deconcentration process, transferring financial resources and their management to health care regions with no management capacity, no monitoring and evaluation system, and on the basis of past levels. For these reasons, ultimate responsibility remains with the MSPBS at the central level.	a.4 Supplementation of MSPBS resources with departmental resources earmarked for health care, stipulated annually in the cooperation agreement. Such resources make up a part of local counterpart financing for program activities.	Budgeting in line wit needs for all levels c Efficient local resour management.
not updated ear	b.1 Inefficient allocation of resources and internal inefficiency in their use. b.2 Inadequate budget allocations for infrastructure maintenance; infrastructure and equipment in serious disrepair.		b.3 Budgeting process based on a formula involving demographic and poverty indicators, to rationalize the regional and departmental budget transfer process. Introduces transparency and equity. b.4 Rehabilitation and equipment based on a needs assessment and indicators of use. MSPBS commitment to allocate enough resources for maintenance.	Cost recovery for ca with private insuranc security. Technical committee the departmental lev with participation by government agencie Health Directorate, D Health Secretariat), t
agement by ablishments of urces Law)	c.1 Impossible to create incentives to encourage productivity and appropriate resource management. c.2 Lack of inputs at the local level.		c.3 Management of own resources by health care establishments.	sector, and social se

TICS OF THE ECTOR	CONSEQUENCES	ACTIONS IN THE PUBLIC SECTOR		
		SHORT TERM (Measures already taken by the government)	MEDIUM TERM With the program (5 years)	LONG TE (10 to 15 ye
and control	d.1 No incentive to develop local management capacity.		d.2 Establishment of improved management mechanisms on the evaluation of which the exercise of managerial responsibilities depends. d.3 Improvement of the input procurement and distribution system. INVEC information system. d.4 Periodic evaluation of health care establishments, connected to technical health care and management training activities.	

PRIMARY HEALTH CARE REFORM PROGRAM (PR-0028)

TYPES OF PROGRESS INDICATORS BY PROJECT COMPONENT, DATA COLLECTED, SURVEY FREQUENCY AND LOCATION

INDICATOR	*TYPE*	*DATA COLLECTED BY INDICATOR*	*SURVEY FREQUENCY*	*SURVEY LOCATION*
COMPONENT I				
Subcomponent 1: strengthening of regional autonomy				
Discussion seminar	Result	Consensus on analysis of institutional capabilities	year 2	National
Legal framework — cooperation agreements	Result	Regulatory capacity and of the MSPBS	year 1	Regional
Number of agreements — Regional Directorate and Departmental Secretariat	Process	Regulatory capacity and of the MSPBS	yearly	Departmental
Number of Departmental Health Councils in operation	Process	Departments' organizational capacity	yearly	Departmental
% of MSPBS budget transferred to regions	Process	Monitoring by central government	yearly	National
Budget allocation to health care in each region, per capita	Result	Equity in resource allocation	yearly	Reg. + Dept.
% performance of budget by department	Result	Regions' level of efficiency	yearly	Regional
% administrative expenses in regional health care budget	Result	System's efficiency	yearly	Regional
Improved management				
Number of establishments retaining own resources and implementing improved management mechanisms	Process	Effective implementation of component	yearly	Establishments
% of cost recovery at participating establishments	Result	Sustainability of component	yearly	Establishments
Average absenteeism of establishment staff (excluding vacations)	Result	Efficiency of component	yearly	Establishments
Cooperation among providers and regulation of private sector				
Number of cooperation agreements concluded with IPS and private sector	Process	Inclusion of providers	yearly	Regional
Private sector regulation bill	Process	MSPBS's regulatory capacity	year 3	National
Enactment of private sector regulation law	Result	MSPBS's regulatory capacity	year 4	National
Design, startup of Office of Health Superintendent	Process	MSPBS's regulatory capacity	year 4	National
Subcomponent 2: "outstanding professional" initiative				
Number of establishments with "outstanding professional" staff members	Process	Dimensional impact of component	yearly	Establishments
% departmental cofinancing for "outstanding professional" initiative	Process	Departments' level of commitment	yearly	Departmental
Subcomponent 3: improvement of vital statistics				
Number of people trained to gather/process data	Process	Promotion of importance of data	yearly	Regional
Number of birth attendants reporting data on births	Result	Elimination of reasons for underreporting births	yearly	Regional
% of incomplete records received by Regional Health Directorate	Result	Level of reliability of data	yearly	Regional
Ratio of registered births/expected births	Result	Decrease in underreporting of births	yearly	Regional
Ratio recorded deaths/expected deaths	Result	Decrease in underreporting of deaths	yearly	Regional

