DOCUMENT OF THE INTER-AMERICAN DEVELOPMENT BANK

GUATEMALA

PROGRAM TO STRENGTHEN THE HOSPITAL SYSTEM

(GU-L1009)

LOAN PROPOSAL

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Tentative lending program	http://opsgs1/ABSPRJ/tentativelending.ASP?S=GU&L=EN
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ABBREVIATIONS

AWP	annual work plan
CAFTA-DR	Central America-Dominican Republic-United States Free Trade Agreement
CAIMI	Centros de Atención Integral Materno-Infantil [centers for comprehensive maternal and child health care]
CGH	Coordinación General de Hospitales [Hospital General Coordination Office]
CHC	Consorcio Hospitalario de Catalunya
COSO	Committee of Sponsoring Organizations
DAM	Departamento de Adquisiciones y Mantenimiento [Procurement and Maintenance Department]
DPE	Departamento de Proyectos y Evaluación [Projects and Evaluation Department]
DRPSA	Departamento de Regulación de los Programas de Salud y Ambiente [Health and Environmental Programs Regulatory Department]
ENCOVI	Encuesta Nacional de Condiciones de Vida [national survey of living conditions]
ENSMI	Encuesta Nacional de Salud Materno Infantil [national maternal and child health survey]
FIS	Fondo de Inversión Social [Social Investment Fund]
FONAPAZ	Fondo Nacional para la Paz [National Fund for Peace]
GDP	gross domestic product
GGAF	Gerencia General Administrativo-Financiera [General Administrative and Financial Management Office]
ICAS	Institutional Capacity Assessment System
IGSS	Instituto Guatemalteco para la Seguridad Social [Guatemalan Social Security Administration]
INE	Instituto Nacional de Estadística [National Statistics Institute]
IRR	internal rate of return
JICA	Japanese International Cooperation Agency
JPO	Japan Special Fund Poverty Reduction Program
LEP	Loan Enhancement Program
MGH	Modelo de Gestión Hospitalaria [hospital management model]
MINFIN	Ministry of Finance
MSPAS	Ministry of Public Health and Social Welfare
NGO	nongovernmental organization
PAHO	Pan American Health Organization
PMSS I and II	Programa de Mejoramiento de Servicios de Salud [Health Services Improvement Programs I and II]
PPMR	Project Performance Monitoring Report
PPP	purchasing power parity

SEGEPLAN	Secretaría de Planificación y Programación de la Presidencia [Presidential Office for Planning and Programming]
SIAFI	Sistema Integrado de Administración Financiera [integrated financial management system]
SIAFI-SAG	Sistema Integrado de Administración Financiera y Sistema de Auditoría Gubernamental [integrated financial management system and government auditing system]
SIAS	Sistema Integral de Atención en Salud [comprehensive health care system]
SIGSA	Sistema de Información Gerencial en Salud [health management information system]
UATH	Unidad de Asistencia Técnica Hospitalaria [Hospital Technical Assistance Unit]
UCPYP	Unidad de Coordinación de Programas y Proyectos [Programs and Projects Coordination Unit]
UNDP	United Nations Development Programme
UPE	Unidad de Planificación Estratégica [Strategic Planning Unit]

PROJECT SUMMARY

GUATEMALA
PROGRAM TO STRENGTHEN THE HOSPITAL SYSTEM
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<table>
<tr><th colspan="5">Financial Terms and Conditions[1]</th></tr>
<tr><td colspan="3">Borrower: Republic of Guatemala</td><td>Amortization period:</td><td>25 years</td></tr>
<tr><td colspan="3">Executing agency: Ministry of Public Health and Social Welfare (MSPAS)</td><td>Grace period:</td><td>4 years</td></tr>
<tr><td>Source</td><td>Amount (US$)</td><td>%</td><td>Disbursement period:</td><td>4 years</td></tr>
<tr><td>IDB (Ordinary Capital)</td><td>50,000,000</td><td>95.6</td><td>Interest rate:</td><td>Variable</td></tr>
<tr><td>Local</td><td>274,000</td><td>0.5</td><td>Inspection and supervision fee:</td><td>0%</td></tr>
<tr><td>Nonreimbursable technical cooperation funding (IDB/JPO) (Annex V)</td><td>1,600,000</td><td>3.1</td><td>Credit fee:</td><td>0.25%</td></tr>
<tr><td>Local contribution, technical cooperation</td><td>408,000</td><td>0.8</td><td rowspan="2">Currency:</td><td rowspan="2">U.S. dollars from the Single Currency Facility</td></tr>
<tr><td>Total</td><td>52,300,000</td><td>100.0</td></tr>
<tr><th colspan="5">Project at a glance</th></tr>
<tr><td colspan="5">Project objective: The goal of the program is to improve the health of Guatemalans. The objective is to strengthen the health services infrastructure through physical investments in the hospital system that are consistent with effective hospital environmental management and support for strengthening hospital management.

Special contractual conditions: a) Precedent to the first disbursement: (i) appointment of the director of the Programs and Projects Coordination Unit (UCPyP), selection of the program coordinators, and designation of the Hospital Technical Assistance Unit staff (see paragraph 3.2); (ii) approval and entry into force of the operations manual and model agreement (see paragraph 3.6); (iii) approval of the action plan for institutional strengthening (see paragraph 4.2); and (iv) approval of the master maintenance plan (see paragraph 3.12); and (b) special conditions for execution: (i) presentation of evidence showing legal ownership of the land (see paragraph 3.9); (ii) presentation of the procurement plan (see paragraph 3.20); (iii) assignment of budget funds for maintenance (see paragraph 3.15); (iv) performance of annual reviews and presentation of annual work plans (see paragraph 3.28); (v) presentation of revised initial basic data (see paragraph 3.26); and (vi) performance of midterm and final program evaluations (see paragraph 3.29).

Exceptions to Bank policies: Establishment of a revolving fund with up to 20% of the total amount of the loan (see paragraph 3.23).

Project consistent with country strategy: Yes [X] No [ ]

Project qualifies as: SEQ [X] PTI [X] Sector [X] Geographic [ ] Headcount [ ]

Procurement: See the procurement plan and paragraphs 3.20 to 3.22.

Verified by CESI on: 26 January 2007.</td></tr>
</table>

[1] The interest rate, credit fee, and inspection and supervision fee mentioned in this document are established pursuant to document FN-568-3 Rev. and may be changed by the Board of Executive Directors, taking into account the available background information, as well as the respective Finance Department recommendations. In no case will the credit fee exceed 0.75%, or the inspection and supervision fee exceed 1% of the loan amount.*

* With regard to the inspection and supervision fee, in no case will the charge 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.

I. FRAME OF REFERENCE

A. Current socioeconomic situation

1.1 Guatemala has undertaken major reforms in the last decade (particularly in the financial sector) and its economic policies have been consistent with a stable macroeconomic framework. In this context, there has been a significant increase in international reserves and fiscal discipline has been maintained. With growth of 3.2% in GDP in 2005 and a preliminary estimate of 4.6% for 2006, Guatemala has reversed the slowdown experienced since 2001 and checked the drop in per capita GDP that had occurred in 2001-2004. This change in direction was promoted by an increase in exports, spurred by the recovery of the United States economy, and a healthy increase in family remittances that led to significant growth in private consumption. This, in the context of the oil shock and the impact of Tropical Storm Stan, reflects the current economic upturn, which contrasts with earlier years.

1.2 **Macroeconomic prospects**. In a favorable external setting and a domestic business climate that continues to improve, the economy is expected to continue growing at a good pace in 2007, with a slight acceleration in GDP growth to 4.8%. The startup of CAFTA-DR will be another positive factor for the investment outlook. Inflation in 2006 remained within the target band of 4% to 6% a year, after having risen to 8.6% in 2005 (mainly as a result of the rise in fuel prices and the pressure on agricultural prices exerted by Tropical Storm Stan). Levels are expected to remain within the target band in 2007. The current account deficit is expected to remain stable in 2007 at about 4% of GDP and international reserves will continue to grow, mainly due to a sustained increase in family remittances. The fiscal deficit, which was moderate in 2005 (1.5% of GDP), rose to about 2.5% of GDP in 2006, chiefly because of the rise in reconstruction costs after the tropical storm and the increase in social spending. The deficit is expected to fall back to below 2% of GDP in 2007.

1.3 **Fiscal reform**. The fiscal area continues to be the cornerstone for macroeconomic management and for the country's development. At the end of 2006, the tax burden continued to stagnate at close to 10% of GDP (the commitment made in the Peace Accords is 12%) and it is not expected to change in 2007. However, the authorities have made efforts to strengthen the tax administration, increase social spending, and improve the efficiency and transparency of public spending. A new multiparty initiative to reactivate the fiscal pact was launched in August 2006 and could lead to reform by the end of 2007. Meanwhile, social spending climbed to 5.4% of GDP in 2005 (the Peace Accords only called for 5%) and preliminary estimates indicate that it rose to a record 6.1% in 2006.

