

GUATEMALA

**IMPROVED ACCESS AND QUALITY OF HEALTH AND NUTRITION
SERVICES – PHASE I**

(GU-L1022)

LOAN PROPOSAL

This document was prepared by the project team consisting of Nohora Alvarado (SPH/CGU) and Ariadna García Prado (SCL/SPH), Project Team Leaders; Isabel Nieves (SCL/SPH); Miguel Coronado (LEG/SGO); Julián Cristia (RES/RES); Rita Sorio (SPH/CBR); Hugo Us (GDI/CGU); Juan Carlos Martell (CID/CGU); José Villatoro (CID/CGU); Carolina Chacón (CID/CGU); and Martha Guerra (SCL/SPH).

CONTENTS

PROJECT SUMMARY

I.	DESCRIPTION AND RESULTS MONITORING	1
A.	Background, challenges, and rationale	1
B.	Objectives and components	5
C.	Key results indicators	11
II.	FINANCING STRUCTURE AND RISKS	11
A.	Program cost	11
B.	Financing instruments	12
C.	Environmental and social safeguard risks	12
D.	Fiduciary risks	12
E.	Other risks	13
III.	IMPLEMENTATION AND MANAGEMENT PLAN	13
A.	Summary of implementation arrangements	13
B.	Summary of arrangements for monitoring results	14
C.	Design activities post approval	15

ANNEXES

Annex I:	Development Effectiveness Matrix (DEM) Summary
Annex II:	Results framework
Annex III:	Procurement plan

APPENDICES

Proposed resolution

ELECTRONIC LINKS	
REQUIRED	
1.	Safeguard Screening Form for classification of projects (SSF) http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=35171377
2.	Annual work plan (AWP) (Plan of activities for the first disbursement and the first 12 months of implementation) http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=35134080
3.	Monitoring and evaluation arrangements http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=35133044
4.	Itemized procurement plan http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=35130889
5.	Environmental and Social Management Report http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=35147265
OPTIONAL	
1.	Design of program evaluations http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=35134229
2.	Ex ante cost-benefit analysis http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=35130893
3.	Institutional analysis, procedures, other aspects of implementation capacity http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=35130886
4.	Draft version of program execution plan (PEP) http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=35134215

5. Participating municipios and coordination with other donors
<http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=35134238>
6. Itemized cost table
<http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=35133332>
7. Comprehensive community-based care for women and children (AINM-C)
<http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=35149073>

ABBREVIATIONS

AINM-C	Atención Integral a la Niñez y la Mujer Comunitaria [Comprehensive community-based care for women and children]
AWP	Annual work plan
DAS	Direcciones de Áreas Departamentales [Departmental health areas]
DMS	Distritos Municipales [Municipal health districts]
ENSMI	Encuesta Nacional de Salud Materno Infantil [National Survey on Maternal and Child Health]
ICAS	Institutional Capacity Assessment System
ICB	International competitive bidding
MMG	Mobile medical group
MSPAS	Ministry of Public Health and Social Welfare
NGO	Nongovernmental organization
PEC	Programa de Extensión de Cobertura [Coverage Expansion Program]
SIAS	Sistema Integral de Atención en Salud [Comprehensive Healthcare System]
SIGSA	Sistema de Información Gerencial de Salud [Health Management Information System]

PROJECT SUMMARY

GUATEMALA

IMPROVED ACCESS AND QUALITY OF HEALTH AND NUTRITION SERVICES – PHASE I (GU-L1022)

Financial Terms and Conditions						
Borrower: Republic of Guatemala Executing agency: Ministry of Public Health and Social Welfare (MSPAS)					OC	FSO
				Amortization period:	30 years	40 years
				Grace period:	66months	40 years
				Disbursement period:	4 years	4 years
Source	Phase I	Phase II	Phase II	Interest rate:	SCF – fixed (FN-507-6)	0.25
IDB (OC)	28 million	25 million	25 million	Inspection and supervision fee:	*	N/A
IDB (FSO)	7 million	0	0	Credit fee:	*	N/A
Counterpart	0	TBD	TBD			
Total	35 million	25 million	25 million	Currency:	U.S. dollars	
Project at a glance						
Project objective: The objective of the program is to improve access, use, and quality of primary and secondary health and nutrition services in at least 77 of the 147 municipios that currently have priority status under the conditional cash transfer program, ¹ in order to improve maternal and child health and reduce chronic malnutrition among children under two years of age. The first phase will focus on: (i) expanding coverage and improving the quality of basic healthcare services at the primary level of care; (ii) improving infrastructure at the primary level of care; (iii) expanding coverage and strengthening the delivery model of the preventive nutrition program, the AINM-C; (iv) improving coverage and delivery of micronutrient supplements to achieve compliance with regulations in force; (v) expanding the supply of skilled professionals in preventive nutrition and maternal and child health on the community teams, mobile teams, and health posts; and (vi) improving the quality and reliability of information generated by the MSPAS and the monitoring and supervision system for the primary and secondary levels of care.						
Special contractual conditions: (a) <u>Precedent to the first disbursement:</u> (i) approval and entry into force of the Operations Manual (paragraph 3.1); (ii) selection of the program coordination team (paragraph 3.2); and (iii) approval of the infrastructure, equipment, and human resources census study, as a special condition precedent to the disbursements corresponding to subcomponent 1.2 (paragraph 3.9); (b) <u>During execution:</u> (i) annual update of the annual work plan and procurement plan (paragraph 3.3); (ii) reimbursement of eligible expenditures chargeable against the loan (paragraph 3.4); (iii) establishment of a baseline for program evaluation purposes within the first year of program execution (paragraph 3.8); (iv) presentation by the borrower of annual financial statements to the Bank (paragraph 3.6); (v) completion of program evaluations (process, midterm, and impact evaluations) (paragraph 3.8); and (vi) partial disbursement of the loan (paragraph 2.2).						
Exceptions to Bank policies: For the reasons described in paragraph 3.3, a waiver of the eligibility requirements established in the procurement policy (document GN-2349-7) is requested in order to enable the participation of eligible World Bank providers.						
Project consistent with country strategy: Yes						
Project qualifies as: SEQ [X] PTI [X] Sector [X] Geographic [X] Headcount []						

* The credit fee and inspection and supervision fee will be established periodically by the Board of Executive Directors as part of its review of the Bank's lending charges, in accordance with the applicable provisions of the Bank's policy on lending rate methodology for Ordinary Capital loans. In no case will the credit fee exceed 0.75% or the inspection and supervision fee exceed, in a given six-month period, the amount that would result from applying 1% to the loan amount divided by the number of six-month periods included in the original disbursement period.

¹ This program is currently called Mi Familia Progresá (MIFAPRO).

I. DESCRIPTION AND RESULTS MONITORING

A. Background, challenges, and rationale

- 1.1 In recent decades, Guatemala has made substantial improvements in the health of its population. Life expectancy has risen by nearly 10 years and maternal and infant mortality have fallen significantly. These gains have been driven by economic growth accompanied by the increase, albeit slight, in social spending and above all by reforms in the health sector to improve maternal and child health in the poorest groups.²
- 1.2 Following the 1996 Peace Accords, the Ministry of Public Health and Social Welfare (MSPAS), with Bank support (GU-0023),³ introduced a reform package to reallocate healthcare expenditures to primary care and extend primary coverage⁴ to groups without access to public healthcare services. For this, the Coverage Expansion Program (PEC) was created, which contracts nongovernmental organizations (NGOs) to provide basic maternal and child healthcare services via mobile medical teams in the poorest municipios in the country. Despite the changes in government, coverage has expanded under the PEC to 4.6 million people in 2009. The PEC evaluation⁵ shows the positive impact the program has had on childhood immunizations and prenatal checkups by healthcare professionals. Over the past decade, the MSPAS has implemented two new programs to complement the PEC: (i) a community-based preventive nutrition strategy for women and children, known as Comprehensive Community-based Care for Women and Children ([AINM-C](#)), which the MSPAS has adopted as its core strategy for reducing chronic malnutrition, expanding it gradually through the PEC;⁶ and (ii) a program to strengthen the secondary level of care, which began in 2006 with support from the World Bank to improve access to institutional birthing.⁷ Lastly, since 2008 the Guatemalan government has been implementing a conditional cash

² World Bank, 2006: Key issues in Central American health reforms: diagnosis and strategic implications. Washington, D.C.

