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Report No: PAD1922

INTERNATIONAL BANK FOR RECONSTRUCTION AND DEVELOPMENT

PROJECT APPRAISAL DOCUMENT

ON A

PROPOSED LOAN

IN THE AMOUNT OF US$100 MILLION

TO THE

REPUBLIC OF GUATEMALA

FOR A

CRECER SANO: GUATEMALA NUTRITION AND HEALTH PROJECT

March 3, 2017

Health, Nutrition & Population Global Practice
Latin America and the Caribbean Region

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CURRENCY EQUIVALENTS

Exchange Rate Effective February 23, 2017

Currency Unit =	Guatemalan Quetzales (GTQ)
US$1 =	GTQ 7.37

FISCAL YEAR

January 1 - December 31

ABBREVIATIONS AND ACRONYMS

BANRURAL	Bank of Rural Development
BF	Belgian Fund
CCT	Conditional Cash Transfer
CG	Canadian Government
COCODES	Community Development Councils, *Consejos Comunitarios de Desarrollo*
COMUDES	Municipal Development Councils, *Consejos Municipales de Desarrollo*
DLI	Disbursement-Linked Indicator
ENSMI	National Maternal and Child Health Survey, *Encuesta Nacional de Salud Materno Infantil*
ESMF	Environmental and Social Management Framework
EU	European Union
FM	Financial Management
FODES	Social Development Fund, *Fondo de Desarrollo Social*
GDP	Gross Domestic Product
GFF	Global Financing Facility
GRS	Grievance Redress Service
IADB	Inter-American Development Bank
IBRD	International Bank for Reconstruction and Development
LAC	Latin America and the Caribbean
M&E	Monitoring and Evaluation
MIDES	Ministry of Social Development, *Ministerio de Desarrollo Social*
MINFIN	Ministry of Public Finance, *Ministerio de Finanzas Públicas*
MIS	Inclusive Health Model, *Modelo Incluyente de Salud*
MSPAS	Ministry of Public Health and Social Assistance, *Ministerio de Salud Pública y Asistencia Social*
PAHO	Pan American Health Organization
PDO	Project Development Objective
PEC	Expansion of Coverage Program, *Programa de Extensión de Cobertura*
PHC	Primary Health Care
PIU	Project Implementation Unit
PPSD	Project Procurement Strategy for Development
QCBS	Quality and Cost Based Selection
RFB	Request for Bids
SAIDC	Spanish Agency for International Development Cooperation
SC	Swiss Cooperation
SDG	Sustainable Development Goals

SESAN	Secretariat for Food Security and Nutrition of the Presidency of the Republic, *Secretaría de Seguridad Alimentaria y Nutricional de la República*
SICOIN	Integrated Financial Management System, *Sistema de Contabilidad Integrada*
SIGSA	Health Information Management System, *Sistema de Información Gerencial de Salud*
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WB	World Bank
WFP	World Food Program

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BASIC INFORMATION

Is this a regionally tagged project?	Country(ies)	Lending Instrument
No		Investment Project Financing

[ ] Situations of Urgent Need of Assistance or Capacity Constraints

[ ] Financial Intermediaries

[ ] Series of Projects

Approval Date	Closing Date	Environmental Assessment Category
24-Mar-2017	31-Mar-2022	B - Partial Assessment

Bank/IFC Collaboration
No

Proposed Development Objective(s)

The Project Development Objective (PDO) is to improve selected practices, services and behaviors known to be key determinants of chronic malnutrition (with an emphasis on the first 1,000 days of life) in the intervention areas.

Components

Component Name	Cost (US$, millions)
Providing Inter-sectoral Services to Address Chronic Malnutrition Risk Factors	81.00
Moving the Focus towards Results	14.75
Supporting Project Management, Monitoring and Evaluation	4.00

Organizations

Borrower : Republic of Guatemala

Implementing Agency : Social Development Fund/ Ministry of Social Development (MIDES)

[ ] Counterpart Funding	[✔] IBRD	[ ] IDA Credit [ ] Crisis Response Window [ ] Regional Projects Window	[ ] IDA Grant [ ] Crisis Response Window [ ] Regional Projects Window	[✔] Trust Funds	[ ] Parallel Financing

Total Project Cost:	Total Financing:	Financing Gap:
100.00	109.00	9.00
	Of Which Bank Financing (IBRD/IDA):	
	100.00	