1.4 **Social situation**. Guatemala has the largest population in Central America (12.6 million in 2005, 48% of whom are indigenous) and can be classified as a middle-income country. Its per capita income (purchasing power parity) in 2005 was US$4,155, which is lower than El Salvador, Belize, Panama, and Costa Rica but higher than the other Central American countries. It has the most uneven income distribution in Central America, with a Gini coefficient of 0.58—the second

highest in Latin America after Brazil. The richest 10% of Guatemalans receive 46.8% of total income while the poorest 20% receive just 2.4%. While 56.2% of Guatemalans live below the poverty line (close to 76% of indigenous people), 21% live in extreme poverty. This situation is reflected in the basic social indicators, which are among the worst in Central America and far below what would be expected of a country with this per capita income level. Guatemala ranks 117th out of a total of 177 countries in the Human Development Index (2005) and the average years of schooling for people over the age of 14, which is 4.3 years, is the second lowest in Latin America.[1]

1.5 Poverty and inequality are rooted in the exclusion of specific groups whose access to social, economic, and political opportunities has been restricted. In particular, three out of every four indigenous Guatemalans live in rural areas, which increases the likelihood that they will be poor. Moreover, 81.4% of indigenous people work in the informal sector, compared with 58.9% of nonindigenous people, and 41.7% of indigenous people are illiterate, compared with 17.6% of nonindigenous people.[2]

1.6 Since the Peace Accords were signed in 1996, major efforts have been made to improve the social situation. However, given the difficult initial situation and the limitations on boosting tax revenues and public spending, the country has been unable to make a substantial improvement in the relative ranking of its social indicators in the region.[3]

B. Health sector

1.7 Guatemala's main health indicators, related to the Millennium Development Goals and the Human Development Index, show very low levels in the following areas: (i) life expectancy from birth of 67.9 years in 2005, which is below the Central American average of 70.8 years; (ii) infant mortality of 39 per 1,000 live births for the period 1997-2002 (49 among the indigenous population); (iii) mortality among children under five of 47 per 1,000; (iv) reported maternal mortality of 153 and "adjusted" mortality of 240 per 100,000 live births; and (v) chronic malnutrition among children under five of 49%, which is among the highest in the world.

1.8 The epidemiological profile of the Guatemalan population corresponds to the second stage in the demographic transition, with intermediate-level mortality and fertility rates and a structure that clearly points to the dual epidemiological burden where both transmissible and nontransmissible diseases persist, with problems of reproductive health, malnutrition, and injuries, but with a predominance of infectious diseases, which are generally accompanied by epidemic outbreaks. The

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[1] Data for sections A and B taken from: (i) PAHO, Basic Indicators, 2005; (ii) IDB, Country Strategy with Guatemala, 2004-2007; (iii) UNDP, Human Development Report, 2005; (iv) World Bank, Country Assistance Strategy, Guatemala; and (v) MSPAS, Health Situation and Financing, 1999-2003.

[2] IDB, Country Strategy with Guatemala.

[3] The Peace Accords established a minimum social spending level of 1.3% for public health. These levels are being complied with (IDB, Country Strategy with Guatemala, 2004-2007).

main causes of death among children under five are acute respiratory infections, diarrhea, and vector-transmitted diseases, such as malaria. The nontransmissible causes affecting adults include cardiovascular diseases, cancer, and other degenerative diseases. Violence has growth significantly in urban areas. In 2004, shooting deaths accounted for 3.5% of the total and gunshot wounds were among the five main causes of morbidity in the metropolitan area.

1.9 Since the Peace Accords were signed and with the health reform approved by the government and supported by the Bank, public spending on health has risen as a percentage of GDP (from 1% to 2.3%). The expansion of basic health services to the most disadvantaged groups in rural areas began in 1997, through the coverage expansion program, which had reached 4.1 million people by 2006. However, problems with access remain and there are wide disparities in coverage and quality. A process of improving health service management has begun, particularly in hospitals, and has already brought some results (see paragraph 1.24).

C. Health reform in Guatemala

1.10 The objectives of the health reform were: (i) to expand coverage and deliver services based on a preventive care model; (ii) to increase public spending on health through actions to reallocate public funds more efficiently and equitably, providing guaranteed access to health care services for the population at greatest risk, in a financially sustainable manner; and (iii) to generate an organized social response by linking the government and social security to nongovernmental organizations (NGOs), private care providers, and community organizations. The following instruments were used to achieve these objectives: (i) the creation of a comprehensive health care system (SIAS), an initiative that promotes a basic health care services plan mapped out by the MSPAS and targeted to the population at greatest risk; (ii) the use of targeting mechanisms under the national health plan framework, particularly for families, indigenous groups, and immigrants; and (iii) transfer of administrative responsibilities and financing to the health sector divisions, as a way of deconcentrating the SIAS.

1.11 Coverage has been expanded through the signature to date of 160 contracts with 88 NGOs to provide care for 4.1 million beneficiaries through a basic package that contains: (i) maternal health care; (ii) child health care; (iii) emergency, intensive care, and disease control services; and (iv) environmental measures. The model inaugurated a new type of contracting in which performance, user satisfaction, service production, productivity, and the expansion of coverage had to be developed during the trial process which, according to studies of control groups, achieved better results than the traditional forms of delivery.[4]

1.12 The reform was financed through two Bank loans (health services improvement program—PMSS stages I and II) and included the design and implementation of a

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[4] La Forgia, G.; Mintz, P., and Cerezo, C., *Is the perfect the enemy of the good? A case study on large-scale contracting for basic health services in rural Guatemala*, World Bank, 2005.

new model for hospital care, which is being implemented in 10 hospitals and is intended to be used throughout the system. It also includes investments in equipment and infrastructure, mainly for mother and child health care. Leadership, administrative, and financial capacity has also been strengthened in key areas of the MSPAS, such as planning, budgeting, financial control, procurement, and others.

1.13 Health sector financing comes from the following four sources, listed in order of importance: households (65.9%), the government (19.6%), companies (10.7%), and external assistance (3.1%). Guatemala has the lowest level of public spending on health in Central America (2.3% of GDP), far below the average for Latin America as a whole.[5] Public spending by the MSPAS, responsible for covering 71% of the population, represented 0.87% of GDP in 2006, though there has been a slight improvement in per capita terms in the last three years. The budget allocated to and executed by the MSPAS has increased yearly by an average of 7% and 11%, respectively, since 1998. In addition, spending on health[6] increased from 7.8% to 8.7% over that period. In the 2006 budget, 97.5% of MSPAS spending was on recurrent expenses, while just 1.4% went for investments. Existing fiscal constraints stemming from the insufficiency of tax revenues make it even more pressing to improve the efficiency, transparency, and equity of social spending.[7]

D. Organization of the health system

1.14 The health system is comprised of a public subsector, a private subsector, and NGOs. The MSPAS basically serves the low-income population while the Guatemalan Social Security Administration (IGSS) and the private sector serve the middle- and high-income segments. The MSPAS is the system's lead agency and is responsible for providing health care services to the general population. Other public providers such as the IGSS, the Military Health Service, and the National Civil Police Hospital cover specific population groups.

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5 World Bank, Mother and Child Health and Nutrition Project, December 2005, page 32.

6 Includes spending by other Guatemalan government agencies (National Fund for Peace (FONAPAZ), Social Investment Fund (FIS), Health Councils).

7 IDB, Country Strategy with Guatemala, 2004-2007.

1.15 The MSPAS has 1,314 health care establishments, 3.2% of which are hospitals and 96.8% are primary care establishments (see Table I-2). The national bed-to-population ratio is about 0.6 per 1,000.[8] Adding in the IGSS establishments, the country has about 0.7 beds per 1,000 people, which is far below the Latin American average of 1.9.[9]

Table I-1
The Guatemalan health system (thousands)

Institution	Population served	With coverage		Without coverage	
		Number	%	Number	%
MSPAS	**9,424**	**6,100***	**48.0**	**3,324**	**26.2**
IGSS	2,044	2,044	16.1	0	0.0
Private	1,100	1,100	8.7	0	0.0
Other	132	132	1.0	0	0.0
Total	**12,700**	**9,376**	**73.8**	**3,324**	**26.2**

Source: CHC, 2006.
* The MSPAS's coverage is calculated based on the production of first medical and nursing consultations provided in all the ministry's services.

Table I-2
Guatemala's public health care establishments[10]

Establishments	Number	%	Beds
Hospitals	43	3.2	
General: small, district	11		411
General: mid-sized, departmental	20		2,662
General: regional	6		756
Referral: national	2		1,521
Specialized	4		696
Health care centers with beds	34	2.6	
Health care centers without beds	246	18.8	
Health posts	972	74.0	
Local maternity clinics	16	1.2	
Periferal clinics	3	0.2	
Total	**1,314**	**100%**	**6,046**

1.16 The services provided by the hospital system are established by category, based on installed capacity. The district hospitals are smaller institutions with general physicians providing outpatient and basic hospital care. The departmental hospitals include the basic specialties of internal medicine, surgery, pediatrics, and gynecology-obstetrics. The regional hospitals are staffed with specialists in fields such as internal medicine and surgery. The national referral hospitals offer high technology in surgery and diagnostic imaging (transplants, cardiovascular surgery, micro-neurosurgery, scans, nuclear magnetic resonance, digital radiology). The

[8] CHC, 2006.
[9] PAHO, *Health Situation in the Americas. Basic Indicators*, 2006.
[10] CHC, 2006.

specialized hospitals treat specific pathologies such as orthopedics, mental health, TB, and infectious diseases.

1.17 The IGSS has 28 third-level hospitals, 51 clinics with second-level treatment capability, and 18 health posts to provide primary care. However, the IGSS has not invested in renovating or rehabilitating its hospitals in the last 10 years.

1.18 **The hospital system in the metropolitan area**. The two high-complexity national referral hospitals (Roosevelt and San Juan de Dios) are located in Guatemala City and, in addition to receiving demand for complex procedures from the whole country, must cover unmet demand originating in the metropolitan area, including demand by a significant number of IGSS beneficiaries. The metropolitan area also has four specialized hospitals and one general hospital. Together, they have a total of 2,389 beds, with the sector distribution shown in Table I-3.

1.19 In 2002, the metropolitan area had a population of 2.5 million, with an estimated 1.8 million being the responsibility of MSPAS services and the remainder coming under the IGSS and the private sector.

Table I-3
Hospital supply in the metropolitan area

Sector	Population (i)	Hospitals	Beds available (iv)	Bed/1,000 pop. ratio	Bed shortage (v)
0. Center	659,644	6 (ii)	2,219	3.36	0
1. Northeast	135,217	0	0	0.00	135
2. Southeast	99,223	0	0	0.00	100
3. Southwest	450,679	1 (iii)	170	0.40	280
4. Northwest	434,343	0	0	0.00	435
Total	**1,779,106**	**7**	**2,389**	**1.34**	**950**

Source: CHC, 2006.