Component II				
Subcomponent 1: human resource development *				
% health care staff that received health care technical training	Process	Effective implementation of component	yearly	Regional
Number of Chaé birth attendants trained	Process	Influence in rural areas	yearly	Regional
Number of management trainees with full training cycle	Process	Structural dimension of component	yearly	Regional
Number of patients referred by trained birth attendants	Result	Integration into the health care system	yearly	Establishments
Number of cases of maternal infection at trained establishments	Result	Improvement in health care services	yearly	Regional
Number of trained establishments with excellent evaluation of impact on quality	Result	Effectiveness of technical training in health care	yearly	Regional
Subcomponent 2: improved input procurement and supply system				
% of establishments regularly providing basic medicines	Process	Operation of distribution system	yearly	Establishments
Average number of days waiting for delivery of requested medicine	Result	Efficiency of system	yearly	Establishments
% establishments with registry of medicine use	Process	Individualization of use and responsibility	yearly	Establishments
Value of inputs and medicines lost as % of total	Result	Decrease in current losses	yearly	Regional
Number of pregnant women receiving medicines at center providing care	Result	Improvement in child health care — MSPBS	yearly	Establishments
Number of children under age 5 with ACI and ADD with supplied pharmaceuticals	Result	Improvement in child health care — MSPBS	yearly	Establishments
Number of birth attendants registered with MSPBS and receiving kits	Process	Territorial scope of program	yearly	Regional
% establishments evaluated for medicine management	Process	Operation of audit system	yearly	Establishments
Subcomponents 3 and 4: infrastructure rehabilitation and equipment; referral system				
Number of establishments refurbished and equipped	Process	Effective performance of component	yearly	Establishments
Number of establishments with communication system installed and training	Process	Effective performance of component	yearly	Establishments
Spending on maintenance as % of value of existing infrastructure, by establishment	Process	Structural modification in budgeting	yearly	Regional
Number of high-risk births referred to refurbished centers	Result	Referral system in operation	yearly	Establishments
Number of hospital infections in refurbished centers	Result	Improvement in quality of care	yearly	Establishments
Occupancy rate at refurbished centers	Result	Efficiency of type "A" centers	yearly	Establishments
Hospital bed turnover at refurbished centers (average stay)	Result	Efficiency of type "A" centers	yearly	Establishments
Budget appropriation to cover the departments' maintenance plans	Process	Fulfillment of maintenance commitment	yearly	Regional
Subcomponent 5: community information and education (IED)				
% of women seen at MSPBS who had heard radio spots	Result	Scope of component	yearly	Regional
% of couples who receive family planning devices at MSPBS and use them	Result	Efficiency of component	yearly	Regional
Number of public performances and other events	Process	Effective execution	yearly	Regional