³ Program to Upgrade Healthcare Services.

⁴ The healthcare system consists of three levels of care: (i) primary care, with services delivered via health posts and the Extended Coverage Program (PEC); (ii) secondary care, via type A (with beds) and type B (without beds) health clinics; and (iii) tertiary care, via district, departmental, regional, and national referral and specialized hospitals.

⁵ *Cristia, Evans and Kim, 2009. Does contracting out primary care services improve child health? The case of rural Guatemala.* Mimeo, Inter-American Development Bank.

⁶ The AINM-C began in 2002 as a pilot program supported by the United States Agency for International Development. It received support from the Inter-American Development Bank in 2005 and has been receiving financing from the World Bank since 2007. To date, it is operating in 70 priority municipios identified by the Guatemalan government, in jurisdictions where there is extended coverage via NGOs, but it has not yet been evaluated. The proposed operation will continue to support the expansion of the AINM-C and will evaluate its impact.

⁷ Institutional birth is understood as a birth attended by skilled healthcare professionals, preferably in a health clinic.

transfer program as part of its social program; the Bank has been providing technical advisory services. The goal of the program is to improve the situation of poor and vulnerable families, and it includes coresponsibilities in health, education, and nutrition in the 147 municipios with the highest poverty rates. In addition, the IDB has approved a sector loan (GU-L1017)⁸ to support the country's efforts to strengthen health and nutrition services in municipios that have been given priority status under the conditional cash transfer program. Although these interventions have helped expand access to services and improve maternal and child health in Guatemala, there are still unmet needs, especially among the rural indigenous population, which remains the most disadvantaged group.

- 1.3 In Guatemala, 43.4% of children under the age of five suffer chronic malnutrition.⁹ The rate is 58.6% among indigenous children compared to 30.6% among non-indigenous children, and 51.8% among rural children compared to 28.8% among urban children.¹⁰ The direct causes of childhood malnutrition are poor nutritional habits and recurring infections. Only one third of children under six months are breastfed exclusively, while children from 6 to 24 months do not receive enough supplemental food at the right time to meet their energy, protein, and micronutrient needs. Women exhibit stunted growth upon reaching reproductive age, and about 20% of children are born with low birth weight (<2,500 grams).¹¹ The prevalence of low birth weights is highest among the indigenous population, contributing to the intergenerational transmission of malnutrition. The high rate of micronutrient deficiencies, especially in iron and vitamin A, among women and children is a serious public health problem. Anemia affects 20.2% of women of childbearing age,¹² and 21.1% and 38.8% of children between the age of 12 and 59 months have vitamin A and iron deficiencies, respectively.¹³
- 1.4 The maternal mortality rate (153/100,000 live births) in 2006 was three times higher in the indigenous population (211/100,000 live births) than in the *ladino*¹⁴ population (70/100,000 live births).¹⁵ Most maternal deaths result from

⁸ Human Capital Investment Program.

⁹ The rate was on the order of 30% and 20% in El Salvador and Nicaragua in 2004.

¹⁰ National Survey on Maternal and Child Health (ENSMI) 2008-2009, Guatemala, 2009.

¹¹ Boy, Erick, N. Bruce, and H. Delgado, "Birth Weight and Exposure to Kitchen Wood Smoke During Pregnancy in Rural Guatemala," *Environmental Health Perspectives*, Vol. 10, 2002.

¹² Monteith, R., P. Stupp, and S. McCracken, 2005. "Reproductive, maternal, and child health in Central America. Trends and challenges facing women and children," Division of Reproductive Health, Centers for Disease Control and Prevention, USAID.

¹³ Micronutrient Initiative, 2005. Vitamin and Mineral Deficiency: National Damage Assessment Reports. National Protection Audits. Ottawa. www.micronutrient.org

¹⁴ In Guatemala, *mestizos* are known as *ladinos*.

¹⁵ SEGEPLAN 2006: "Hacia el Cumplimiento de los Objetivos de Desarrollo del Milenio en Guatemala [Fulfilling the Millennium Development Goals in Guatemala]."

complications in childbirth and during the first 24 hours following childbirth. The institutional birth rate in rural areas is 36.4%. Many rural women received just one prenatal checkup (54.3%), and only a few receive two or three prenatal checkups (21.9% and 5%, respectively). Moreover, very few (20.8%) received a postpartum checkup in 2008. Other factors contributing to maternal mortality, especially among indigenous women, are iron deficiency and maternal malnutrition.

- 1.5 The infant mortality rate remains high compared to other countries in the region.¹⁶ The most frequent causes are acute respiratory infections and diarrheal illnesses, although the underlying cause in at least half the cases is malnutrition.¹⁷
- 1.6 The following is a brief description of the structure of the health sector and its principal challenges:
- 1.7 Guatemala's healthcare system has three component systems: the public, private, and social security systems. Traditional medicine is practiced alongside, but not in coordination with, these component systems.¹⁸ The public system consists of the MSPAS at the central level, the departmental health areas (DAS), and the municipal health districts (DMS). It is a fragmented system, which reflects the limited coordination between the levels of care and facilities, as well as weak referral and cross-referral mechanisms. The level of fragmentation is exacerbated by the weakness of the MSPAS as the apex agency of the system. Other problems in the public healthcare system are as follows:
- 1.8 **Inadequate and unequal access to health and nutrition services.** Public healthcare services are not equally accessible to all segments of the population. A full 95% of low-income groups and 91% of the indigenous population must travel for over an hour to reach these services.¹⁹ Despite the fact that the government has expanded the geographic coverage of health and nutrition services, an estimated 14% of the population still has no access.²⁰ In addition, the system continues to focus on curative care and specialized and hospital services in urban areas, and more resources need to be channeled towards primary care. Primary and secondary healthcare services fall far short of adequately meeting the needs of the population: infrastructure is dilapidated, some areas lack health posts or clinics, and there are problems with quality of care (lack of inputs, equipment, and skilled personnel).

¹⁶ See [Comparative table between countries](#).

¹⁷ The recent food crisis unleashed by the El Niño drought along with the global financial crisis has exacerbated these problems (with children who once suffered chronic malnutrition now suffering acute malnutrition) and the indicators have probably worsened.

¹⁸ There is a legal framework for promoting a multicultural health system, but in practice no coordination or integration exists between the formal and traditional health models.

¹⁹ Gragnolati and Marini. *Health and Poverty in Guatemala*. Policy Research Working Paper No. 2966, LAC Region, World Bank, Washington, D.C., 2003.

²⁰ World Bank, Expanding Opportunities for Vulnerable Groups Project, 2009; project appraisal document on proposed loan.