(i) Population in the Guatemala Health Area for which the MSPAS was responsible in 2002 (70% of the total).
(ii) Hospitals: Roosevelt, San Juan de Dios, Infectology, Mental Health, Orthopedics, San Vicente.
(iii) Amatitlán Hospital.
(iv) Beds for patients with acute and chronic diseases.
(v) Based on a minimum ratio of 1 per 1,000 people.

E. Main problems in the health sector

1.20 The main problems that undermine the operation of the current health care services structure and the hospital system are described below.

1.21 **The low coverage of health services** is a major problem on account of: (i) its size (in 2006[11], 1.7 million Guatemalans, or 13% of the total population, had no health

[11] Third Presidential Report to the Congress, January 2007.

care; (ii) its implications (the population without coverage was mainly indigenous, rural, and peri-urban); and (iii) the lack of equity in the system, since the shortfall in coverage mainly affects the poor. The low hospital coverage is reflected in the fact that there are just 0.7 beds for every 1,000 people. In the specific case of the metropolitan area, Table I-3 shows that four of the five sectors of the department of Guatemala have serious problems with regard to access to hospital services. The northwest and southwest sectors have the largest population (885,022) but have just one hospital with 170 beds (Amatitlán, which is old and in poor physical condition).

1.22 With regard to the indigenous population, although some progress has been made in terms of adapting to its culture and values, further work in this area is required. The main aspects that make access for them difficult include: (i) language; (ii) communications and the way patients and their families are treated; (iii) different food and sanitation habits; and (iv) a medical response to patient needs that frequently fails to consider their traditions and habits.

1.23 **Weak implementation of systems**. The limited operation of the health care services system, the objective of which is to coordinate the levels of care and guarantee operation of the referral and counter-referral systems, implies functional disintegration between the different levels of complexity in the health sector.

1.24 **Deterioration of hospital infrastructure and equipment**. The 43 MSPAS hospitals have deteriorated owing to lack of investment and maintenance. The departmental hospitals are between 30% and 70% run down (see Rationale and criteria). Hospitals' critical areas lack adequate maintenance, such as electricity, potable water, steam, and medical gas systems. In general, there is a shortage of sanitary services, medical staff, and other equipment. In the two national referral hospitals—Roosevelt and San Juan de Dios—saturation and overcrowding contribute to the deterioration of the infrastructure and the drop in the quality of health services. In July 2006, this situation meant that out of 529 patients who required Roosevelt Hospital's surgery or orthopedic treatment (patients with gunshot wounds, fractures, or serious injuries), just 271 were able to obtain bed care.[12] Also, there is not enough equipment as a result of the absence of policies and strategies to implement and strengthen permanent programs to equip health care services that keep up with advances in technology and medical science. Equipment wears out owing to demand and continuous use, and cannot be replaced on a timely basis.

1.25 **Inappropriate use of hospitals**. There is a high concentration on ambulatory care (orthopedics, stomatology, general medicine, dermatology, general surgery, otorinolaringology, gynecology and obstetrics, and pediatrics) in the third-level national referral centers, particularly at Roosevelt and San Juan de Dios (for example, there are 14 out-patients for every patient discharged at Roosevelt). This

[12] No hay, no sirve, un día en el Hospital Roosevelt [There isn't any; it doesn't work: A day at the Roosevelt hospital], El Periódico Guatemala (http://www.elperiodico.com.gt/ Edition 792, Article 27809).

raises the costs and makes it difficult to provide care in cases that require specialized attention.

1.26 **Poor hospital management**. Management procedures in the health care establishments, particularly the hospitals, are minimal, which makes resources application difficult. Commitments are required to improve the financial and administrative independence of hospitals, optimize personnel management, and provide adequate management of epidemiological information and medical records. The procurement process in MSPAS hospitals takes about six months. However, better results were obtained after applying a new management model (see paragraph 1.33).

F. Country strategy in the sector

1.27 In the context of the health reform initiated by the government in 1995 and improvements in coverage and the redirection of public spending into cost-efficient services, the country focused its actions on strengthening the MSPAS, interagency coordination, expansion of primary-level coverage, and more efficient hospital management.

1.28 Aware of sector needs, the current government has formulated a **national health agenda** (2006-2020) whose foundations include the need to comply with the commitments of the Peace Accords and the Millennium Development Goals. To achieve these objectives, the MSPAS seeks to: (i) strengthen its leadership role; (ii) meet the health requirements of the population by delivering services with quality, equity, and an intercultural and gender approach at the different levels of care; (iii) strengthen decentralization; (iv) improve the input procurement process; (v) modernize the MSPAS's administrative and financial management; (vi) strengthen human resources development and management; (vii) promote environmental sanitation; and (viii) improve protection from the risks posed by the consumption of noxious substances, food, and medications. The *Plan Visión de País* [country vision plan] has recently been finalized, which proposes the creation of a national health system that responds, under the framework of a health system model, to the different epidemiological profiles with sociocultural realities. The plan was signed by representatives of all the political parties in 2006.

G. Bank strategy in the sector

1.29 The central objective of the Bank's 2004-2007 strategy with Guatemala (May 2005) is poverty reduction, and to that end it includes two interrelated strategic objectives: (i) to improve conditions for more efficient production and incorporate excluded sectors into the productive process; and (ii) to strengthen human capital with equity. The proposed program is consistent with this second objective, since it focuses on improving health care services, particularly by strengthening hospital management and the renovation and rehabilitation of hospital infrastructure.

H. Coordination with other donors

1.30 Since 2004, the MSPAS has been working to coordinate the activities of the different donors by formulating strategies and programs for which it subsequently seeks financial support. The program to expand coverage is one of the ministry's priorities and its objective is to deliver basic health and nutrition services (being executed through NGOs, with 4.1 million beneficiaries covered to date). The program is financed in coordination with the government, the IDB, Plan International, the INTERVIDA Foundation, and the United States Agency for International Development (USAID). There are plans to support the program to strengthen the second level of care with financing from the World Bank, the Swedish International Development Cooperation Agency (SIDA), and the IDB, the latter with funds from PMSS II.

1.31 Also, to coordinate and boost the efficiency of participation by the international community, the MSPAS has led activities to prepare a Sector-wide Approach to Health, which will result in a single system for project and program planning and budgeting, administrative management, implementation, and monitoring and evaluation. With support from loan 1221/OC-GU, studies were conducted in 2005 that served as the foundation for preparing the national health agenda, which was presented and discussed during 2006 by the different actors and the private and public health sectors, Congress, and the Donors' Group. Actions in the coming months will focus on drafting the five-year health plan (definition of programs, costs, and sources of financing). As a step prior to the entry into force of the Sector-wide Approach to Health, the MSPAS is coordinating the signature of a memorandum of understanding between it, the IGSS, the Ministry of Finance (MINFIN), and the Presidential Office for Planning and Programming (SEGEPLAN) on the one hand, and bilateral and multilateral organizations on the other. Generally speaking, all the actions will be directed toward implementing the national health policy, based on the national health agenda and the five-year health plan. The Sector-wide Approach to Health also includes a single coordinating unit in the MSPAS for all sector actors, which will include the Programs and Projects Coordination Unit (UCPyP) and the Strategic Planning Unit (UPE).

I. Other programs and lessons learned

1.32 The Bank has financed and continues to finance different programs in the health sector as well as a sector operation to improve efficiency in social spending, with budget protection actions for the program to expand basic health services coverage.[13] These operations have supported sector reform, particularly in terms of increasing coverage. The activities of the proposed program are complementary to and coordinated with PMSS II, particularly with regard to the hospital management

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[13] Program to upgrade health care services, PMSS I (1995) (US$25 million); health services improvement program (PMSS II) (1999) (US$55.4 million); and a sector program for improving the quality of social expenditure (2005) (US$100 million).

component, and to the JICA hospital equipment components. It also complements the World Bank's maternal and infant health and nutrition program, by improving the institutions at the next referral level for the comprehensive maternal and child health care centers (CAIMIs) (see Summary of related projects).

1.33 Under its component IV (ProHospital), PMSS II financed a pilot program for improvements in the management model for seven MSPAS hospitals and in their investment plans to rehabilitate their infrastructure. Recently, the program extended the model to another three public hospitals. One of the strategic tools that the program uses to improve management is the "Management Agreement," signed by the MSPAS and the hospital, which links production activities, returns, and resources. The evaluation of ProHospital[14] indicates that the management structure it introduced achieved significant results in terms of increased productivity. The average increase in care levels between 2002 and 2005 was 19.6% in out-patient visits, 10.8% in discharges, 9.3% in emergency services, and 6.8% in surgeries, which is a significant improvement over the hospitals in the control group. The hospitals also presented large increases in bed turnover.

1.34 The main lessons learned from the Bank's earlier operations are the need to: (i) adequately evaluate the execution capacity of the executing agency and the responsible institutions in order to establish the pertinent institution-building mechanisms; (ii) simplify project design to ensure execution; (iii) include information systems, baselines, and properly-defined indicators for evaluation of the program's execution and outcomes; (iv) introduce more flexible program execution instruments; and (v) evaluate the project risks, particularly those related to the political context and the fiscal impact.

J. Program strategy

1.35 In recent years, health sector activities have focused on increasing the coverage of basic services and on strengthening the sector's institutional framework to improve the quality of the services delivered by public and private providers. However, the budgetary constraints of recent years have led to definancing of the health sector, limiting the funds available for adequate maintenance and renovation of hospital infrastructure and equipment, worsening the problems of coverage and quality of hospital services, and overloading demand for care at the national referral hospitals in the metropolitan area.

1.36 Aware of these problems, the government has asked the Bank for support to finance activities to improve the treatment capability of hospitals as quickly as possible, through the rehabilitation and improvement of hospital infrastructure. At the same time, the program will expand on the achievements of PMSS II with respect to hospital management and will boost the productivity and quality of the services provided by the hospitals.

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[14] Proposal for institutional adjustment of the management model (CHC, 2006).