Financing (in US$, millions)

Financing Source	Amount
Global Financing Facility	9.00
IBRD-87300	100.00
Total	**109.00**

Expected Disbursements (in US$, millions)

Fiscal Year	2018	2019	2020	2021	2022
Annual	10.00	25.00	30.00	30.00	5.00
Cumulative	10.00	35.00	65.00	95.00	100.00

INSTITUTIONAL DATA

Practice Area (Lead)
Health, Nutrition & Population

Contributing Practice Areas

Social Protection & Labor

Climate Change and Disaster Screening

This operation has been screened for short and long-term climate change and disaster risks

Gender Tag

Does the project plan to undertake any of the following?

a. Analysis to identify Project-relevant gaps between males and females, especially in light of country gaps identified through SCD and CPF

Yes

b. Specific action(s) to address the gender gaps identified in (a) and/or to improve women or men's empowerment

Yes

c. Include Indicators in results framework to monitor outcomes from actions identified in (b)

Yes

SYSTEMATIC OPERATIONS RISK-RATING TOOL (SORT)

Risk Category	Rating
1. Political and Governance	High
2. Macroeconomic	Moderate
3. Sector Strategies and Policies	High
4. Technical Design of Project or Program	Moderate
5. Institutional Capacity for Implementation and Sustainability	High
6. Fiduciary	High
7. Environment and Social	Substantial
8. Stakeholders	Moderate
9. Other	
10. Overall	High

COMPLIANCE

Policy

Does the project depart from the CPF in content or in other significant respects?

[ ] Yes [✔] No

Does the project require any waivers of Bank policies?

[ ] Yes [✔] No

Safeguard Policies Triggered by the Project	Yes	No
Environmental Assessment OP/BP 4.01	✔	
Natural Habitats OP/BP 4.04		✔
Forests OP/BP 4.36		✔
Pest Management OP 4.09		✔
Physical Cultural Resources OP/BP 4.11	✔	
Indigenous Peoples OP/BP 4.10	✔	
Involuntary Resettlement OP/BP 4.12		✔
Safety of Dams OP/BP 4.37		✔
Projects on International Waterways OP/BP 7.50	✔	
Projects in Disputed Areas OP/BP 7.60		✔

Legal Covenants

Sections and Description
Institutional Arrangements (recurrent). Schedule 2, Section I.A.1

Throughout Project implementation, the Borrower shall ensure that MIDES-FODES functions in a manner and with adequate staffing and budgetary resources, all acceptable to the Bank, and as set forth in the Operations Manual.

Sections and Description
Institutional Arrangements. Schedule 2, Section I.A.2

No later than three (3) months after the Effective Date, the Borrower, through MIDES-FODES, shall hire a financial management specialist, an accountant, a budget officer, a procurement specialist and a social specialist, all with qualifications and experience, and under terms of reference, acceptable to the Bank.

Sections and Description
Institutional Arrangements (specific deadline for establishment and thereafter, recurrent for operating and maintaining). Schedule 2, Section I.A.3

For purposes of providing general Project oversight and coordination, the Borrower through MIDES-FODES shall, not later than three months after the Effective Date, establish, and thereafter operate and maintain, throughout the implementation of the Project, a committee (the Steering Committee), with functions, responsibilities and composition, including representatives of MSPAS, SESAN, MIDES and MIDES-FODES, all acceptable to the Bank, and as set forth in the Operations Manual.

Sections and Description
Inter Institutional Arrangements (recurrent). Schedule 2, Section I.B.1

For purposes of facilitating the implementation of the Project, the Borrower, through MIDES-FODES, shall enter into separate arrangements with: (a) MSPAS; (b) SESAN, ("Inter Institutional Arrangements"), all under terms and conditions acceptable to the Bank, including, inter alia: (i) the establishment of the coordination mechanisms among MIDES-FODES, MSPAS and SESAN, as applicable, to be used in connection with the implementation of the Project; and (ii) the terms and conditions governing MSPAS and SESAN as beneficiaries of Project activities.

Sections and Description
Water Subproject Agreements (recurrent). Schedule 2, Section I.C.1

To facilitate the carrying out of Part 1(c)(i) of the Project, and prior to the implementation of any Water Subproject under said Part of the Project that falls within the administrative jurisdiction of any given Participating Municipality, the Borrower, through MIDES-FODES, shall enter into an agreement with said Participating Municipality (the "Water Subproject Agreement"), under terms and conditions acceptable to the Bank and set forth in the Operations Manual, which shall include, inter alia, the obligation of said Participating Municipality to operate and maintain the Water Subproject in a manner acceptable to the Bank.