*To be supplemented with evaluation to be conducted by training team

INDICATORS FOR MONITORING PROGRESS IN SECTOR MODERNIZATION ACTIVITIES – *Component I*

	Year 1	Year 2	Year 3	Year 4	Ye
egional autonomy					
stitutional capabilities	Study findings	National seminar	Ministerial resolution		
ork – cooperation					
etween Regional rates and departmental	Five agreements in force (fulfillment 60% goals)	Five agreements in force (fulfillment 70% goals)	Five agreements in force (fulfillment 80% goals)	Five agreements in force (fulfillment 90% goals)	Five agreemer (fulfillment 100
mong providers ate, IPS)	Design and approval of appropriate legal framework	At least five agreements	At least 10 agreements	At least 20 agreements	At least 30 agr
lational Health Council tional Health System ed)	Proposal CNS functions Supplemental legislation	Approval of supplemental legislation			
departmental budget resources	Ministerial resolution and agreement with Ministry of Finance. At least 10% of budget according to formula	Formula continues to be improved. 20% to 30% of budget according to formula	30% to 40% regional budget allocation according to formula	40% to 50% regional budget allocation according to formula	50% + budge according to f
regulation	Taxonomy	Regulatory framework	Approval of legislation	Setup of Superintendency	
emination and ilding activities	Development of regional bulletin	At least three bulletins circulated. Minutes of four discussion events.	At least six bulletins and minutes of eight events.	At least 10 bulletins and minutes of 12 events	At least 15 bul minutes of 15
npetition in the labor ng Professional")	Initiative recognized and operating; at least 15% of the proposed goal	25% of the proposed goal	50% of the proposed goal	75% of the proposed goal	100% of the g 75 positions h
proved management 1/	Five regional hospitals with level 1 improved management mechanisms	At least 10 establishments involved in level 2 improved management mechanisms	At least 20 establishments involved in level 3 improved management mechanisms	At least 40 establishments involved in level 3 improved management mechanisms	At least 50 est involved in lev management r

ed management mechanisms: involve the Regional Directorate of the MSPBS, the Departmental Health Secretariat and the Regional Hospital (HR).
es main health centers, Regional Hospital and authorities mentioned.
es health posts, health centers, Regional Hospital, the authorities mentioned and local authorities.

MSPBS/OPCI-IDB
PRIMARY HEALTH CARE REFORM PROGRAM (PR-0028)

ANNUAL INVESTMENT PLAN UNDER THE PROGRAM

MAIN PROCUREMENT PACKAGES UNDER THE PROJECT	FINANCING (US$000)			PROCUREMENT METHOD ICB or OTHER	PREQUALI-FICATION YES/NO	PUBLICATION OF SPN		
						SEM/ YEAR	PRESS	
	IDB	LOCAL	TOTAL				INT'L	LOCAL
			YEAR 1					
1. Works: hospital infrastructure	2,137.5	0.0	2,137.5	ICB	YES	YEAR	YES	YES
2. Medical equipment, furniture, implements, and transportation	1,612.5	0.0	1,612.5	ICB	NO	YEAR	YES	YES
3. Communications equipment and vehicles (referral system)	0.0	0.0	0.0	-	-	-	-	-
4. Equipment for information system and INVEC	234.3	0.0	234.3	LCB	NO	YEAR	NO	YES
5. Medicines and inputs	2,323.8	292.7	2,616.5	ICB	NO	YEAR	YES	YES
Subtotal	6,308.1	292.7	6,600.8					
			YEAR 2					
1. Works: hospital infrastructure	3,505.5	0,0	3,505.5	ICB	YES	YEAR	YES	YES
2. Medical equipment, furniture, implements, and transportation	2,644.5	0,0	2,644.5	ICB	NO	YEAR	YES	YES
3. Communications equipment and vehicles (referral system)	958.0	0,0	958.0	ICB	NO	YEAR	YES	YES
4. Equipment for information system and INVEC	0.0	0,0	0.0	-	-	-	-	-
5. Medicines and inputs	0.0	0,0	0.0	-	-	-	-	-
Subtotal	7,108.0	0,0	7,108.0					
			YEAR 3					
1. Works: hospital infrastructure	3,648.0	0.0	3,648.0	ICB	YES	YEAR	YES	YES
2. Medical equipment, furniture, implements, and transportation	2,752.0	0.0	2,752.0	ICB	NO	YEAR	YES	YES
3. Communications equipment and vehicles (referral system)	958.0	0.0	958.0	ICB	NO	YEAR	YES	YES
4. Equipment for information system and INVEC	0.0	0.0	0.0	-	-	-	-	-
5. Medicines and inputs	2,131.0	2,237.8	4,368.8	ICB	NO	YEAR	YES	YES
Subtotal	9,489.0	2,237.8	11,726.8					

ICB = International Competitive Bidding
LCB = Local Competitive Bidding
SPN = Special Procurement Notice