1.37 The program is intended to deconcentrate patient distribution for hospital care in the metropolitan area by building three hospitals to serve a large population for whom physical access to hospital services is difficult. It will also rehabilitate the physical infrastructure of three regional hospitals, the orthopedics and rehabilitation hospital, and a select group of departmental hospitals. The program will help to make the investments sustainable in the long term, by establishing systems for infrastructure and equipment maintenance and hospital waste management.

II. THE PROGRAM

A. Objectives and description

2.1 The goal of the program is to improve the health of Guatemalans. The objective is to strengthen the health services infrastructure through physical investments in the hospital system that are consistent with effective hospital environmental management and support for strengthening hospital management.

B. Program structure

2.2 The program's activities are organized into four components: (i) strengthening of the health services system; (ii) infrastructure and equipment maintenance and hospital waste management; (iii) strengthening of hospital management; and (iv) monitoring and evaluation.

1. Component I. Strengthening of the health services system (US$40.7 million)

a. Construction of hospitals for Guatemala's metropolitan health system (US$25.5 million)

2.3 The objective of this subcomponent is to set up networks of services to ease current demand on the national referral hospitals and solve the shortfall in hospital coverage in areas with large populations. Preinvestment, infrastructure, and equipment costs will be financed for three medium-complexity 92-bed hospitals, at an estimated average cost of US$8.5 million each. The preinvestment and investment studies include environmental measures based on the country's standards.

2.4 The sites for the hospitals were selected on the following basis: (i) the size of the population with no access or with difficult access to hospital services; (ii) existing or planned alternative hospital infrastructure (private or IGSS hospitals) that includes or anticipates service agreements with the MSPAS; (iii) the growth rate of the urban population in the zones considered; (iv) the flow of patients referred from those zones to the two national referral hospitals in Guatemala City; and (v) the existence of a network of less complex services to support the referral and counter-referral processes in the new hospitals. Three areas in the department of Guatemala were selected on the basis of the above criteria: Northwest, Northeast, and South (see Rationale and criteria).

2.5 The hospitals will form part of the public system (MSPAS) but with a management model that will permit the sale of services to other institutions such as the IGSS, which also lacks sufficient hospital infrastructure in those zones. They will be general hospitals (with the four basic specialties: clinical medicine, surgery, gynecology and obstetrics, and pediatrics) with additional specialties in traumatology and neonatal care, given the epidemiological profile observed. The hospitals will provide basic services for outpatient consultation, emergencies, hospitalization, obstetrical surgery, clinical laboratory, and diagnostic imaging.

2.6 The sites for the three hospitals in the municipalities should be large enough to provide for a low-rise building solution and allow for future expansions. Basic electricity, water, road infrastructure, mass transportation, and communications facilities should be available.

b. Rehabilitation of hospital infrastructure (US$15.2 million)

2.7 The objective of this subcomponent is to rehabilitate the infrastructure of the selected hospitals to improve hospital system conditions. Preinvestment, infrastructure, and equipment costs will be financed for hospitals in the system so that they comply with the country's environmental standards. The hospitals were prioritized based on criteria that will maximize access to the local and regional health systems and ease the burden of unnecessary patient referrals to higher complexity hospitals. On that basis, the three regional hospitals that do not have other sources of external financing were deemed eligible, plus the specialized orthopedics and rehabilitation hospital, and 13 departmental hospitals with no external financing.

2.8 Three of the eligible departmental hospitals have been selected because they are implementing a management model that is being financed by PMSS II (Sololá, Chiquimula, and Jutiapa). The other 10 were evaluated and prioritized on the basis of the following four criteria: (i) extent to which the infrastructure and equipment has deteriorated; (ii) the hospital's referral population; (iii) the percentage of the departmental population living below the poverty line; and (iv) the number of hospital discharges (see Rationale and criteria). On that basis, the hospitals listed in Table II-1 were selected preliminarily. The estimated final costs of the investment projects, which will be used in the bidding documents will determine whether other departmental hospitals can be rehabilitated with the program funds set aside for this component.

Table II-1
List of hospitals selected for rehabilitation

No.	Name and location of the hospital	Type	Cost (US$000)
Preselected hospitals			
	Dr. Von Anh Orthopedics and Rehabilitation, Guatemala City	Specialized	1,762.6
	Quetzaltenango Regional, Quetzaltenango	Regional	1,694.2
	Escuintla Regional, Escuintla	Regional	1,114.3
	Cobán Regional, Alta Verapaz	Regional	1,026.8
	Sololá, Sololá	Departmental	1,302.4
	Chiquimula, Chiquimula	Departmental	1,698.2
	Jutiapa, Jutiapa	Departmental	1,381.8
Classification based on eligibility criteria			
1	San Marcos, San Marcos	Departmental	450.5
2	Chimaltenago, Chimaltenango	Departmental	522.8
3	Jalapa, Jalapa	Departmental	547.5
4	Coatepeque, Quetzaltenango	Departmental	1,848.6
5	Salama, Baja Verapaz	Departmental	367.7
6	Mazatenango, Suchitepequez	Departmental	1,506.3
	Total		**15,223.6**

2.9 **Financing for the investment plans will be tied to compliance with the management commitments between the MSPAS and the hospitals,** which will include implementation of the package of management innovations described under Component III. These include the management of epidemiological information and medical records through the introduction of clinical charts on patients. Commitments to allocate budget resources for the maintenance of rehabilitated hospitals will also be included, based on the criteria established under Component II, together with the establishment of specific maintenance units in the hospitals' internal operating structure.

2. Component II. Infrastructure and equipment maintenance and hospital waste management (US$5.6 million)

2.10 This component is intended to support the technical and financial strengthening of the MSPAS to program and execute strategies to ensure that the program investments will be sustainable. Four activities will be financed to achieve this objective: (i) organization and operation of a system to maintain the hospital investments; (ii) implementation of an efficient hospital waste management system; (iii) strengthening of the MSPAS's regulatory capacity for the two preceding activities; and (iv) an action plan to ensure effective operation and maintenance of the hospitals benefiting from the program. Also, to ensure that the funding needed to maintain the program's investments will be available, the MSPAS has agreed to

increase its budget for the maintenance of the physical plant and hospital equipment.

2.11 The maintenance system will have the following features: (i) funds will be budgeted for a specific purpose and may not be used or transferred to activities that are different from the ones described in the maintenance plan and in the physical-financial programming; and (ii) the mechanism will be regulated by the stipulations of the operations manual and the MSPAS's integrated financial management system (SIAFI). Priority in assigning the funds will be given to preventive and corrective maintenance of the program's investments.

2.12 Hospital waste management will be financed for the hospitals benefiting from the program, through the establishment of three collection and treatment systems, one in each of the three beneficiary regional hospitals. Two alternative operating mechanisms will be financed: (i) outsourcing of the service by contracting a specialized firm or firms; and (ii) provision of the service by the MSPAS's existing unit responsible for waste management, to which end the program will finance a vehicle, an incinerator, and two support technicians for each system.[15] The management plan includes: collection, transportation, treatment (incineration and/or sterilization) and final disposal of the waste. Consulting services will be financed to provide training and technical assistance for the MSPAS in regulating maintenance management, technology and environmental management in hospitals, and in the development of technical standards for investments (infrastructure and equipment), use of technology, and environmental management.

2.13 The component will also finance consulting services to perform a diagnostic analysis and draft an action plan that identifies the needs and sources of budgetary and human resources to ensure the sustainable operation of the hospitals after the works have been completed and the program has ended.

3. Component III. Strengthening of hospital management (US$2 million—US$1.6 million from the Japan Fund)

2.14 This component, financed with Japanese technical cooperation resources, is intended to facilitate implementation of the hospital management model (MGH) developed by the MSPAS in eight hospitals that will benefit from this operation and in the Puerto Barrios hospital.[16] The MGH focuses on three areas: (i) institutional, through the decentralization of the hospitals' organizational structure to managerial levels and technical and management committees; (ii) resources, through decentralization of budgetary and human resources and the MSPAS's procurement function to the hospitals; and (iii) reorganization of services (pharmacy, nursing,

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[15] Once the three systems have been identified, a decision will be made on which mechanism will be used for each.

[16] Excluding the hospitals of Sololá, Chiquimula, Jutiapa, and Mazatenango, which are already implementing the MGH and including the Puerto Barrios Hospital, which was rehabilitated with funds from the Japanese government.

etc.) and the provision of new services, such as orientation for the public. Execution of these activities will fall within the framework of investment, management, and maintenance agreements to be signed by the hospitals and the MSPAS. The agreements will establish that both parties undertake to carry out a complete hospital strengthening package, consisting of investments in infrastructure, maintenance commitments, hospital waste management, and improvements in hospital management.[17] The agreements will also include incentives for attaining production and performance targets. This component will finance three activities:

a. **Strengthening of the MSPAS to implement and monitor the MGH**. The objective of this activity is to strengthen the Hospital General Coordination Office (CGH) and its Hospital Technical Assistance Unit and the Projects Unit so they can develop and coordinate implementation of the MGH. The following will be financed: (i) contracts for four experts in institutional change and management models to train at least six members of the units to apply the model, personnel to implement it, and hospital officials; (ii) nine workshops in the hospitals to disseminate and discuss the MGH with officials prior to its implementation; and (iii) contracts for six consultants specializing in human resources, financial management, medical services, maintenance, information systems, and monitoring, to support the installation of the new management offices and services.

b. **Implementation of the organizational structure**. The objective of this activity is to make the model operational, which includes the creation of new management levels and management services in the hospitals. The contracting and training of experts will be financed—an average of seven for the departmental hospitals and eight for the regional ones—who will perform the functions of these new positions (see plan of operations GU-T1062).

c. **Implementation of a pilot module for services for the indigenous population**. The objective of this activity is to develop more appropriate hospital medical practices for indigenous groups. Implementation of an indigenous care module is proposed, as a pilot project in the Cobán regional hospital, where 93% of the population is indigenous. The module will finance: (i) a general coordinator for the pilot project; (ii) cultural facilitators to promote access and orient indigenous patients during their hospital stays and discharges; and (iii) technical professionals in the indigenous neonatal field, to assist women during pregnancy and delivery and to provide pediatric care.