Sections and Description
Water Subproject Agreements (recurrent). Schedule 2, Section I.C.2

The Borrower, through MIDES-FODES, shall exercise its rights and carry out its obligations under each Water Subproject Agreement in such manner as to protect the interests of the Borrower and the Bank and to accomplish the purposes of the Loan. Except as the Bank shall otherwise agree, the Borrower, through MIDES-FODES, shall not assign, amend, abrogate or waive terminate or fail to enforce any Water Subproject Agreement or any of its provisions, except as the Bank shall otherwise agree.

Sections and Description
Conditional Cash Transfers (recurrent). Schedule 2. Section I.D.
Throughout Project Implementation, the Borrower, through MIDES, shall provide Conditional Cash Transfers under Part 2 of the Project in accordance with the updated CCT Operations Manual acceptable to the Bank.

Sections and Description
Operations Manual (recurrent). Schedule 2, Section I.E.1 to 3

1. The Borrower, through MIDES-FODES, shall adopt and thereafter carry out the Project in accordance with the provisions of a manual (the Operations Manual), acceptable to the Bank, which shall include, inter alia: (a) a detailed description of Project activities and institutional arrangements for the Project; (b) the Project administrative, accounting, auditing, reporting, financial (including cash flow aspects in relation thereto), procurement and disbursement procedures; (c) the monitoring indicators for the Project; (d) the institutional and administrative mechanisms established to ensure inter-institutional coordination; (e) the functions, responsibilities and composition of the Steering Committee; (f) the ESMF; and (g) the procedures to ensure the consultation and participation of indigenous peoples throughout the implementation of the Project.

2. Except as the Bank may otherwise agree in writing, the Borrower, through MIDES-FODES, shall not abrogate, amend, suspend, waive or otherwise fail to enforce the Operations Manual or any provision thereof.

3. In case of any conflict between the terms of the Operations Manual and those of this Agreement, the terms of this Agreement shall prevail.

Sections and Description
Independent Evaluation. Schedule 2, Section I.F.1 to 3

1. For purposes of carrying out Part 2 of the Project, the Borrower, through MIDES-FODES, shall:
No later than 120 days after the Effective Date, select, hire and retain an Independent Evaluation Entity with qualifications and experience, and under terms of reference acceptable to the Bank, in accordance with Section III of this Schedule (specific); and

2.cause the Independent Evaluation Entity to: (a) carry out a periodical technical verification of the level of achievement of the DLIs set forth in Schedule 4 of the Loan Agreement; and (b) (i) prepare Independent Evaluation Reports covering a period of one calendar quarter, of such scope and detail as set forth in the Operations Manual, and (ii) furnish each Independent Evaluation Report to the Borrower, no later than forty five (45) days after the

end of each calendar quarter (recurrent); and

3. No later than thirty (30) after the receipt of each Independent Evaluation Report, forward to the Bank each said report (recurrent).

Sections and Description
Financial Institution Agreement (recurrent). Schedule 2, Section I.G.1

For purposes of carrying out Part 2 of the Project, the Borrower, through MIDES-FODES shall amend and maintain an agreement with the Financial Institution (the Financial Institution Agreement) on terms and conditions acceptable to the Bank, including, inter alia the Financial Institution's obligations to provide, on behalf of the Borrower, the Conditional Cash Transfers to Eligible Beneficiaries and to comply with the Anti-Corruption Guidelines, all in a manner acceptable to the Bank.

Sections and Description
Anti-Corruption (recurrent). Schedule 2, Section I.H

The Borrower, through MIDES-FODES, shall ensure that the Project is carried out in accordance with the provisions of the Anti-Corruption Guidelines.

Sections and Description
Safeguards (recurrent). Schedule 2, Section I.I.1 to 3

1. The Borrower, through MIDES-FODES, shall carry out the Project in accordance with the EMSF.

2. Except as the Bank shall otherwise agree, the Borrower, through MIDES-FODES, shall not assign, amend, abrogate, terminate, fail to enforce or waive the ESMF or any of its provisions thereof.