- 1.9 In addition to the geographic obstacles and supply problems, there are cultural and economic barriers. According to the 2006 National Survey of Living Conditions, 11% of Guatemalans prefer not to use the formal healthcare system for cultural reasons,²¹ 9% do not have enough time, and 62% report not having enough money to use the system.²² The public healthcare system has major weaknesses in matters of inclusion and cultural relevance. Although some initiatives have been pursued to tailor formal health services to the needs of the indigenous population,²³ these have been isolated interventions.
- 1.10 **Limited inclusion of effective nutrition promotion measures in preventive healthcare services.** Although the MSPAS has implemented the AINM-C through the Coverage Expansion Program (PEC), there are still poor municipios and communities without it. In addition, coordination of the AINM-C with healthcare services must be improved. Accordingly, support is needed mainly to help the MSPAS incorporate effective preventive nutrition measures into primary care, strengthen community-based educational programs to change eating habits and their coordination with healthcare services, and improve the distribution and coverage of micronutrient supplements.²⁴
- 1.11 **Scarcity and inefficient and inequitable distribution of human resources.** Among the factors limiting and stalling improvements in primary care access and quality are the scarcity of health professionals and technicians with the skills to meet the healthcare and nutrition needs of rural and poor populations. There is a glaring shortage of doctors, registered nurses, and nutritionists in Guatemala, with about 10 doctors and 2 registered nurses for every 10,000 people.²⁵ These professionals are concentrated in cities, mostly in hospitals. In 2007, 47% of doctors and 33% of technical personnel hired by the MSPAS were located in the metropolitan capital region, home to 22% of the Guatemalan population, and of these doctors, 79% worked in hospitals.²⁶ Furthermore, the training programs provided by universities and schools do not offer an approach based on health promotion and prevention, which is critical in primary care. Expanding the supply of skilled professionals in rural areas will require additional efforts by the MSPAS

²¹ Reasons include lack of confidence in the system, health professionals do not speak their language, etc.

²² The respondents are referring to money to buy medicines and travel to the health post or clinic.

²³ See, for example, the program implemented by Medicus Mundi and the European Union. *Del dicho al hecho... Los avances de un primer nivel de atención en salud incluyente* [From vision to reality... Progress on the path to inclusive primary health care]. Guatemala, 2008.

²⁴ Marini, A. and M. Gragnolati. *Malnutrition and Poverty in Guatemala*. World Bank, Policy Research Working Paper No. 2967, 2003.

²⁵ The number of doctors ranges from 30.8 per 10,000 people in urban areas to just 2 per 10,000 people in rural areas. See *Health in the Americas*, 2007, Vol. II, Pan American Health Organization, p. 408.

²⁶ MSPAS, "Caracterización del personal y acciones de desarrollo de la Dirección General de Recursos Humanos 2004-2007 [Description of personnel and development actions in the Human Resources Division, 2004-2007]." PAHO Observatory of Human Resources in Health 1.

to improve human resource management, including, *inter alia*, adequate incentives for personnel.

- 1.12 **Weaknesses in the MSPAS monitoring and supervision system.** The Supervision, Monitoring, and Evaluation Unit at MSPAS headquarters oversees services at the level of the health areas and health clinics, but does not extend to the level of primary care. The departmental health areas (DAS) supervise care at that level, and they have an information and monitoring system for primary healthcare services, and specifically for the PEC, which produces information on services provided to individuals. However, the DAS have limited resources. Moreover, the quality of the data generated by the Health Management Information System (SIGSA) is low, which makes it harder for the MSPAS to monitor results and programs from the central level. The quality issues are mostly due to problems with primary data capture and errors in data compilation, which is typically manual, at the level of the health areas.
- 1.13 **Response by the Guatemalan government and the Bank in the sector.** As noted in paragraph 1.2, the Guatemalan government has invested in maternal and child health among the most disadvantaged groups and the Bank has supported and is continuing to support it in these efforts. The proposed operation will extend coverage of basic health and nutrition services to communities still without access, in municipios given priority status based on their poverty ranking, as well as respond to the increase in demand for services generated by the conditional cash transfer program. This operation will be coordinated with the World Bank program “Expanding Opportunities for Vulnerable Groups.” At the request of the MSPAS, each institution will finance the same program in different municipios with priority status,²⁷ with the exception of component 3 (see paragraph 1.26), which is not part of the World Bank program.
- 1.14 **The government’s strategy and the Bank’s country strategy.** The social pillar of the Government Plan 2008-2011 gives priority to investments in education, health, and nutrition in poor and extremely vulnerable households. The cornerstone of the government’s social policy is the conditional cash transfer program. The first objective of the Bank’s country strategy with Guatemala for 2008-2011²⁸ emphasized the importance of technical and/or financial support to help reduce chronic malnutrition, maternal and infant mortality, and diseases prevalent among poor children. This project is consistent with the Government Plan and the Bank’s country strategy.

B. Objectives and components

- 1.15 The objective of the program is to improve access, use, and quality of primary and secondary health and nutritional services in at least 77 of the 147 municipios that currently have priority status under the conditional cash transfer program, in order

²⁷ See [List of departments and municipios to receive IDB and World Bank financing](#).

²⁸ See document GN-2501.

to improve maternal and child health and reduce chronic malnutrition among children under two years of age. The specific objectives are to: (i) improve access to and use of health and nutritional services at the primary and secondary levels of care by expanding and strengthening the supply of healthcare services to meet the demand generated by the conditional cash transfer program; (ii) improve the quality of the preventive nutrition services provided by MSPAS at the primary and community levels of care; (iii) improve the quality of the supply of human resources in primary care, match it to sector needs, and strengthen human resource management at the MSPAS, especially with respect to planning, staffing, and tenure of healthcare professionals in isolated rural areas; and (iv) improve the information systems at the MSPAS and strengthen its capacity to monitor and supervise its policies and programs.

- 1.16 The program is structured as a multiphase investment loan consisting of three phases. The first phase will have an execution period of four years; the second and third phases will have execution periods of three years each. The content of each phase, as well as the transitions between phases, will be based on geographic criteria (activities will first be implemented in the poorest municipios) and complexity (the complexity of the interventions will gradually increase in order to build capacity in stages).²⁹ The multiphase instrument will serve to test, evaluate, and scale up innovations included in the program and make the corresponding adjustments prior to expanding the program.
- 1.17 The scope of the first phase is as follows: (i) to expand coverage and improve the quality of basic healthcare services at the primary level of care; (ii) to improve infrastructure at the primary level of care by refurbishing, building, and/or equipping health posts; (iii) to expand coverage and strengthen the delivery model of the preventive nutrition program, the AINM-C, as well as improve coordination of the program between the community and primary care facilities; (iv) to improve coverage and delivery of micronutrient supplements to achieve compliance with regulations in force; (v) to expand the supply of skilled professionals in preventive nutrition and maternal and child health on the community teams, mobile teams, and health posts; and (vi) to improve the quality and reliability of the information generated by the MSPAS and the monitoring and supervision system at the primary and secondary levels of care. The first phase will cover at least 47 of 77 municipios in six of the country's poorest departments.³⁰ The second and third phases will extend the program to the remaining municipios, focusing on the primary and secondary levels of care.
- 1.18 The milestone triggers for the program's second phase are presented in Table I-1.

²⁹ For example, interventions at the primary level of care will be firmly established before activities at the secondary level of care are initiated.