4. Component IV. Monitoring and evaluation (US$1 million)

2.15 This component is intended to support the MSPAS in program supervision, monitoring, and evaluation, and public information.

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[17] The investment, management and maintenance agreements provided for in this operation will link the management agreement applied in PMSS II to the commitments for investment in physical plant, maintenance, and hospital waste management.

2.16 **Monitoring and evaluation system**. The program will finance consulting services for: (i) compiling information in the hospitals to be rehabilitated to complete the program's baseline; (ii) designing technical specifications and setting up the monitoring and evaluation system; (iii) performing the midterm and final evaluations of the program using the indicators in the logical framework; (iv) monitoring the investment, management, and maintenance agreements; and (v) presenting progress reports on the program.

2.17 **Project supervision**. The program will finance technical assistance and training for: (i) the design and validation of project supervision manuals; (ii) the development of rules and procedures for supervision; (iii) training for MSPAS and hospital officials; and (iv) specifications for the contracting and supervision of outsourced hospital maintenance and hospital waste management services.

2.18 **Public information**. The program will finance events for the presentation and dissemination of outcomes and achievements and to share experiences in infrastructure project execution, MGH implementation, and environmental management and maintenance in hospitals.

C. Program administration

2.19 To build up the technical and administrative-financial capacity of the MSPAS units directly involved in program execution, financing will be provided to contract experts in the following areas:

Position	Executing unit	Component
Technical coordinator	UCPyP	Program
Administrative and financial coordinator		
Procurement experts	GGAF - Procurement Unit	Program
Professional in sanitary infrastructure	UPE - Projects and Evaluation Department (DPE)	1 - 2
Professional in sanitary engineering		
Professional in hospital management	CGH	3
Professional in environmental management and hospital waste disposal		

D. Cost and financing

2.20 The program will cost a total of US$52.3 million, with US$50 million in Bank financing and US$1.6 million from the Japan Fund. The local contribution of US$682,000 will include US$408,000 (in kind) for Component III on hospital management and US$274,000 for financial costs. JICA has expressed interest in providing support with funding for the program in the future.

Table II-2
Program costs (US$000)

Investment category	IDB	Local	JPO/ LEP	Local/ JPO	Total	%
Component I. Strengthening of the health services system	40,724	-	-	-	40,724	78%
Subcomponent I-a. Hospital construction	25,500	-	-	-	25,500	49%
Subcomponent I-b. Rehabilitation	15,224	-	-	-	15,224	29%
Component II. Infrastructure and equipment maintenance and hospital waste management	5,573	-	-	-	5,573	11%
Component III. Strengthening of hospital management	-	-	1,600	408	2,008	4%
Component IV. Monitoring and evaluation	1,000	-	-	-	1,000	2%
Administration	1,103	-	-	-	1,103	2%
Audits	100	-	-	-	100	0%
Contingencies	1,500	-	-	-	1,500	3%
Financial costs	-	274	-	-	274	1%
Interest	-	242	-	-	242	0%
Inspection and supervision	-	-	-	-	-	0%
Credit fee	-	32	-	-	32	0%
Total	**50,000**	**274**	**1,600**	**408**	**52,282**	**100%**

III. PROGRAM EXECUTION

A. Borrower and executing agency

3.1 The borrower will be the Republic of Guatemala. The executing agency will be the MSPAS, through the Programs and Projects Coordination Unit (UCPyP), the line unit responsible for coordinating projects and programs financed with external and grant resources, which reports to the Office of the Minister, with the collaboration of the other MSPAS line agencies.

B. Project execution and administration

3.2 The **UCPyP** will be responsible for technical, administrative, and financial coordination of the program and will be supported by the Strategic Planning Unit (UPE) and the Hospital General Coordination Office (CGH) for technical execution of the components, and the General Administrative and Financial Management Office (GGAF) for support in program administrative and procurement areas. The GGAF's Procurement and Maintenance Department (DAM) will carry out the program's bidding and contracting processes. The UCPyP has a director and will have a technical coordinator and an administrative coordinator for program purposes, who will coordinate with the GGAF. **Appointment of the director of the UCPyP selection of the program coordinators, and appointment of the**

Hospital Technical Assistance Unit staff (see paragraph 3.18) will be a special condition precedent to the first disbursement.

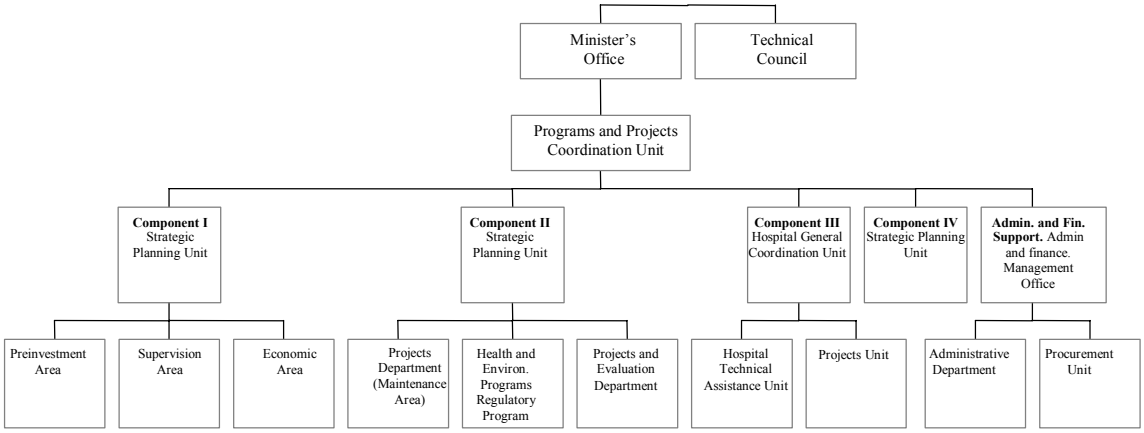
3.3 To coordinate execution of program activities, the UCPyP will meet periodically with the MSPAS units and departments directly involved in program execution. The basic functions of the UCPyP will be: (i) to manage and supervise execution of the annual work plans (AWPs); (ii) to oversee compliance with the different stages in the project cycle and their development; (iii) to implement the recommendations and actions determined by the technical council (see paragraph 3.4); (iv) to coordinate the development of the investment, management, and maintenance projects with the hospitals and their care units; and (v) to present reports on the program and the information required by the Bank for the Project Performance Monitoring Report (PPMR), and to make recommendations for closer coordination between the different MSPAS areas and the program.

3.4 **Technical council**. The program will be supported by the MSPAS technical council, which will provide advisory and strategic direction for the program. The council is composed of the Minister of Health, who chairs it, the Deputy Ministers, the Managing Directors, and the General Manager, the Executive Secretary of the Minister's Office, and the coordinator of the UPE. Its main function will be to ensure internal linkage and coordination in the MSPAS, establish the operational mechanisms and actions that need to be implemented, and start up the UCPyP. When the council deals with technical aspects of the program, the director of the UCPyP will participate and present the documentation related to the program to the council for consideration. Specifically, the council will be responsible for: (i) approving the operations manual and the AWPs; (ii) approving the action plan for institutional strengthening; and (iii) based on the monitoring and evaluation reports, formulating recommendations to improve execution.

3.5 **General Administrative and Financial Management Office (GGAF)**. The GGAF will support the program's administrative and financial management and will be in charge of the financial, budget, accounting, and procurement functions necessary to execute the components. This office will be supported by the Administrative Division for budget and accounting management and by the Procurement Department for bids and contracting.

C. Execution structure

Graph III-1. MSPAS execution structure



D. Program execution plan

3.6 **Operations manual**. Execution will be governed by the operations manual, which establishes the terms and conditions for executing the program and contains, among other things: (i) the operating and execution structure for the components; (ii) the eligibility criteria for the components; (iii) the procedures for contracting goods and services; (iv) the control and monitoring systems; and (v) the responsibilities for administering, operating, and maintaining the works and services. **Approval and entry into force of the operations manual and the model agreement (see paragraph 3.18) will be a special condition precedent to the first disbursement**.

1. Component I. Strengthening of the health services system

3.7 The UPE will be responsible for identifying the land necessary for the new hospitals and arranging for its legal ownership, and for preparing the contracts and supervising all the consulting and technical assistance services necessary for preinvestments and investments in infrastructure and equipment for the new hospitals, and for the hospitals selected for rehabilitation.

3.8 To execute this component, the UPE's preinvestment area will be responsible for coordinating and supervising the project designs on the basis of pertinent technical, social, and environmental specifications for the infrastructure works and equipment. The supervision area will be responsible for monitoring project execution and preparing the contracts for external supervision and oversight of works and projects. The economic area will support the above activities in estimating project costs and in monitoring financial execution.

3.9 In the case of subcomponent I-a, before the works get under way, the UCPyP must have presented to the Bank's satisfaction evidence of the legal ownership of the

land, rights-of-way, and other rights necessary to begin the studies and works, based on the eligibility criteria defined in the operations manual.

3.10 In the case of subcomponent I-b, the final costs of the investment projects will be determined based on the preinvestment studies. They will be used to prepare the bid documents and to determine how many of the prioritized hospitals can be rehabilitated with program funds, based on the criteria set out in the Rationale and criteria document. Once that is determined, the executing agency, through the corresponding health area, will sign an investment, management, and maintenance agreement with the selected hospital, based on terms and conditions agreed upon in advance with the Bank.

2. Component II. Infrastructure and equipment maintenance and hospital waste management

3.11 The UPE will be responsible for executing this component, with support from: (i) the maintenance area; (ii) the Health and Environmental Programs Regulatory Department (DRPSA); and (iii) the Projects and Evaluation Department. The UPE's maintenance area will prepare a master maintenance plan for the system hospitals, based on the needs presented by the country's hospitals and the investment, management, and maintenance agreements of the program hospitals. The plan will cover five years and will prioritize needs and actions annually, with the corresponding budget.