3. The Borrower, through MIDES-FODES, shall ensure that the terms of reference of any consultancy in respect to Part 1 of the Project shall be satisfactory to the Bank following its review thereof and, to that end, such terms of reference shall duly incorporate the requirements of the Bank's Safeguard Policies then in force, as applied to the advice conveyed through such technical assistance.

Sections and Description
Project Reports (recurrent). Schedule 2, Section II.A.1

The Borrower, through MIDES-FODES, shall monitor and evaluate the progress of the Project and prepare Project Reports in accordance with the provisions of Section 5.08 of the General Conditions and on the basis of indicators set forth in the Operations Manual. Each Project Report shall cover the period of one calendar semester, and shall be furnished to the Bank not later than forty-five (45) days after the end of the period covered by such report.

Sections and Description

Financial Management, Financial Reports and Audits (recurrent).

Schedule 2, Section II.B.1 to B4

1. The Borrower, through MIDES-FODES, shall maintain or cause to be maintained a financial management system in accordance with the provisions of Section 5.09 of the General Conditions.

The Borrower, through MIDES- FODES, shall have the Conditional Cash Transfers under Part 2 of the Project audited in accordance with the provisions of Section 5.09 of the General Conditions. Each audit of the Conditional Cash Transfers under Part 2 of the Project shall cover the period of one fiscal year of the Borrower, or any other period acceptable to the Bank. The audited Conditional Cash Transfers under Part 2 of the Project for each such period shall be furnished to the Bank not later than six months after the end of such period.

2. The Borrower, through MIDES-FODES, shall prepare and furnish to the Bank not later than forty-five (45) days after the end of each calendar semester, interim unaudited financial monitoring reports for the Project covering the pertinent calendar semester, in form and substance satisfactory to the Bank.

3. The Borrower, through MIDES-FODES, shall have the Financial Statements for Parts 1 and 3 of the Project audited in accordance with the provisions of Section 5.09 (b) of the General Conditions. Each audit of the Financial Statements for Part 1 and 3 of the Project shall cover the period of one fiscal year of the Borrower, or any other period acceptable to the Bank. The audited Financial Statements for Parts 1 and 3 of the Project for each such period shall be furnished to the Bank not later than six months after the end of such period.

4. The Borrower, through MIDES- FODES, shall have the Conditional Cash Transfers under Part 2 of the Project audited in accordance with the provisions of Section 5.09 of the General Conditions. Each audit of the Conditional Cash Transfers under Part 2 of the Project shall cover the period of one fiscal year of the Borrower, or any other period acceptable to the Bank. The audited Conditional Cash Transfers under Part 2 of the Project for each such period shall be furnished to the Bank not later than six months after the end of such period.

Sections and Description

Procurement (recurrent). Schedule 2, Section III

All goods, works, non-consulting services and consulting services required for the Project and to be financed out of the proceeds of the Loan shall be procured in accordance with the requirements set forth or referred to in the Procurement Regulations and the provisions of the Procurement Plan.

Conditions

Type	Description
Effectiveness	Article V (a) The Inter Institutional Arrangements have been duly executed by their respective parties thereto. (b) The Operations Manual has been adopted in a manner and with contents acceptable to the Bank.

Type	Description
Disbursement	Withdrawal Conditions. Section IV.B of Schedule 2. Notwithstanding the provisions of Part A of this Section, no withdrawal shall be made: (a) for payments made prior to the date of this Agreement; and (b) with respect to Category (2), unless: (i) the Borrower has: (A) carried out a socio cultural assessment of the CCT Program under terms of reference acceptable to the Bank; and (B) updated CCT Operations Manual in a manner to include the recommendations of the above-referenced socio cultural assessment, and with contents acceptable to the Bank; and (ii) the Borrower has amended the Financial Institution Agreement to incorporate the Financial Institution’s obligation to comply with the Anti-Corruption Guidelines, in a manner and with contents acceptable to the Bank.

Type	Description
Disbursement	Withdrawal Conditions. Section V of Schedule 2. Other Undertakings Without limitation to the provisions set forth in Section IV.B.1. of this Schedule, each withdrawal under Category (2) shall be made only after the Borrower has

furnished to the Bank: (a) the Independent Evaluation Report acceptable to the Bank, confirming the achievement of the respective DLI or DLIs set forth in Schedule 4 to this Agreement, and in the Operations Manual; and (b) supporting documentation acceptable to the Bank confirming that Conditional Cash Transfers in an amount at least equal to the amount to be withdrawn under this Category in respect of each DLI, have been made, and that said Conditional Cash Transfers have not been presented before to the Bank as Eligible Expenditures or as satisfactory evidence for withdrawals under this Agreement or any other agreement providing for Bank financing.