³⁰ [See List of departments and municipios in which Bank activities will be implemented, by order of priority, during the first phase of the program.](#)

Table I-1

Milestones ³¹	Means of verification
<ol style="list-style-type: none"> 1. Upon completion of the program impact evaluation and the AINM-C and mobile medical group (MMG) process evaluations, the MSPAS presents a proposal incorporating the main recommendations of these evaluations into the design of the second phase. 2. At least 50% of the priority municipios involved in the first phase of the program have full MMG teams (with trained technical and community staff, and inputs) that visit the community at least once per month. 3. The AINM-C is being implemented in at least 50% of the jurisdictions receiving primary care services (MMGs and NGOs) in 31³² of the 47 municipios covered by the first phase. 4. At least 50% of the eligible population (pregnant women and children under 24 months covered by NGOs and MMGs) in 31 of the 47 municipios involved in the first phase receive the micronutrient powder and iron and folic acid supplements according to MSPAS regulations. 5. The MSPAS signs annual agreements with educational institutions (training institutes and universities) to meet the demand for decentralized training of technical and professional staff in the primary care teams in the 77 municipios with priority status. It also sets the criteria for renewing the agreements. 6. The monitoring and supervision system for the primary level of care is in operation in at least 50% of the health areas encompassing the priority municipios. 7. The MSPAS presents a proposal for expanded financing to cover the recurrent costs of the MMGs and the AINM-C, for their implementation during the second phase of this program using fiscal resources. 	<p>Evaluation studies and MSPAS proposal approved by the Minister of Health.</p> <p>Final evaluation report on the MMG process.</p> <p>AINM-C process evaluation.</p> <p>Report from the MSPAS information and monitoring system</p> <p>Delivery of signed agreements and the criteria for renewing them.</p> <p>Report from the MSPAS monitoring and evaluation unit, validated by the Minister of Health.</p> <p>Presentation of a proposal validated by the Minister of Health.</p>

1.19 The first phase of the program has four components, described as follows.

1.20 **Component 1. Improving access and quality of healthcare services at the primary care level.** The objective of this component is to expand and strengthen the supply and quality of primary healthcare services, in order to increase access for beneficiaries of the conditional cash transfer program who remain without coverage. Financing will be provided for the following subcomponents:

1.21 **Subcomponent 1.1. Improving the healthcare delivery model (US\$9.9 million).** Financing will be provided to cover the per-beneficiary cost of the package of health and nutrition services and the personnel costs of the mobile medical groups (MMGs),³³ including vehicle purchases or rentals and transportation costs. The MMGs will be contracted by the DAS and administered by the DMS. This intervention will complement the services currently offered by primary care providers (health posts and NGOs) by serving areas not yet covered. Midterm and

³¹ Activities designed to meet the milestones will be financed by the program.

³² Sixteen are among the municipios given priority status under the conditional cash transfer program in 2009 and are already benefiting from the strengthened AINM-C and micronutrient supplements.

³³ MMGs are mobile groups that will travel to isolated rural communities at least once per month to provide basic health and nutrition services.

final evaluations of this intervention will be conducted in the first phase, with adjustments made based on the findings.

- 1.22 **Subcomponent 1.2. Strengthening infrastructure and equipment at the primary level of care (US\$3.6 million).** Financing will be provided to refurbish and equip health posts in communities located in the municipios covered by this phase. Financing will also be provided to build new health posts and retrofit existing structures, as well as for the equipment needed by the MMGs and health posts.
- 1.23 **Component 2. Improving preventive nutrition services.** The objectives of this component are to: (i) expand coverage and strengthen the delivery model of the preventive nutrition program, the AINM-C, and its coordination with the primary level of care; and (ii) improve coverage and delivery of micronutrient supplements to come into compliance with regulations in force and prevent chronic malnutrition among children under two years of age. The delivery of these nutritional services in the community and the healthcare services provided under the first component are complementary and will be coordinated as part of the same package of basic services. In order to fulfill these objectives, financing will be provided for the following subcomponents:
- 1.24 **Subcomponent 2.1. Strengthening the community-based preventive nutrition strategy (AINM-C) (US\$6.5 million).** In order to boost the effectiveness of the AINM-C model in preventing chronic childhood malnutrition, this subcomponent will strengthen: (i) the quality of service delivery;³⁴ (ii) targeted care for children under 24 months; (iii) the community team;^{35, 36} (iv) supervision of the AINM-C; and (v) the operative links between the community level and the institutional level of nutritional services at the primary level of care.³⁷ The subcomponent will finance the cost of personnel responsible for delivering AINM-C services, as well as the cost of training and the materials needed to deploy the AINM-C.
- 1.25 **Subcomponent 2.2. Improving and expanding micronutrient supplement coverage (US\$2.1 million).** Financing will be provided for micronutrient

³⁴ Marini, A., L. Bassett, M. Bortman, R. Flores, M. Griffiths, and M. Salazar. "Promoción del crecimiento para prevenir la desnutrición crónica: Estrategias con base comunitaria en Centro América [Promoting growth to prevent chronic malnutrition. Community-based strategies in Central America]." World Bank, Latin America and Caribbean Region, June 2009.

³⁵ There will be three educators per 10,000 people in the PEC and two educators per 5,000 people in the MMGs to provide one-on-one counseling immediately after weight is taken and to conduct home visits to children who do not attend the sessions or are sick, not breastfeeding, or not gaining weight, as well as pregnant women who are in their final trimester or with some identified risk.

³⁶ The educators will travel with the MMGs but will have their own means of transportation and communication for when home visits are necessary.

³⁷ This will be achieved by: (i) using instruments that facilitate case referrals to the healthcare system; (ii) promoting better integration of educators in the work of the healthcare teams; (iii) conducting joint follow-up of referrals; and (iv) standardizing educational messages from educators and healthcare teams.

supplements (premixed vitamins and minerals in powder form for children; iron and folic acid for women) and consulting services to improve distribution logistics and control of distribution and delivery, down to the local level. Also, the subcomponent will finance the design and implementation of a system to reliably record the amount of micronutrients administered to each individual, in order to verify that deliveries match the dosing and frequency guidelines established in MSPAS regulations.³⁸

- 1.26 **Component 3. Managing the development of human resources in nutrition and health.** The objective of this component is to expand the supply of human resources in primary care, make it responsive to sector needs, and strengthen human resource management at the MSPAS, especially with respect to planning, staffing, training, and retention of health personnel in isolated rural areas. Financing will be provided for the following subcomponents:
- 1.27 **Subcomponent 3.1. Developing and training human resources (US\$5.5 million).** Financing will be provided to train health post staff, the mobile teams of the NGOs, and the MMGs, including community staff. The training proposal will focus on strengthening skill sets for good performance at the local level and the specific technical and job competencies for primary care. In addition, financing will be provided for decentralized strategies for training professional and technical personnel to provide maternal and child healthcare and preventive nutrition services.
- 1.28 **Subcomponent 3.2. Strengthening the role of the MSPAS as the lead agency in human resource management (US\$0.2 million).** The objective of this subcomponent is to promote improvements and efficiency in the management of processes and the performance of functions in the human resources area of the MSPAS. Financing will be provided primarily to: (i) implement an information subsystem for human resource planning and management; (ii) develop and implement human resource strategic planning and management instruments and methodologies at the central level; and (iii) offer specialized courses in human resource management for MSPAS technical and executive staff.
- 1.29 **Subcomponent 3.3. Developing alternatives for staffing and retention of healthcare professionals (US\$0.6 million).** The objective is to help the MSPAS identify and adopt viable proposals for the staffing and retention of technical and professional personnel in isolated rural areas. Financing will be provided for pilot projects based on incentive mechanisms as well as the corresponding evaluations, for the purpose of identifying and implementing the most viable and sustainable proposal.

³⁸ See [MSPAS micronutrient regulations](#).