3.12 The funds programmed will be reviewed by the technical council and the Minister's Office, which will authorize their inclusion in the MSPAS's budget, broken down by hospital. In particular, distribution of the funds during the fiscal period will be verified to ensure that maintenance services cover the whole operating year and that they are used to finance expenditures that are eligible under the program. **Presentation of the master maintenance plan will be a special condition precedent to the first disbursement of the program.**

3.13 To ensure that a source of funds is available for the operation and effective maintenance of the investments in infrastructure and equipment financed by the program, the executing agency will maintain a budget line for that purpose and will establish criteria for its use. In turn, each hospital will manage a budget item called "maintenance of equipment and physical infrastructure" in accordance with the master maintenance plan and will prepare an annual maintenance plan with its corresponding budget. This information, together with the programming of funds, will be included in the MSPAS's annual budgets.

3.14 Programming of resources for hospital maintenance will be based on a growing allocation that will seek to increase gradually from 1.63% at present to about 3%, the percentage of the MSPAS's operating budget to maintain the physical plant and equipment of the hospitals benefiting from the program, without detriment to the funds for the other hospitals, in accordance with the following guidelines set out in the program's operations manual.

Table III-1
Programming of funds for the maintenance of equipment and physical plant
(US$000)

Year	Year 1	Year 2	Year 3	Year 4	Total
IDB loan	489	692	914	1,118	3,213
MSPAS budget	146	130	126	175	577
Total	**635**	**822**	**1,040**	**1,293**	**3,790**

3.15 **The allocation of funds in the MSPAS's annual budget for each year of program execution and demonstration of how those funds have been spent will be a special contractual condition for execution.**

3.16 The UPE, in coordination with the Health and Environmental Programs Regulatory Department (DRPSA), will prepare the contracts for the specialized firm or firms that will provide comprehensive management of hospital waste in a selected area or areas, and will present a proposal for the ministry to operate the hospital waste management system in one or more of the three areas of influence of the regional hospitals assisted by the program. The operation and cost-effectiveness of this proposal will be evaluated during execution. The UPE and the DRPSA will also prepare consulting and technical assistance contracts to build up the MSPAS's regulatory capacity in the field of maintenance and management of hospital waste.

3.17 For purposes of preparing and monitoring the plans of action for the effective operation of the hospitals after the works have been completed, the UCPyP will contract studies on the sustainability of the interventions and implement their recommendations, in coordination with the technical council, and the MSPAS's Human Resource Directorate, and Maintenance Area and other executive branch institutions.

3. Component III. Strengthening of hospital management

3.18 The Hospital General Coordination Office (CGH) will be responsible for executing this component, with support from the Hospital Technical Assistance Unit (UATH) and the Projects Unit. The CGH will set out the guidelines for implementing the management model in the areas of institutional organization, decentralization of resources, and reorganization of services. The UATH will monitor implementation of the model and the design of and compliance with aspects related to management under the investment, management, and maintenance agreements, and training for the hospital's medical and administrative teams in its implementation. The Projects Unit will provide support for monitoring program activities.

4. Component IV. Monitoring and evaluation

3.19 The UCPyP, in its capacity as general program coordinator, will be responsible for coordinating and executing the activities in this component. The UCPyP will be responsible for contracting and supervising all the consulting and technical

assistance services needed to: (i) compile information in the hospitals to be rehabilitated to complete the program's baseline; (ii) design the technical specifications and start up the monitoring and evaluation system; (iii) monitor the investment, management, and maintenance agreements; and (iv) perform the midterm and final program evaluations.

E. Procurement

3.20 The procurement of goods and services and the selection and contracting of consultants for the program will be governed by the Bank's policies established in documents GN-2349-7 and GN-2350-7, respectively. A procurement plan has been agreed on with the executing agency. The plan covers program procurements and contracting for the first 18 months and should be updated each year, as established in the above-mentioned documents. The procurement thresholds and procedures are shown in Table III-2.

Table III-2
Procurement and contracting procedures

	Works	Goods and services
International competitive bidding (ICB)	Over US$1,500,000	Over US$250,000
National competitive bidding (NCB)	From US$200,000 and up to US$1,500,000	From US$50,000 and up to US$250,000
Shopping	Under US$200,000	Under US$50,000

3.21 These thresholds were established based on the amounts that the MSPAS has been managing in the procurement processes under PMSS II since 2002. For the selection and contracting of consultants, the borrower may use any of the methods established in Bank policies. For the purposes of paragraph 2.7 of document GN-2350-7, the shortlist of consultants whose contracts are estimated to cost less than US$200,000 equivalent each may be comprised entirely of local consultants.

3.22 With respect to Bank supervision of procurements, the following contracts will be subject to ex ante review: (i) contracts for works whose total cost is an estimated US$1.5 million equivalent or more; (ii) contracts for goods whose total cost is an estimated US$250,000 equivalent or more; (iii) all direct contracting; (iv) contracts with consulting firms whose total cost is an estimated US$200,000 equivalent or more; (v) contracts with individual consultants whose total cost is an estimated US$50,000 equivalent or more; (vi) all single-source selections of consulting firms. The other contracts will be subject to ex post review by the Bank, in accordance with Appendix 1 to the Policies for the procurement of works and goods financed by the IDB and Appendix 1 to the Policies for the selection and contracting of consultants financed by the IDB.

F. Execution period and disbursement schedule

3.23 The program will have a disbursement period of four years. As an exception to Bank policy (Manual OA-345), it is recommended that a revolving fund with the equivalent of 20% of the total loan be placed at the executing agency's disposal, given the number of simultaneous contracts and payments and the flows of funds. The schedule for disbursements in presented in Table III-3.

Table III-3
Disbursement schedule (US$000)

Source	Year 1	Year 2	Year 3	Year 4	Total
IDB	2,555	28,640	16,651	2,153	50,000
JPO/LEP	19	10	875	696	1,600
Percentage	5%	56%	34%	5%	100%

G. Maintenance

3.24 The works and equipment financed by the program will be adequately maintained in accordance with generally-accepted technical standards, and reports will be presented to the Bank within the first quarter of each calendar year for the five years after the first of the works is completed, describing the status of the works and equipment and the annual maintenance plan for that year. The government will take all necessary steps to correct shortcomings if the Bank's inspections or the reports it receives determine that maintenance is below the agreed levels.

H. Monitoring and evaluation

3.25 The UCPyP will be responsible for coordinating physical and financial programming, monitoring of program performance, and program evaluations with the administrative and technical units (mainly the UPE and CGH). The MSPAS's health management information system (SIGSA) and the integrated financial management system (SIAFI) will be used for these activities. Several mechanisms and tools are available for monitoring program performance: (i) the program startup workshop; (ii) the indicators in the logical framework; (iii) the multiyear program execution plan; (iv) the annual work plans; (v) the procurement plan; (vi) the baseline; and (vii) the midterm and final evaluations.

3.26 **Baseline**. The baseline indicators associated with the program's goals will be obtained through the national maternal and child health survey (ENSMI), coordinated by the MSPAS and the National Statistics Institute (INE). The work of compiling the information is expected to begin in April 2007 and the results should be ready in September of the same year. These surveys are expected to be repeated every two years and will be used as input for program monitoring. The other data in the baseline will be provided by the MSPAS and to that end it will present, within three months after the date that the loan contract is signed, the initial basic data for the program, using the categories agreed on in advance with the Bank. It will also

present the procedure and methodology to be used to compile, process, maintain, and report on the annual data to be compared with the initial basic data to evaluate program results, based on guidelines and methods agreed on beforehand with the Bank.

3.27 **Semiannual progress reports**. The MSPAS, through the UCPyP, will present progress reports on program execution to the Bank within the 60 days after the end of each six-month period. The reports will describe: (i) the actions and activities carried out; (ii) the outputs obtained and the targets met, based on the indicators in the logical framework; and (iii) the main difficulties encountered and the solutions proposed to remedy them. The reports will also indicate the funds used per component, compared with the funds programmed, and give updated projections for flows of funds.

3.28 **Reviews and annual work plans**. Based on the semiannual reports and within the third quarter of each year, the MSPAS and the Bank will review the program and examine progress. The reviews will serve to agree on the AWPs to be presented to the Bank no later than the last day of the final quarter of the year, which will adjust the activities and goals to be hit in the following year and will project the program to its conclusion.

3.29 **Midterm and final evaluations**. A midterm evaluation will be performed at the end of the second year of the program or when 50% of the funds have been committed (whichever comes first). The evaluation will be financed by the program and, based on the records of the operation, the indicators in the logical framework, and the technical specifications in the operations manual, it will verify the following in the field: (i) the outcomes and achievements in terms of improvements in the quality and efficiency of hospital services; (ii) improvements in efficiency, coverage, and access to services and better treatment capabilities in the hospitals; (iii) the operation of the mechanism for the maintenance of infrastructure and medical and hospital equipment; (iv) the improvement in the managerial and regulatory capacity of the MSPAS in environmental management and maintenance; (v) the improvement in hospital management; (vi) the sustainability of hospital investments; and (vii) the operation of the program coordination and execution mechanisms. In addition, for purposes of estimating achievement of the internal rate of return (IRR) (see paragraph 4.8), hospital discharges for diseases whose protocols of care identify lack of treatment as resulting in death will be measured. The evaluation will also determine hospital user satisfaction, with special focus on the indigenous population and the Cobán Hospital, in which the pilot module for treatment of the indigenous population will be implemented. At the end of this evaluation and for the purposes of timely reviews and adjustments during execution, the UCPyP will present a report on the progress indicators established in the program monitoring matrix[18], which will be included in the PPMR. The final

[18] This matrix includes the indicators in the logical framework and efficiency targets.

evaluation will be performed when at least 90% of the financing has been committed.