2. Without limitation to the provisions of section 5.03 of the General Conditions, the Borrower, through MIDES, shall ensure, until completion of the Project, that adequate budgetary resources are allocated and made available to MIDES-FODES for the implementation of the Project.

PROJECT TEAM

Bank Staff

Name	Role	Specialization	Unit
Christine Lao Pena	Team Leader(ADM Responsible)	Health	GHN04
Carlos Marcelo Bortman	Team Leader	Health	GHN04
Monica Lehnhoff	Procurement Specialist(ADM Responsible)	Procurement	GGO04
Lourdes Consuelo Linares Loza	Financial Management Specialist	Financial	GGO22
Christian Borja-Vega	Team Member	Water and sanitation	GWA04
Claudia Rokx	Team Member	Nutrition	GHN04
Dianna M. Pizarro	Safeguards Specialist	Social	GSU04
Gabriela Grinsteins	Counsel	Counsel	LEGLE
Gunars H. Platais	Environmental Specialist	Environment	GEN04
Marco Antonio Aguero	Team Member	Water and sanitation	GWA03
Maria E. Colchao	Team Member	Program assistant	GHN04
Maria Gabriela Moreno Zevallos	Team Member	Program assistant	GHN04

Maria Virginia Hormazabal	Team Member	Financial - Disbursements	WFALA
Marvin Ploetz	Team Member	Economic Analysis	GHN04
Meera Shekar	Team Member	Nutrition	GHNDR
Sara Francesca Giannozzi	Team Member	Social Protection	GSP04
Tania Dmytraczenko	Team Member	Program Leader	LCC2C
Vanina Camporeale	Team Member	Health	GHN04
William David Wiseman	Team Member	Social Protection	LCC1C

Extended Team

Name	Title	Organization	Location

GUATEMALA
CRECER SANO: GUATEMALA NUTRITION AND HEALTH PROJECT

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I. STRATEGIC CONTEXT

A. Country Context

1. **Guatemala is among the countries with the highest poverty rate in Latin America and Caribbean (LAC), and income growth among the bottom 40 percent of the population has been negligible in recent years.** From 2000 to 2014, the poverty rate (US$4 per day poverty line) increased from 55 to 60 percent, in striking contrast to the decline in poverty in LAC. The change in shared prosperity, as measured by the average income growth of the bottom 40 percent of the population, was negligible between 2006 and 2014, again in contrast to most LAC countries. High poverty is also reflected in the country's social indicators, such as stunting rates for children under-five, affecting in particular the poor (66 percent), rural dwellers (59 percent), and Indigenous groups (61 percent).

2. **Growth has been modest and the country has one of the lowest per capita spending on social sectors in LAC**. Although Guatemala experienced less of an economic decline during the 2009 recession than most of LAC, economic growth remains modest (averaging 3.4 percent between 2000 and 2013), and per capita income growth even more modest (1.2 percent). Rather than catching up with richer countries, Guatemala has diverged: its gross domestic product (GDP) per capita is now 6.7 percent of United States GDP per capita (current), compared to 8.4 percent in 1960. Although public social spending as a share of GDP increased in the last decade, it has stagnated in recent years. At just 8.1 percent of GDP in 2014, it is the lowest in Central America, behind countries such as Nicaragua and Honduras.

3. **The 1996 Peace Accords established an important agenda for creating a new model of inclusive growth, but significant gaps in terms of access to social services and outcomes remain**. The Peace Accords created an impetus for increasing state capacity and promoting equity for women and Indigenous people. However, after almost 21 years, health and education outcomes in Guatemala remain below those of its peer countries. In addition, for all measures of human capital, the ethnic gap is striking and there is also often a significant gender gap.[1]

4. **The new Administration that took office in January 2016 has placed health, education, stronger economic growth, and increased transparency at the center of its policy agenda.** Recognizing the important role that human capital development plays in contributing to economic growth (and vice versa), the Government's 2016-2020 Plan[2] emphasizes the need for improvements in health and education, and reduction of chronic malnutrition. In February 2016, the Government established the Commission to Reduce Chronic Malnutrition, and in March 2016, the President officially launched the National Strategy to Prevent Chronic Malnutrition 2016-2020. The Government also recently updated its Primary Health Care (PHC) Model, adopting a multidimensional (individual-family-community) approach and integrating complementary aspects of traditional Indigenous health beliefs and practices. The Government is also committed to improving transparency and accountability by institutionalizing

[1] World Bank. 2016. *Building Bridges in Guatemala: Systematic Country Diagnostic (SCD)*. Washington, DC.