- 1.30 **Component 4. Strengthening the information systems and the supervision and monitoring capacity of the MSPAS.** The objectives of this component³⁹ are to: (i) improve information on service delivery at the primary and secondary care levels; (ii) strengthen the supervision and monitoring system at the primary care level; and (iii) improve policy and program monitoring capacity at the MSPAS. To fulfill these objectives, financing will be provided for the following subcomponents:
- 1.31 **Subcomponent 4.1. Improving information systems (US\$0.7 million).** The Health Management Information System (SIGSA) will be strengthened at three levels: (i) at the health district level, the MSPAS initiative to implement electronic medical records for the population served by health posts, clinics, and MMGs will be supported, with financing for 60 municipios with priority status; (ii) at the health area level, the capacity to receive and process data from the district level and generate data will be strengthened; and (iii) at the central level, the capacity to provide remote-access technical support and to back up system databases will be strengthened.
- 1.32 **Subcomponent 4.2. Strengthening the monitoring and supervision system at the primary and secondary care levels (US\$1.7 million).** Financing will be provided to hire supervisors and cover transportation costs at the health area level, for which purpose the central level will be strengthened. These activities⁴⁰ will serve to ensure regular, timely supervision of the primary and secondary care services provided in the municipios with priority status.⁴¹ In addition, financing will be provided for external technical audits and the corresponding annual reports.
- 1.33 **Subcomponent 4.3. Improving policy and program monitoring capacity at the MSPAS (US\$1 million).** A program impact evaluation, particularly of the AINM-C and the MMGs, will be conducted, to include the establishment of a baseline and an endline and midterm monitoring studies. The information gathered to perform this evaluation will be used to monitor the indicators in the results framework.
- 1.34 **Cultural relevance in service delivery.** This is a crosscutting element of activities that will be incorporated into each of the components. Component 1: (i) survey of indigenous and non-indigenous therapists; (ii) identification of opportunities for incorporating indigenous therapists in primary care and amendment of the MSPAS healthcare guidelines to reflect their functions; (iii) design and implementation of activities to strengthen communication between midwives and health services in the referral and monitoring of pregnant women; and (iv) service delivery preferably in the local language. Component 2: (i) design and inclusion of an intercultural

³⁹ The MSPAS information and monitoring system will be used during implementation of the program, although the purpose of this component is to strengthen it.

⁴⁰ Financing will be provided for computer equipment and support services.

⁴¹ Financing and implementation of this subcomponent has been coordinated with the World Bank.

module for educators; (ii) incorporation of midwives in activities to promote exclusive breastfeeding; and (iii) studies to identify the main determinants of health and nutrition status among indigenous and non-indigenous children. Component 3: (i) design and inclusion of intercultural modules; and (ii) activities to facilitate the incorporation of personnel who speak the local language and are familiar with the local culture. Component 4: modification of SIGSA instruments to allow for standardized recording of the ethnicity of service users.

C. Key results indicators

- 1.35 The program is expected to have a positive impact on chronic malnutrition and maternal and child health. Specifically, the development or impact indicators are: (i) prevalence of chronic malnutrition among children under two; and (ii) anemia among children under two and pregnant and lactating women.
- 1.36 Component 1 activities will expand access to and use of basic healthcare services and increase the percentage of women receiving prenatal check-ups by qualified medical personnel and the percentage of children receiving the full schedule of immunizations. Component 2 activities will improve community-based preventive nutrition services and micronutrient supplementation in women and children. Component 3 activities are expected to generate a supply of healthcare professionals trained to provide health and nutrition services in the MMGs and at the health posts. Lastly, component 4 activities will strengthen the primary and secondary care supervision system.

II. FINANCING STRUCTURE AND RISKS

A. Program cost

- 2.1 The total cost of the multiphase program will be US\$85 million. The first phase will cost US\$35 million, and the second and third phases will cost US\$25 million each. Component costs for the first phase are presented in Table I-2.

Table I-2. Summary cost table for the first phase⁴²

	Total IDB	%
COMPONENT 1. Improving access and quality of healthcare services at the primary care level	13,557,417	38.7
COMPONENT 2. Improving preventive nutrition services	8,653,547	24.7
COMPONENT 3. Managing the development of human resources in nutrition and health	6,296,717	18.0
COMPONENT 4. Strengthening the information systems and the supervision and monitoring capacity of the MSPAS	3,517,673	10.1
Program administration	2,336,000	6.7
Audits	100,000	0.3
Contingencies	538,646	1.5
TOTAL	35,000,000	

⁴² For more information, see the [itemized cost table](#).

B. Financing instruments

- 2.2 The financing instrument for this operation is a multiphase program loan (MPL) structured in three phases, which will promote the continuity (through the fulfillment of milestones) of program-financed activities. The disbursement period for the first phase will be four years (see Table I-3). A partial disbursement of up to US\$250,000 may be made upon fulfillment of the conditions precedent stipulated in the General Conditions and with the Bank's authorization. This partial disbursement will be used to finance startup activities, especially to contract the program support team, purchase its basic equipment, and establish the baseline.

Table 1-3. Disbursement schedule for the first phase

Source	Year 1	Year 2	Year 3	Year 4	Total
IDB	4,340,162	6,906,735	7,926,863	8,826,240	28,000,000
FSO	1,085,041	1,726,683	1,981,716	2,206,560	7,000,000
Total	5,425,203	8,633,418	9,908,579	11,032,800	35,000,000
% Annual	15.5%	24.6%	28.3%	31.5%	100%

C. Environmental and social safeguard risks

- 2.3 This program has been classified as a category "B" operation. Because it primarily entails minor refurbishment works and the construction of some health posts, no significant environmental impacts are expected. An environmental assessment of the program produced a number of recommendations that have been incorporated into the Operations Manual. The project team will ensure compliance with the Environment and Safeguard Compliance Policy (OP-703) and the Disaster Risk Management Policy (OP-704).
- 2.4 The program will have positive social impacts inasmuch as it will provide access to health and nutrition services to poor communities without coverage. In addition, specific activities in the area of cultural relevance (see paragraph 1.34) are planned. The project team will ensure compliance with the Indigenous Peoples Policy (OP-765) during program design and execution.

D. Fiduciary risks

- 2.5 The institutional assessment of the MSPAS⁴³ and the Bank's fiduciary team indicate that the fiduciary risk is medium. A combination of ex post and ex ante reviews will be used for procurements below the thresholds for international competitive bidding (ICB). Ex post reviews will be conducted semiannually during the first year or as determined by the Bank based on the experience acquired. The reviews will be performed through external audits and by the fiduciary team at the Bank's Country Office in Guatemala. All procurements in amounts above the ICB

⁴³ The assessment was conducted using the Institutional Capacity Assessment System (ICAS).

thresholds will be subject in their entirety to ex ante review. Once the operation has been approved by the government, the institutional capacity assessment of the MSPAS will be updated to confirm the procurement review arrangements. In order to strengthen the execution capacity of the MSPAS, the institutional capacity assessment includes an institutional strengthening plan,⁴⁴ and there are also plans to hold regular workshops on fiduciary and implementation issues and prepare an Operations Manual.

E. Other risks

- 2.6 The scarcity of healthcare professionals in rural areas could produce a bottleneck, hampering efforts to expand the supply of services and/or compromising the quality of service delivery. Component 3 includes measures to mitigate this risk.
- 2.7 There is a risk of a possible change in administration at program startup. To mitigate this risk, the proposal is to step up Bank dialogue with the presidential candidates and the new administration to ensure ownership of the program.
- 2.8 Sustainability. In the present context, there is no possibility of expanded financing to cover the recurrent costs corresponding to the first phase of the program. However, the MSPAS is expected to begin to finance recurrent costs in the second phase of the program, as specified in the milestones table. The recurrent costs of the program represent 0.05% of Guatemala's gross domestic product. These costs will be more than offset by the beneficial effects of the program. The ex ante cost-benefit analysis of the program's main activities⁴⁵ indicates a return of US\$1.40 for every US\$1 invested.⁴⁶

III. IMPLEMENTATION AND MANAGEMENT PLAN

A. Summary of implementation arrangements

- 3.1 Borrower and executing agency. The borrower will be the Republic of Guatemala, and the executing agency will be the Ministry of Public Health and Social Welfare (MSPAS), with support from its various attached entities and a program-financed support team. The counterpart will: (i) handle general and financial administration of the program; (ii) execute the program, including preparing and implementing the annual work plan (AWP); (iii) monitor progress; (iv) plan and monitor the procurement of goods, works, and services; (v) prepare and process payments; (vi) keep an adequate financial accounting system for program transactions; and (vii) prepare semiannual reports and deliver them to the Bank, in addition to others that will be identified in the Operations Manual. **The approval and entry into**

⁴⁴ See the [MSPAS institutional capacity assessment](#).

⁴⁵ MMG delivery of the basic package of healthcare services, which includes the AINM-C and the delivery of micronutrient supplements.