3.30 **Financial statements and audits**. The program's external audits will be performed by a firm of independent auditors in accordance with Bank policies and requirements (documents AF-300 and AF-400), which will be hired following the procedures established in the document on the selection of external auditing services (AF-200), following the guidelines established in the terms of reference for external auditors for projects financed by the Bank. (AF-400). Presentation of an annual report on the program's financial statements will be required within 120 days after the end of the fiscal year. The auditing costs have been included in the program and will be financed with loan proceeds.

3.31 **Ex post evaluation**. The borrower has expressed its interest in being able to perform an ex post evaluation of the program, which will evaluate the operation of the new hospitals, among other things. The funds to finance that evaluation could be obtained as a result of the Sector-wide Approach to Health (see paragraph 1.31).

IV. FEASIBILITY AND RISKS

A. Institutional feasibility

4.1 The Institutional Capacity Assessment System (ICAS) was applied in 2006 to evaluate the MSPAS's capacity in the areas of activities programming, administrative organization, personnel management, goods and services management, financial management, and internal and external controls. In general, these areas present medium development and medium risk levels. The results were as follows:

Table IV-1
ICAS results

Area	Score	Development level	Risk level
Programming of activities	76.92%	Medium	Medium
Administrative organization	81.82%	Satisfactory	Low
Personnel management	85%	Satisfactory	Low
Goods and services management	74.07%	Medium	Medium
Financial management	87.10%	Satisfactory	Low
Internal controls	62.50%	Medium	Medium
External controls	66.67%	Medium	Medium

4.2 Based on ICAS findings and recommendations, the MSPAS prepared a plan of action to bolster institutional capacity, an exercise that was coordinated by the UPE and the GGAF. The **MSPAS will present the timetable for implementing the**

actions in the plan and their source of financing as a special condition precedent to the first disbursement of the loan.

4.3 In the area of procurement, the MSPAS hired consulting services to perform a study on the organizational development of its Procurement Department, which includes production of the following outputs: (i) preparation of a proposal for the organization and functions of the procurement department and the purchasing department of the executing units; (ii) preparation of manuals of rules and procedures for the procurement of goods and services; (iii) support for the analysis and design of the information system on the execution and control of procurement processes; (iv) support for the training program in procurement; (v) technical assistance for MSPAS procurement and contracting processes; and (vi) technical assistance for contracting inputs that the MSPAS uses recurrently. The final outputs of the consulting services will be delivered to the MSPAS during the first quarter of 2007, and it will formulate an action timetable for their implementation during the program.

4.4 The MSPAS institution-building process described in the previous paragraphs will ensure an adequate institutional framework for efficient program execution. In addition, the specific consulting services on technical coordination and administrative and financial management, procurement, environmental and hospital waste management, and hospital management, and the specialized firms contracted to prepare the functional medical studies, the design of the construction and rehabilitation projects, and project supervision, will reinforce its institutional and technical capacity needed to carry out the present operation. Accordingly, the MSPAS has the institutional and technical capacity necessary to execute the present operation under the coordination of the UCPyP, which has solid experience in executing earlier programs financed by the IDB, the World Bank, and other donor agencies (see Summary of related projects).

B. Technical feasibility

4.5 The hospital investments to be financed by the program have been analyzed at the preinvestment level. Specialized consultants were hired when the program was being prepared to update the information on the general technical specifications for the investments in physical plant and equipment for the hospitals prioritized by the program and the scaling and estimated cost of the investments. The bid documents for the preinvestment studies will be used to ensure that the interventions financed by the program are least-cost solutions in all cases, designed on the basis of the requirements for minimum standards of hospital system services, the capacity of health personnel, and local realities in terms of materials, technical and structural solutions, environmental characteristics, and ease of construction and maintenance. See paragraph 4.18 on the subject of human resource availability.

C. Socioeconomic feasibility

4.6 The program is expected to bring significant direct and indirect benefits. The main direct benefits include: (i) a reduction in morbidity and mortality rates; (ii) a

reduction in the number of hours of work that are lost, by reducing waiting times for medical attention as a result of decongesting the metropolitan area's hospital system; (iii) a reduction in the time required to gain access to hospital care; and (iv) more cost-efficient hospital management that responds to the public's requirements. Also, the program is expected to have major indirect benefits, such as a significant reduction in healthy life years lost.

4.7 The earlier health programs carried out in the country (PMSS I and II) brought about an important increase in coverage on the primary care level, through NGOs contracted by those programs and expansion of the public system. However, the investments to rehabilitate and maintain the hospital system were limited. In this context, the achievements in increasing primary care coverage and its impact on the reduction in morbidity and mortality rates now need to be complemented with an improvement in the short term in the treatment capabilities of the hospital services, through the rehabilitation of hospital infrastructure and better management of those institutions. Thus, the returns on the investments already made in the first level of care will improve by strengthening the supply in the second and third levels, in addition to responding to growing demand by the public for hospital services. In particular, given the high maternal and infant mortality rates observed, it is crucial to improve emergency obstetrical and neonatal services in hospitals. Also, to address the challenges of the demographic transition in Guatemala, the hospital system needs infrastructure to provide a rapid and cost-efficient response to acute cases associated with chronic diseases.

4.8 Two alternative methodologies were used to make very preliminary calculations of the returns on program investments (See Calculation of the program's internal rate of return). First, the benefit obtained from deaths and prolonged illnesses avoided among the working population was estimated for a 92-bed hospital, using GDP (purchasing power parity) divided by the working population as the economic value. This information was used to calculate the IRR for the three new hospitals. Second, the number of deaths that would have to be avoided as a result of program investments (including rehabilitation) to reach an IRR of at least 20% was calculated, using the value of a statistical life in Guatemala as the economic value. This last value was estimated by extrapolating from the results of international studies on willingness to pay to reduce the risk of mortality. In the first case an annual benefit per new hospital of approximately US$4.4 million was calculated, for an IRR of 21% if the useful life of the hospital is 10 years and 23% if it is 20 years, assuming conservatively that (i) the project maintains the same ratio of discharges per bed/year in the new hospitals as in the existing ones, (ii) 1% of discharges correspond to deaths avoided, 5% to lengthy illnesses avoided, and 94% have no significant effect, and (iii) the percentage of hospital services used by the working population is the same as the percentage represented by that group out of the total population. This calculation does not consider other benefits such as the well-being of the population. In the second case, in which these other benefits are being taken into account, it was calculated that the program's investments (including necessary recurrent costs) would have to produce annual benefits of

US$20 million starting in the fifth year to obtain an IRR of 20% (assuming a useful life of the investments of 20 years). In this scenario, to achieve this level of benefits and considering an estimate of the value of a statistical life in Guatemala, the hospitals benefiting from the program would have to avoid at least 44 deaths a year,[19] a figure that will probably be exceeded by far. The midterm and final evaluations will include a measure of deaths avoided as a result of the program.

D. Financial feasibility

4.9 To ensure coverage of the incremental recurrent costs that the program will generate and the sustainability of its actions, the MSPAS, within the budget ceiling assigned by MINFIN and approved by the economic authorities, will assign the budget resources necessary for those purposes. These costs are mainly related to human resources and maintenance of hospital facilities, infrastructure, and equipment.

4.10 Congress did not pass the 2007 national budget and therefore the 2006 budget has continued in effect, which does not include room for this program, given that its formulation had not begun in 2006. So as not to affect the start of program execution, MINFIN believes it can find the necessary leeway in the current budget or negotiate an increase with Congress when congressional approval of the project is sought, given that the country's political agenda gives priority to the health and social welfare sector. Since budget ceilings do not diminish historically, once the investment projects in infrastructure are completed, there will be a sum available that can be used to cover the program's recurrent costs. Projected recurrent costs for the new hospitals represent only 2% of the MSPAS's current recurrent costs budget, well below the increase observed in the ministry's budget in the last few years.

4.11 The program will finance a study on the sustainability of the interventions, which will produce action plans for the proper operation and functioning of the hospitals once the works are completed.

E. Social and environmental impact

4.12 The program will have a significant positive social impact. Through the increase in efficient and equitable access to public hospital services, the program will improve health care for Guatemalans, particularly poor and indigenous groups. Also, the selection criteria for the hospitals to be rehabilitated included the poverty index in the region and the program will promote a health care model geared to the characteristics of indigenous groups. By improving the supply of public health services, this operation promotes social equity (SEQ) as described in the Report on the Eighth General Increase in the Resources of the Bank (AB-1704). It also

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[19] Or alternatively, some of these avoided deaths could be replaced by a higher number of prolonged illnesses avoided.

qualifies as a poverty-targeted investment (PTI) project, since it will improve access to health services for the poor population (see Rationale and criteria).

4.13 The operation will promote the use of suitable guidelines and processes for managing potable water, liquid waste removal, and hospital waste, as well as energy security and conservation, reducing the negative environmental impact currently caused by the hospitals to be rehabilitated, and minimizing the future impact of the three new hospitals. Also, the costs of contracting third-party services for hospital waste management and direct attention to this area by the MSPAS will be financed. Component II includes specialized consulting services and monitoring and supervision of the civil works that will ensure that these criteria are reflected in the architectural designs.

F. Benefits and beneficiaries

4.14 Reorganization of the hospital stock in the metropolitan area by constructing three hospitals in zones with high population growth and difficulties gaining physical access to hospital services will decongest patient distribution, minimize treatment costs, and improve the quality, efficiency, and equity of care. Also, rehabilitation of hospitals in zones with high poverty indexes will increase access to services and the treatment capabilities of those hospitals.

4.15 The program's benefits will include a reduction in morbidity and mortality, a reduction in loss of time (and therefore in opportunity costs) both in seeking treatment and in the recovery process, and more cost-efficient use of individual and public resources (see paragraph 4.6). Among other improvements, the program is expected to increase the number of pregnant women whose deliveries are attended by qualified personnel by 19 percentage points, and the number of cases of acute respiratory infections and acute diarrhea treated among children under five by 7 percentage points. Also, bed turnover and the percentage of surgeries per operating room in the rehabilitated hospitals will be significantly higher (10%) than the average for hospitals on the same level that are not included in the program, by the midpoint and end of the program.