[2] *Política General del Gobierno 2016-2020. Secretaría de Seguridad Alimentaria y Nutricional de la República*. National Development Plan *K'atun Nuestra* Guatemala 2032.

management for results in public administration and promoting social audits and other mechanisms to enhance citizen participation.

B. Sectoral and Institutional Context

4. **Guatemala has made significant progress on several health indicators in the last 25 years, but maternal mortality and chronic malnutrition remain high, with the latter posing a serious development problem.** Between 1990 and 2013, under-five mortality declined steeply from 81 to 31 deaths per 1,000 live births, while infant mortality declined from 60 to 26 deaths per 1,000 live births. Although the maternal mortality ratio declined between 1990 and 2014, at 93 deaths per 100,000 live births in 2014, it remains higher than the LAC average of 71 deaths per 100,000.[3] Moreover, although chronic malnutrition decreased from 55 percent in 1995 to 46.5 percent in 2014/15 according to National Maternal and Child Health Surveys (*Encuesta Nacional de Salud Materno Infantil*, ENSMI), it is the highest in LAC and among the highest in the world, exceeding rates of countries with significantly lower per capita incomes, such as Bangladesh, Ethiopia, and Vietnam. Guatemala's high chronic malnutrition affects the quality of its human capital and, as a consequence, its growth and development potential. Moreover, it is estimated that the cost of malnutrition in 2004 represented 11.4 percent of GDP in Guatemala.[4]

5. **Major drivers of chronic malnutrition (maternal health, child feeding practices, as well as limited access to safe water, sanitation, and quality health services that integrate cultural norms and traditional medicine) are interlinked.** The 1990 Causes of Malnutrition Framework developed by the United Nations Childrens' Fund (UNICEF) underscores the role that childcare practices, dietary quality, access to water, and adequate sanitation and health care play in malnutrition. Maternal stature and nutrition are important predictors of intrauterine growth retardation and size at birth,[5] the effects of which extend to the next generation.[6] Complementary feeding, growth promotion, and immunization are critical for the 7-24 month age group along with interventions, such as deworming and administering anthelminths to reduce the incidence of parasite and bacterial infections among pregnant women, infants, and children.[7] Sanitation and hygiene plays a key role in the prevention of diarrheal morbidity and mortality. In 2014/15, only 53.2 percent of children 0-5 months were exclusively breastfed, and 50 percent of children 6-23 months adequately fed. Moreover, only 51.7 percent of children 12-23 months in the lowest income quintile received all of their required vaccinations, compared to 62.4 percent of children in the highest income quintile.[8] Overall, less than half of the population has access to primary health services, partly due to the discontinuation of the Expansion of Coverage Program (*Programa de Extensión de Cobertura*, PEC), which provided primary health services through nongovernmental organizations. Finally, in 2015, only 71 percent of rural areas had access to piped water (compared to 97 percent of urban areas) and 49 percent to improved sanitation (compared to 78 percent of urban

[3] World Development Indicators 2015.
[4] Martinez and Fernandez 2008; UNICEF/Central American Institute for Fiscal Studies 2011.
[5] Ozaltin et al. 2010.
[6] Ramakrishnan et al. 1999.
[7] Horton el al. 2008a, also see Horton et al. 2008b.
[8] ENSMI 2014/15.

areas).[9] As identified in the National Development Plan (K'atun 2032), this situation is further exacerbated by the impact of climate change on infrastructure, including water and sanitation. With long operational lifetimes, infrastructure assets are sensitive not only to the climate at the time of their construction, but also to climate variations in the future.