⁴⁶ For the complete analysis, see [Analysis of project cost and economic viability](#).

force of the Operations Manual will be a special condition precedent to the first disbursement.

- 3.2 In order to guarantee effective coordination between the World Bank and the IDB, a coordination team will be assembled, to include the MSPAS and the coordinators of both programs. **The selection of the program coordination team will be a condition precedent to the first disbursement.**
- 3.3 Fiduciary aspects. Goods, works, and consulting services will be procured in accordance with the Bank's policies. For the procurement of micronutrient supplements under subcomponent 2.2 only, a single bidding process open to eligible IDB and World Bank providers and financed by both institutions will be held, for the purpose of obtaining economies of scale and competitive prices.⁴⁷ Procurements will be subject to a combination of ex post and ex ante reviews as established in paragraph 2.5, the annual work plan, and the procurement plan, which will be updated annually.
- 3.4 Retroactive financing will be available for eligible expenditures pursuant to OP-504 that were incurred on or after the date of approval of the project profile (20 October 2009), including up to US\$200,000 for: the contracts for the core support team for program execution,⁴⁸ computer equipment, and the logistics services and office supplies needed for the team to function.
- 3.5 Disbursements will be made via an advance funding mechanism in accordance with the financing plan prepared by the executing agency in coordination with the Bank, which will be managed through the general account of the Treasury. Disbursements will be processed in accordance with the Operations Manual and the Bank's disbursement guidelines.
- 3.6 The borrower will deliver the program's annual consolidated financial statements to the Bank within 120 days after the end of the fiscal year. The annual and final audits will be conducted by a firm of independent auditors acceptable to the Bank using proceeds from the loan.

B. Summary of arrangements for monitoring results

- 3.7 Indicators will be generated using administrative records from SIGSA along with primary data from specific surveys. The MSPAS will deliver annual work plans and semiannual progress reports to the Bank, indicating the achievements made in each component based on the results indicators.
- 3.8 Evaluations (process, midterm, and impact) of the program, particularly of the AINM-C and the MMGs, will be conducted to identify operational problems and potential solutions and improve the effectiveness of these interventions. A program

⁴⁷ This will enable the MSPAS to purchase micronutrient supplements at once for all departments participating in the World Bank and IDB programs.

⁴⁸ General program coordinator, coordinators for each component, financial administrative coordinator, and procurement specialists.

baseline will be established for evaluation purposes within the first year of program execution.

C. Design activities post approval

- 3.9 The Operations Manual will be completed during program execution and the following activities will be pursued to strengthen the design of the operation: (i) **approval of the infrastructure, equipment, and human resources census study, as a special condition precedent to the disbursements for subcomponent 1.2;** (ii) diagnostic assessment of the logistics and control system for distribution of micronutrient supplements, and design of interventions to resolve system weaknesses; (iii) study and pilot projects on human resources and incentives to reduce turnover among health and nutrition professionals working in rural areas; (iv) study on referral and cross-referral networks and mechanisms; and (v) survey to update information on the availability and skills of indigenous and non-indigenous therapists.

Development Effectiveness Matrix Summary

Indicator	Score	Maximum Score
I. Strategic Relevance	High	
Section 1. IDB Strategic Development Objectives	5.6	10
Country Diversification	2.0	2
Corporate Initiatives	0.0	2.5
Harmonization and Alignment	1.6	3.5
Beneficiary Target Population	2.0	2
Section 2. Country Strategy Development Objectives	5.4	10
Country Strategy Sector Diagnosis	1.8	6
Country Strategy sector objective & indicator	3.6	4
II. Development Outcomes - Evaluability	Highly satisfactory	
3. Evidence-based Assessment & Solution	8.9	10
4. Evaluation & Monitoring Plan	10.0	10
5. Cost-Benefit or Cost-Effectiveness	7.0	10
6. Risks & Mitigation Monitoring Matrix	7.5	10
III. IDB's Role - Additionality		
Section 7. Additionality	7.0	10
Technical Assistance provided prior to the project	0.0	3
Improvements in management of financial, procurement, monitoring or statistics internal controls	4.0	4
Improvements in environmental, health and labor performance	3.0	3

I. Strategic relevance: This operation is structured as a multiphase investment loan. Its objective is to improve access, use, and quality of health and nutrition services in 77 priority municipios identified by the government, in order to complement the conditional cash transfer program also operating in these municipios. The program goal is to improve maternal and child health and reduce chronic malnutrition among children under two years of age, which are two basic health problems in Guatemala. The project will target the poorest and most vulnerable segments of the country's population and will use country systems for financial administration, monitoring and evaluation, and environmental management activities.

II. Evaluability: A very rigorous diagnostic assessment has been conducted of the main problems in the health sector in relation to the identified problems: maternal and infant mortality and chronic malnutrition among children under 24 months, a critical age in childhood development. The operation calls for activities to address the identified problems, and generally has a very clearly defined logic, including indicators for monitoring outcomes. A comprehensive evaluation plan has been prepared, combining experimental and quasi-experimental methods to test the central hypotheses of the program with respect to the AINM-C model and the provision of services by mobile medical teams. The evaluation plan includes adequate indicators and a rigorous schedule for measuring the contributions of program-financed activities to the fulfillment of development objectives.

III. Additionality: The operation calls for the use and strengthening of information and monitoring/evaluation systems in the health sector. In addition, it is tied to technical-cooperation resources that will enable the country to take inventory of the sector's human resources and conduct related pilot studies. In general, the emphasis of the human resources needed to improve the quality of and access to basic healthcare services is geared towards improving job performance in the sector.

GUATEMALA
IMPROVED ACCESS AND QUALITY OF HEALTH AND NUTRITION SERVICES – PHASE I
(GU-L1022)

RESULTS FRAMEWORK

Project objective:	To improve access, use, and quality of primary and secondary health and nutritional services in at least 77 of the 147 priority municipios identified under the conditional cash transfer program MIFAPRO, in order to improve maternal and child health and reduce chronic malnutrition among children under two years of age.						
Outcome indicators / Direct effects *	2011 baseline			Target upon completion of first phase of program		Means of verification	Target population
Chronic malnutrition among children from 6 to 24 months	44.5%			38.5%		Impact evaluation survey	Population covered by MMG and strengthened AINM-C in 77 municipios
Anemia among children from 6 to 24 months	65%			53.6%		Impact evaluation survey	Population covered by MMG and strengthened AINM-C in 77 municipios
Anemia among pregnant and lactating women	22%			18.2%		2008 and subsequent National Maternal and Child Health Survey (ENSMI)	Population in 77 municipios
COMPONENT 1: Improving access and quality of healthcare services at the primary care level							
Output indicators	2011 baseline	2012	2013	2014	Cumulative target	Means of verification	Target population
1) Population covered by MMGs (in thousands)	0	107	235	343	343	MMG population survey	New population covered by MMGs in 47 municipios
2) Number of refurbished health posts	0	15	32	47	47	MSPAS report	47 municipios
3) Number of newly constructed health posts	0	4	8	12	12	MSPAS report	47 municipios

Intermediate outcome indicators	2011 baseline	2012	2013	2014	Cumulative target	Means of verification	Target population
1) Percentage of pregnant women receiving at least two checkups by MMG doctors or nurses, including one in the first trimester	0%	15%	22%	30%	30%	MSPAS information system	Pregnant women in communities covered by MMGs in the 47 municipios
2) Percentage of pregnant women seen by MMGs before the 12th week of pregnancy	0%	11%	16%	21%	21%	MSPAS information system	Pregnant women in communities covered by MMGs in the 47 municipios
3) Percentage of newborns seen for a checkup by MMGs in the first 28 days of life	0%	20%	30%	40%	40%	MSPAS information system	Pregnant women in communities covered by MMGs in the 47 municipios
4) Percentage of children under 12 months receiving full schedule of required immunizations by MMGs	0%	40%	60%	80%	80%	MSPAS information system	Children under 12 months in communities covered by MMGs in the 47 municipios
COMPONENT 2: Improving preventive nutrition services							
Output indicators	2011 baseline	2012	2013	2014	Cumulative target	Means of verification	Target population
1) Addition population of children from 0 to 24 months in communities covered by the strengthened AINM-C under the NGO extension strategy (in thousands)	0	47	47	47	47	PEC population census	New population covered by AINM-C in the 77 priority municipios in which NGOs provide extended coverage