4.16 With the construction of the three new hospitals, the direct beneficiary population will be an estimated 1.2 million people, and the country's entire population will benefit indirectly. Hospital rehabilitation will benefit 5.1 million people directly (66% of whom are poor and 47% of whom are indigenous), not counting the population from all over the country that will be able to benefit from the rehabilitation of the specialized traumatology hospital.

G. Risks

4.17 **Execution capacity**. The program directs most of its resources and investments to hospital renovation and rehabilitation, which means that the MSPAS's contracting and works supervision capacity needs to be strengthened. Based on the results and recommendations of the ICAS evaluation (2005, updated in 2007), the Strategic Planning Unit (UPE) and the Procurement and Maintenance Department (DAM)

are being strengthening with funding from PMSS II and the measures identified in the institutional strengthening action plan will be implemented shortly.

4.18 **Sustainability**. This operation presents the following risks with regard to sustainability: (i) the difficulties facing implementation of a system to provide maintenance for the investments in infrastructure and equipment; (ii) lack of budgetary funds to pay for the necessary human resources; (iii) the shortage of human resources to operate the hospitals; and (iv) the possibility that funds for the operation will be taken from the budget allocated to primary health care. To mitigate the first risk, the program design includes a maintenance mechanism that guarantees the allocation of the financial resources needed to operate and maintain the infrastructure and equipment financed by the program. To mitigate the second risk, the operation includes development of a plan of action that identifies sources of budgetary and human resources to operate the hospitals. As for the third risk, a Sector-wide Approach to Health is being agreed on for the health sector (see paragraph 1.31), which will include a human resources training program. To mitigate the last risk, the Ministry of Finance is arranging for an increase in the sector's budget.

4.19 **Implementation of a hospital management model**. The program promotes the implementation of a new management model, parallel to the upgrading of infrastructure, to ensure more efficient management of resources. There is the risk of initial resistance to change by officials in the hospitals where the model will be implemented. To mitigate this risk, the physical rehabilitation of the hospitals is conditional on implementing the model. As the efficiency, productivity, and quality of services improves during the project, resistance is expected to diminish.

PROGRAM TO STRENGTHEN THE HOSPITAL SYSTEM (GU-L1009)

LOGICAL FRAMEWORK

Narrative summary	Indicators	Means of verification	Assumptions
Goal To improve the health of the Guatemalan population.	The percentage of pregnant women whose deliveries are attended institutionally increases from 41% in 2007 (baseline)[1] to 60% in 2011. The percentage of cases of acute respiratory infection (ARI) and acute diarrheal disease (ADD) treated among children under five increases from 14% and 23% in 2007 (baseline) to a minimum of 20% and 30% in 2011, respectively.[2]	National Mother and Child Health Survey (ENSMI) 2007 and 2012.	The ENSMI is conducted in 2007 and the data are published before the end of the year. The investments are completed on time and are operational.
Purpose To strengthen the health services infrastructure through physical investments in the hospital system that are consistent with effective hospital environmental management and support for	**Access:** (i) The percentage of patients from Mixco, Villanueva and Zone 18 treated at the two national referral hospitals in Guatemala falls from 34% in 2007 (baseline)[3] to 20% in 2011. (ii) The percentage of outpatient consultations out of total patients treated at the national referral hospitals fall from 36% in 2006 (baseline) to 20% in 2011.	Hospital patient records.	The Ministry of Finance (MINFIN) and the MSPAS guarantee that funds will be allocated for the operation of the new hospitals. The new management model is implemented in the program hospitals, ensuring effective referrals in the system.

[1] The currently reflected baseline pertains to data on deliveries attended by qualified personnel in the 2002 ENSMI. The MSPAS will finance an ENSMI in 2007 and will include information on institutional deliveries, the results of which should to be available in October 2007, so that the baseline can be updated.

[2] The baseline pertains to the 2002 ENSMI. The MSPAS will finance an ENSMI in 2007, the results of which should be available in October 2007, at which time the baseline can be updated. If the survey includes information on neonatal mortality, this indicator will replace the ARI and ADD indicators.

[3] Pertains to the average obtained for 2006. This information needs to be revised to include the average for the first two months in 2007.

Narrative summary	Indicators	Means of verification	Assumptions
strengthening hospital management.	(iii) The total volume of care (outpatient, emergency, and admissions) in the hospitals rehabilitated under the program increases by 10% by 2009 and 20% by 2011, from the 2006 baseline.[4]		The MSPAS's statistical system operates effectively.
	Efficiency:	Hospital administrative records; midterm and final evaluations.	
	(i) Bed turnover in the rehabilitated hospitals is 5% and 10% higher than the average for hospitals on the same level not included in the operation, in 2009 and 2011, respectively.	MSPAS administrative records; midterm and final evaluations.	
	(ii) The percentage of operating room surgeries in the program-rehabilitated hospitals is 5% and 10% higher than the average for hospitals on the same level not included in the operation, in 2009 and 2011, respectively.		
	Deterioration of the system:	MSPAS administrative records.	The MSPAS incorporated the methodology for calculating the deterioration index developed during program preparation.
	The degree of deterioration of the regional and departmental hospital systems drops from 0.583 in 2007 (baseline) to at least 0.4 in 2009.[5]		
	Maintenance:	Program administrative records.	
	(i) The total budget allocated for maintenance at the hospitals being rehabilitated under the program increases from 1.63% in 2007 to 2% in 2009, and 3% in 2011.	Financial reports by the MSPAS and the program hospitals, and the maintenance plans and evaluation reports on hospital maintenance.	
	(ii) Execution of the hospital maintenance budget is 100% for each year of program execution.		

[4] The baseline is found in Tables 8, 9, and 11 of the program's Annex IV.

[5] The deterioration index for departmental hospitals is determined using the formula: Id = 1 – ICR (d), where Id is the extent of deterioration and ICR is the relative needs index for the variables that measure the level of hospital deterioration. The electronic reference "Justificación y Criterios Utilizados para la Construcción y Rehabilitación de Hospitales del Programa" [Rationale and Criteria used for the Construction and Rehabilitation of Program Hospitals] presents the methodology and base for calculating the deterioration index.

Narrative summary	Indicators	Means of verification	Assumptions
	Quality: (i) The level of satisfaction among the indigenous population with the services received increases from X% in 2009 to Y% in 2011.[6]	User satisfaction survey, as part of the midterm and final evaluations.	
Component I Hospital system strengthened up to quality standards and with expanded treatment capabilities.	Completion of programming of investments in infrastructure and equipment during each year of execution. 100% of the establishments selected for rehabilitation and equipment under the program are rehabilitated and in operation by the end of year two of the program. Three new hospitals have been completed and are in operation by the end of the program.	Program progress reports. Program progress reports. Reports on MSPAS clearance visits.	The MSPAS has adequate standards for works and equipment. The physical works and equipment installations comply with existing MSPAS standards.
Component II The MSPAS's technical and financial capacity to manage maintenance and hospital waste strengthened.	100% of the rehabilitated hospitals have maintenance and hospital waste management plans by the end of year three of the program. 100% of the technical standards for investments in infrastructure, equipment, technology use, and environmental management are revised, updated, and implemented starting in year two of the program.	Financial execution report by the integrated financial management system (SIAFI). Reports by the program monitoring and evaluation system. Reports by the Strategic Planning Unit.	The MSPAS assigns the technical and human resources required to support the execution of program activities.

[6] The baseline for purposes of this indicator will be developed as part of the midterm evaluation.

Narrative summary	Indicators	Means of verification	Assumptions
Component III Hospital management model developed and extended to the program hospitals.	By the end of years three and four of execution, at least 50% and 75% (respectively) of the program hospitals that implement the management model: a. Meet the goals for productivity, efficiency, quality, and user satisfaction established in the management agreements by the end of the program. b. Have established new management offices (a minimum of two per hospital) and a customer service office with a complaints book by the end of the program. c. Apply medical protocols to guide medical care by the end of the program. d. Carry out: (i) staff selection on the local level through job profiles; (ii) purchasing based on needs and a basic table established on the local level; and (iii) preparation of the local budget based on the SIAFI by the end of the program. The nine hospitals benefitting from this component will have at least one bilingual cultural facilitator by the end of year three of the program.	Reports by the program monitoring and evaluation system. Reports by the program monitoring and evaluation system. Reports by the program monitoring and evaluation system. Reports by the program monitoring and evaluation system. Reports by the program monitoring and evaluation system. Reports by the program monitoring and evaluation system.	Hospital officials are interested in adopting and applying methodologies, applications, and instruments for hospital modernization.
Component IV Project monitoring, supervision, and evaluation system implemented.	Monitoring and evaluation system implemented by the end of year two of the program. Works supervision and oversight manual approved and put into effect by the MSPAS, by the end of year two of the program. 100% of the program hospitals participate in events to disseminate the program by year two. The program carries out public information campaign on the hospital modernization process in Spanish and in the indigenous languages used in the different localities by year two.	Reports by the program monitoring and evaluation system. Administrative order putting it into effect. Reports by the program monitoring and evaluation system. Reports by the program monitoring and evaluation system.	The MSPAS assigns the technical and human resources necessary to support the execution of program activities. There is adequate liaison between the MSPAS and the IGSS to coordinate the service delivery network.

DOCUMENT OF THE INTER-AMERICAN DEVELOPMENT BANK

PROPOSED RESOLUTION DE-__/07

Guatemala. Loan ____/OC-GU to the Republic of Guatemala
Program to Strengthen the Hospital System

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 Guatemala, as Borrower, for the purpose of granting it a financing to cooperate in the execution of a program to strengthen the hospital system. Such financing will be for the amount of up to US$50,000,000, from the resources of the Single Currency Facility of the Bank's Ordinary Capital, and will be subject to the Financial Terms and Conditions and the Special Contractual Conditions of the Project Summary of the Loan Proposal.

(Adopted on _____ 2007)

LEG/OPR/RGII/IDBDOCS#905117
GU-L1009