6. **Quality of care also remains an issue, with the sector facing a shortage of health professionals and medical inputs**. A 2016 social-cultural assessment showed that access to quality health care is exacerbated by discriminatory practices and lack of sufficient recognition of traditional systems and medicinal practices that have been the primary source of health care for Mayan Indigenous populations in Guatemala for centuries. Many public health care providers do not adequately take into account cultural norms related to touch and diet, or the role of midwives and key actors in family health decision-making processes. This has generated fear and distrust, especially among Indigenous communities, reducing incentives to seek official medical services, making public medical services a "last resort" option.

7. **Budget constraints, funding flow bottlenecks, and inefficient spending limit the coverage and quality of services and social programs.** While public health expenditures increased from 1.8 percent of GDP in 2007 to 2.2 percent in 2014, they are lower than the LAC average of 3.8 percent.[10] Despite the 2008 Government policy mandating free-of-charge provision of health services in public facilities, private spending as a share of total health expenditures has been almost twice as large as the public share (63 percent vs. 37 percent respectively). Budget allocations to the health sector are inadequate to address the significant coverage gaps and quality issues related to staffing and availability of essential inputs, while funding delays and inefficient resource management, such as poor targeting and lack of coordination, hamper implementation.[11] Budget constraints and delayed release of funds also affect the Government's Conditional Cash Transfer (CCT) Program,[12] forcing transfers to be rationed. As a result, many intended CCT beneficiaries do not receive the full annual benefit they are entitled to, nor do they receive transfers in a timely manner, weakening the link between transfers and fulfillment of co-responsibilities and limiting the Program's potential to support the poor's increased access and utilization of health services.

8. **The Government's Zero Hunger Program yielded mixed results, but provided useful lessons.** Launched in 2012, the Program targeted 166 municipalities (out of 340) with the highest chronic malnutrition rates, using a multisectoral approach involving several ministries, and public, private, and civil society organizations. In 2012, the Ministry of Public Finance (*Ministerio de Finanzas Públicas*, MINFIN) and the Ministry of Public Health and Social Assistance (*Ministerio de Salud Pública y Asistencia Social*, MSPAS) signed a results-based budgeting agreement to track progress made in implementing the First 1,000 Days of Life Initiative under the Program. Evaluations indicate that chronic malnutrition for children ages 3-59 months decreased from 60.1 percent in 2012 to 58.4 percent in 2013 in Program

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[9] Water, Sanitation and Hygiene Team Presentation, World Bank 2016.

[10] World Bank Guatemala Social Sector Expenditure and Institutional Review (2016).

[11] World Bank Health System Functional Review 2016.

[12] Guatemala's CCT targets families with children between 0-15 years, promoting regular health visits for children aged 0-6 years and pregnant women, and school attendance for children aged 6-15 years. Annex I provides more information.

areas, while stunting increased for children under one.[13] They also highlighted the need for prioritized multisectoral services, and better coordinated efforts with fewer institutions in fewer prioritized areas. The 2016 social assessment also noted that the Program's shortcomings could partly be attributed to insufficient understanding of cultural dietary practices and preferences, and lack of proper communication, for example, on the benefits of nutritional supplements and how to integrate them into local diets.

9. **Nevertheless, some promising PHC interventions appear to have shown results in reducing chronic malnutrition in Guatemala.** Preliminary results show that in four districts where the Inclusive Health Model (*Modelo Incluyente de Salud*, MIS) was piloted by MSPAS, the prevalence of chronic malnutrition in children 24-27 months declined, on average, by two percentage points per year from 2013 to 2016. The MIS integrates essential traditional Indigenous health beliefs and practices into public health services. Other districts have also shown some improvement in reducing chronic malnutrition and studies are needed to learn from their experiences.

10. **Given the magnitude of chronic malnutrition in Guatemala, the Government seeks World Bank (WB) support for the implementation of its National Strategy to Prevent Chronic Malnutrition 2016-2020.** This multisectoral National Strategy seeks to address the main risk factors for chronic malnutrition, by increasing its target population's access to improved PHC, water and sanitation services, as well as information and additional resources to promote and support healthy behaviors. WB support features complementary instruments, including: (i) this WB- financed Nutrition and Health Project (P159213; IBRD 8730) to target needed investments and interventions in priority areas; (ii) the First Improved Governance of Public Resources and Nutrition Development Policy Loan (P160667; IBRD-86600) to support needed policy reforms; (iii) future technical assistance to support evaluation of the National Strategy to Prevent Chronic Malnutrition 2016-2020; (iv) support for South-South dialogue; and (v) the buy-down of the interest and/or other IBRD loan charges on the Project loan through the Global Financing Facility (GFF) loan to more concessional terms, to free up resources from interest payments and/or other IBRD loan charges that the Government will match and reinvest in the CCT Program. This support will complement ongoing assistance of other development partners, such as the Belgian Fund (BF), Canadian Government (CG), European Union (EU), Inter-American Development Bank (IADB), Pan American Health Organization (PAHO), Spanish Agency for International Development Cooperation (SAIDC), Swiss Cooperation (SC), UNICEF, United States Agency for International Development (USAID), and World Food Program (WFP).