2) Number of children in communities covered by the strengthened AINM-C under MMG strategy (in thousands)	0	6	14	20	20	MMG population census	New population covered by AINM-C in the 47 municipios in which MMGs operate
3) Percentage of children from 0 to 24 months who were weighed for two consecutive months in the final trimester under the AINM-C	0%	25%	35%	45%	45%	MSPAS information system	Children from 0 to 24 months covered by strengthened AINM-C in the 47 municipios
4) Percentage of children from 0 to 24 months who were weighed under the AINM-C the same number of times as months of life minus one	0%	10%	15%	20%	20%	MSPAS information system	Children from 0 to 24 months covered by strengthened AINM-C
Intermediate outcome indicators	2011 baseline	2012	2013	2014	Cumulative target	Means of verification	Target population
1) Percentage of children from 12 to 24 months receiving two Vitamin A supplements at or after 12 months of age by NGO mobile teams or MMGs	0%	35%	50%	70%	70%	MSPAS information system	Children from 0 to 24 months covered by strengthened AINM-C in the 47 municipios
2) Children from 6 to 59 months receiving the required micronutrient supplements in powder form by NGO mobile teams or MMGs	0%	40%	60%	80%	80%	MSPAS information system	Children from 0 to 24 months covered by strengthened AINM-C in the 47 municipios
COMPONENT 3: Managing the development of human resources in nutrition and health							
Output indicators	2011 baseline	2012	2013	2014	Cumulative target	Means of verification	Target population
1) Number of community personnel in the priority municipios who participated in basic training	0	2600	5400	8200	8200	MSPAS report	Community personnel in the MMGs in the 47 priority municipios

2) Number of technical personnel in MMGs who participated in basic training	0	95	200	295	295	MSPAS report	Technical personnel in the MMGs in the 47 priority municipios
3) Number of healthcare personnel at the primary care level (NGO mobile teams and health posts) who participated in basic training	0	115	215	281	281	MSPAS report	Health post personnel in the 47 priority municipios
4) Number of human resources professionals and technical specialists at the MSPAS (central and health area levels) who have completed the specialized course in human resources management	0	50	79	79	79	MSPAS report	Human resources at the central level of the MSPAS
5) Percentage of MMGs with at least one member who speaks the local language in the jurisdiction of coverage	0	60%	70%	80%	80%	MSPAS information system	Technical personnel in the MMGs in the 47 priority municipios
Intermediate outcome indicators	2011 baseline	2012	2013	2014	Cumulative target	Means of verification	Target population
1) Percentage of trained institutional facilitators, NGO mobile teams, and MMGs conducting weight exams according to regulation	0%	-	50%	-	50%	AINM-C process evaluation	Technical personnel in the MMGs in the 47 priority municipios
COMPONENT 4: Strengthening the information systems and the supervision and monitoring capacity of the MSPAS							
Output indicators	2011 baseline	2012	2013	2014	Cumulative target	Means of verification	Target population
1) Number of districts that have implemented electronic records at health posts and in MMGs	20	80	130	147	147	MSPAS report	Population in the 147 priority municipios
2) Number of health areas that have implemented the new primary care monitoring and supervision system	0	6	12	23	23	MSPAS report	Population in the 147 priority municipios

[illegible]

GUATEMALA
IMPROVED ACCESS AND QUALITY OF HEALTH AND NUTRITION SERVICES – PHASE I
(GU-L1022)

PROCUREMENT PLAN
(Period covered by this Procurement Plan: from 2011 to 2015)

Ref. No.	Category and description of procurement contract	Estimated cost of procurement (US\$000)	Procurement method	Review (ex ante or ex post)	Source of financing and percentage		Prequalification Yes/No	Estimated dates		Status	Comments
					IDB %	Local/ Other %		Publication of specific procurement notice	Completion of contract		
Works											
C.I.O.1	Refurbishment works for existing infrastructure (47 health posts) to strengthen the health services network (several NCB processes)	1,563,855	NCB	Ex post	100%		No			Pending	
C.I.O.2	Construction of 12 new health posts to strengthen the health services network	547,349	NCB	Ex post	100%		No			Pending	
Goods											
C.I.B.1	Furnishings for 59 health posts to strengthen the health services network (2 NCB processes)	319,880	NCB	Ex post	100%		No			Pending	
C.I.B.2	Medical equipment for 59 health posts to strengthen the health services network (2 NCB processes)	274,669	NCB	Ex post	100%		No			Pending	

Ref. No.	Category and description of procurement contract	Estimated cost of procurement (US\$000)	Procurement method	Review (ex ante or ex post)	Source of financing and percentage		Prequalification Yes/No	Estimated dates		Status	Comments
					IDB %	Local/ Other %		Publication of specific procurement notice	Completion of contract		
CIII.B.1	Computer equipment for the information subsystem for human resources management (38 computers, 28 printers, and 1 server)	44,000	S	Ex post	100%		No			Pending	
CIV.B.1	Computer equipment to strengthen the general health information system, at the local level of health districts (75 computers, 75 printers)	44,277	S	Ex post	100%		No			Pending	
CIV.B.2	Software licenses for health districts and health areas (25 health districts, 21 health areas)	16,626	S	Ex post	100%		No			Pending	
CIV.B.3.	Licenses for use on the central server (2 licenses)	250,000	ICB	Ex ante	100%		No			Pending	
CIV.B.4	Local servers for health areas (21 servers)	151,807	NCB	Ex post	100%		No			Pending	
CIV.B.5	Central servers (2 servers)	14,458	S	Ex post	100%		No			Pending	
CIV.B.6	External hard drives (21 units)	3,289	S	Ex post	100%		No			Pending	

Ref. No.	Category and description of procurement contract	Estimated cost of procurement (US\$000)	Procurement method	Review (ex ante or ex post)	Source of financing and percentage		Prequalification Yes/No	Estimated dates		Status	Comments
					IDB %	Local/ Other %		Publication of specific procurement notice	Completion of contract		
Non-consulting services											
CI.S.1	Logistics for workshops to introduce the MMG model, at the DAS, DMS, and community levels; several contracts with an average cost of US\$2,000	5,964	S	Ex post	100%		No			Pending	
CI.S.1	Logistics for workshops to improve delivery of the AINM-C, define functions, anthropometric survey; several contracts with an average cost of US\$2,000	12,500	S	Ex post	100%		No			Pending	
CI.S.2	Transportation for educators (vehicle rentals); several contracts with an average cost of US\$1,875.	221,250	S	Ex post	100%		No			Pending	
CI.S.3	Air transportation to Honduras, for visit to implement weight-gain methodology	5,000	S	Ex post	100%		No			Pending	
CIIS.1	Logistics for workshops on human resources information services	2,000	S	Ex post	100%		No			Pending	
CIIS.2	Publication of outreach material on the information system	500	S	Ex post	100%		No			Pending	