MAIN PROCUREMENT PACKAGES UNDER THE PROJECT	FINANCING (US$000)			PROCUREMENT METHOD ICB or OTHER	PREQUALI-FICATION YES/NO	PUBLICATION OF SPN		
						SEM/ YEAR	PRESS	
	IDB	LOCAL	TOTAL				INT'L	LOCAL
			YEAR 4					
1. Works: hospital infrastructure	2,223.0	0,0	2,223.0	LCB	NO	YEAR	NO	YES
2. Medical equipment, furniture, implements, and transportation	1,677.0	0,0	1,677.0	ICB	NO	YEAR	YES	YES
3. Communications equipment and vehicles (referral system)	0.0	0,0	0.0	-	-	-	-	-
4. Equipment for information system and INVEC	0.0	0,0	0.0	-	-	-	-	-
5. Medicines and inputs	0.0	0,0	0.0	-	-	-	-	-
Subtotal	3,900.0	0,0	3,900.0					
			YEAR 5					
1. Works: hospital infrastructure	1,026.0	0.0	1,026.0	LCB	NO	YEAR	NO	YES
2. Medical equipment, furniture, implements, and transportation	774.0	0.0	774.0	ICB	NO	YEAR	YES	YES
3. Communications equipment and vehicles (referral system)	0.0	0.0	0.0	-	-	-	-	-
4. Equipment for information system and INVEC	0.0	0.0	0.0	-	-	-	-	-
5. Medicines and inputs	774.9	2,324.8	3,099.7	ICB	NO	YEAR	YES	YES
Subtotal	2,574.9	2,324.8	4,899.7					
GRAND TOTAL	29,380.0	4,855.3	34,235.3					

ICB = International Competitive Bidding
LCB = Local Competitive Bidding
SPN = Special Procurement Notice

RE1/LEG/1266
Original:Spanish

PROPOSED RESOLUTION

PARAGUAY. LOAN No. ___/OC-PR.
(Primary Healthcare Reform Program)

The Board of Executive Directors

RESOLVES:

That the President of the Bank, or such representative as he shall designate, is authorized, in the name and on behalf of the Bank as administrator of the Intermediate Financing Facility Account, hereinafter referred to as the "account" to enter into such contract as may be necessary with the Republic of Paraguay, as Borrower, and to adopt other pertinent measures to use the resources of the account to pay a part of the interest due by the Borrower on outstanding balances of the amounts indicated below, which are part of the loan authorized by Resolution DE- / . Such contract will be in accordance with the provisions set forth in Document FN-263-2, as amended, approved by the Board of Executive Directors on December 21, 1983.

The amounts referred to above are the following: (a) twelve million five hundred thousand dollars of the United States of America (US$12,500,000); (b) sixteen million two hundred eighty five thousand four hundred twenty five German marks (DM16,285,425); and (c) one billion one hundred ninety five million three hundred fifty thousand Japanese yen (JP¥$1,195,350,000).

REG1/LEG/1265
Original:Spanish

PROPOSED RESOLUTION

PARAGUAY. LOAN /OC-PR TO THE REPUBLIC OF PARAGUAY
(Primary Healthcare Reform Program)

The Board of Executive Directors

RESOLVES:

That the President of the Bank, or such representative as he shall designate, is authorized, in the name and on behalf of the Bank, to enter into such contract or contracts as may be necessary with the Republic of Paraguay, as Borrower, for the purpose of granting it a financing to cooperate in the execution of a Primary Healthcare Reform Program. The financing, which will be subject to the "Special Contractual Conditions" and the "Terms and Financial Conditions" of the Executive Summary of the Loan Proposal, will be for the following amounts: (a) nineteen million five hundred thousand dollars of the United States of America (US$19,500,000); (b) sixteen million two hundred eighty five thousand four hundred twenty five German marks (DM16,285,425); and (c) one billion one hundred ninety five million three hundred fifty thousand Japanese yen (JP¥$1,195,350,000). Such amounts form part of the Single Currency Facility of the Ordinary Capital resources of the Bank.