Ref. No.	Category and description of procurement contract	Estimated cost of procurement (US\$000)	Procurement method	Review (ex ante or ex post)	Source of financing and percentage		Prequalification Yes/No	Estimated dates		Status	Comments
					IDB %	Local/ Other %		Publication of specific procurement notice	Completion of contract		
CIIS.3	Training for technical and executive personnel in the Human Resources Division	8,000	S	Ex post	100%		No			Pending	
CIIS.4	Logistical services for seminars on human resources	5,000	S	Ex post	100%		No			Pending	
CIV.S.1	Installation of electrical networks for computer equipment at local DMS level (75 networks)	13,554	S	Ex post	100%		No			Pending	
CIV.S.2	Internet connections for computer equipment at local DMS level (75 connections)	32,530	S	Ex post	100%		No			Pending	
CIV.S.3	Ink cartridges for printers at local DMS level (750 units); 2 shopping processes	36,145	S	Ex post	100%		No			Pending	
CIV.S.4	Data entry services at local DMS level (23 data entry operators)	83,133	S	Ex post	100%		No			Pending	
CIV.S.5	Logistics for training information technology personnel (2 workshops)	3,614	S	Ex post	100%		No			Pending	
Consulting services											
CLI.1	Consultant for MMG implementation support team, DMS information technology assistant (47 contracts for 48 months)	594,578	NICQ	Ex post	100%		No			Pending	

Ref. No.	Category and description of procurement contract	Estimated cost of procurement (US\$000)	Procurement method	Review (ex ante or ex post)	Source of financing and percentage		Prequalification Yes/No	Estimated dates		Status	Comments
					IDB %	Local/ Other %		Publication of specific procurement notice	Completion of contract		
CI.I.2	Consultant for MMG implementation support team, DAS accountants (8 contracts for 48 months)	121,466	NICQ	Ex post	100%		No			Pending	
CI.I.3	Consultant for MMG implementation support team, DAS technical assistant (8 contracts for 48 months)	101,205	NICQ	Ex post	100%		No			Pending	
CI.I.4	Consultant to support the Comprehensive Healthcare System (SIAS) / Human Resources Division, medical specialist (2 contracts for 48 months)	131,566	NICQ	Ex post	100%		No			Pending	
CI.I.5	Consultant to support SIAS/HR, nutrition specialist (2 contracts for 48 months)	101,205	NICQ	Ex post	100%		No			Pending	
CI.I.6	Consultant to evaluate the first phase of the program	80,000	NICQ	Ex post	100%		No			Pending	
CI.I.1	Consultant to improve the delivery of the AINM-C, strengthening of the AINM-C methodology and model	45,000	NICQ	Ex post	100%		No			Pending	

Ref. No.	Category and description of procurement contract	Estimated cost of procurement (US\$000)	Procurement method	Review (ex ante or ex post)	Source of financing and percentage		Prequalification Yes/No	Estimated dates		Status	Comments
					IDB %	Local/ Other %		Publication of specific procurement notice	Completion of contract		
CII.I.2	Consultant to improve the delivery of the AINM-C, development and implementation of supervision plans	45,000	NICQ	Ex post	100%		No			Pending	
CII.I.3	Consultant to improve the delivery of the AINM-C, logistics improvements	45,000	NICQ	Ex post	100%		No			Pending	
CIII.I.1	Consultant to identify motivational factors for remaining in rural areas (3 months)	20,000	NICQ	Ex post	100%		No			Pending	
CIII.I.2	Consultant to support the proposed development of the incentives system	20,000	NICQ	Ex post	100%		No			Pending	
CIII.I.3	Consultant to establish baseline and evaluate the incentives mechanism	40,000	NICQ	Ex post	100%		No			Pending	
CIII.I.4	Specialized consultant in information technology for the human resources management subsystem	8,000	NICQ	Ex post	100%		No			Pending	
CIII.I.3	Consultant to support the SIGSA in the information subsystem for human resources management	60,000	NICQ	Ex post	100%		No			Pending	

Ref. No.	Category and description of procurement contract	Estimated cost of procurement (US\$000)	Procurement method	Review (ex ante or ex post)	Source of financing and percentage		Prequalification Yes/No	Estimated dates		Status	Comments
					IDB %	Local/ Other %		Publication of specific procurement notice	Completion of contract		
CIV.I.1	Consultant to support the MSPAS in program implementation, general program coordinator (48 months)	120,000	NICQ	Ex post	100%		No			Pending	
CIV.I.2	Consultant to support the MSPAS in program implementation, component coordinators (4 consultants for 48 months)	384,000	NICQ	Ex post	100%		No			Pending	
CIV.I.3	Consultant to support the MSPAS in program implementation, financial administration coordinator (48 months)	96,000	NICQ	Ex post	100%		No			Pending	
CIV.I.4	Consultants to support the MSPAS in program implementation, accountants (2 consultants for 48 months)	180,000	NICQ	Ex post	100%		No			Pending	
CIV.I.5	Consultant to support the MSPAS in program implementation, procurement officer (48 months)	60,000	NICQ	Ex post	100%		No			Pending	
CIV.I.6	Consultant to support the MSPAS in program implementation, procurement specialist (48 months)	60,000	NICQ	Ex post	100%		No			Pending	

Ref. No.	Category and description of procurement contract	Estimated cost of procurement (US\$000)	Procurement method	Review (ex ante or ex post)	Source of financing and percentage		Prequalification Yes/No	Estimated dates		Status	Comments
					IDB %	Local/ Other %		Publication of specific procurement notice	Completion of contract		
CIV.I.7	Consultant to support the MSPAS in program implementation, procurement assistant (48 months)	48,000	NICQ	Ex post	100%		No			Pending	
CIV.I.8	Consultant to support the MSPAS in program implementation, SIAS Division, engineering specialist (6 months)	24,000	NICQ	Ex post	100%		No			Pending	
CIV.I.9	Consultant to support the MSPAS in program implementation, SIAS Division, architecture specialist (36 months)	96,000	NICQ	Ex post	100%		No			Pending	
CIV.I.10	Consultant to support the MSPAS in program implementation, consultant to support program monitoring (48 months)	60,000	NICQ	Ex post	100%		No			Pending	
CLF.1	Consulting firm to evaluate MMGs	540,000	QCBS	Ex ante	100%		No			Pending	
CLF.2	Consulting firm for preinvestment studies for infrastructure works (new and refurbishment works)	0	QCBS	Ex post	100%		No			Pending	
CLF.3	Consulting firm to supervise infrastructure works (new and refurbishment works)	312,289	QCBS	Ex ante	100%		No			Pending	
CIIF.1	Consulting firm to evaluate AINM-C	450,000	QCBS	Ex ante	100%		No			Pending	

Ref. No.	Category and description of procurement contract	Estimated cost of procurement (US\$000)	Procurement method	Review (ex ante or ex post)	Source of financing and percentage		Prequalification Yes/No	Estimated dates		Status	Comments
					IDB %	Local/ Other %		Publication of specific procurement notice	Completion of contract		
	strategy										
CIV.F.1	Consulting firm to support the MSPAS in program implementation, generation of regular reports on the loan	300,000	QCBS	Ex ante	100%		No			Pending	
CIV.F.2	Consulting firm to support the MSPAS in program implementation, annual surveys for monitoring service delivery	240,000	QCBS	Ex ante	100%		No			Pending	

Goods and works: ICB: International Competitive Bidding; LIB: Limited International Bidding; NCB: National Competitive Bidding; S: Shopping; DC: Direct Contracting; FA: Force Account; PSA: Procurement through Specialized Agencies; PA: Procurement Agents; IA: Inspection Agents; PLFI: Procurement in Loans to Financial Intermediaries; BOO/BOT/BOOT: Build, Own, Operate / Build, Operate, Transfer / Build, Own, Operate, Transfer; PBP: Performance-based Procurement; PLGB: Procurement under Loans Guaranteed by the Bank; PCP: Community Participation Procurement. Consulting firms: QCBS: Quality- and cost-based selection; QBS: Quality-based selection; FBS: Selection under a fixed budget; LCS: Least-cost selection; CQS: Selection based on the consultants' qualifications; SSS: Single-source selection. Individual consultants: IICQ: International Individual Consultant selection based on Qualifications; NICQ: National Individual Consultant selection based on Qualifications.