C. Higher Level Objectives to which the Project Contributes

11. **The Project is aligned with the WB's twin goals to reduce poverty and promote shared prosperity, the Guatemala Country Partnership Framework for FY17-20,[14] and the WB Human Development Strategic Framework.**[15] In areas prioritized for high rates of chronic malnutrition and maternal and child mortality, the Project will support interventions to improve access to health,

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[13] SESAN-International Food Policy Research Institute 2014.
[14] Report No. 103738-GT, discussed by the Board of Executive Directors on November 17, 2016.
[15] World Bank. Human Development Strategic Framework presented as part of the Human Development Practice Group Board Update in February 2017.

nutrition, water and sanitation services, especially for the poorest and Indigenous peoples, and support the CCT Program to increase both financial protection and demand for critical health and nutrition services. The Project contributes to Pillar 1 (Fostering Inclusion of Vulnerable Groups) of the Country Partnership Framework, and directly supports the objective of increasing access to basic health, nutrition and water and sanitation services. The Project is also aligned with Pillar 2 of the Human Development Strategy by supporting investments to promote "a strong healthy start for all" and strengthening the health system to improve access to quality, affordable services, and accountability for results. Lastly, the Project is expected to have climate co-benefits by considering water and sanitation infrastructure resilience in the context of climate change variability to ensure proper supply of quality drinking water and water disposal (Annex 1). Based on available information at the time of Project appraisal, climate co-benefits are estimated at 25 percent of the Project amount.

12. **The Project comes at a critical juncture in global efforts to reduce malnutrition.** The Project's objectives are in line with the Sustainable Development Goal (SDG) to end malnutrition by 2030, including achieving internationally agreed targets on stunting and wasting in children under five years of age and addressing the nutritional needs of adolescent girls, pregnant and lactating women, and older persons by 2025. The Project also supports SDG 3 to ensure healthy lives and promote well-being for all, SDG 6 to ensure access to clean water and sanitation for all, and SDG 10 to reduce inequalities within countries. Guatemala is also participating in the Scaling Up Nutrition Movement.[16]

II. PROJECT DEVELOPMENT OBJECTIVES

A. PDO

The Project Development Objective (PDO) is to improve selected practices, services and behaviors known to be key determinants of chronic malnutrition (with an emphasis on the first 1,000 days of life) in the intervention areas.

B. Project Beneficiaries

13. **The Project will benefit children 0-24 months, pregnant women, and their families in the intervention areas.** The Project's main target population is located in seven departments (out of 22), most of which have predominantly Indigenous populations (Alta Verapaz, Chiquimula, Huehuetenango, Quiche, San Marcos, Sololá, and Totonicapán). These departments were selected based on high rates of stunting and maternal and child mortality, large numbers of children under five, and a high proportion of rural and Indigenous populations (mainly in the highlands). Households and communities are also expected to benefit from improved access to services through both supply-side (water and sanitation, health and nutrition services) and demand-side (reliability of CCT services and enhanced knowledge) interventions. Some interventions will be implemented countrywide, such as communication campaigns to raise awareness about nutrition issues and technical assistance to key implementing ministries, including MSPAS, the Ministry of Social Development *(Ministerio de Desarrollo Social*, MIDES) and the

[16] The Scaling Up Nutrition Movement seeks to eliminate all forms of malnutrition, by strengthening political commitments and accountability for those commitments. Members include representatives of governments, civil society, the United Nations, donors, businesses and scientists.

Secretariat for Food Security and Nutrition of the Presidency of the Republic (*Secretaría de Seguridad Alimentaria y Nutricional de la Presidencia de la República*, SESAN). Interventions will be coordinated in a two-phase process: Phase I will include the departments of Alta Verapaz, Chiquimula, Huehuetenango, and Quiché, while Phase II will include the departments of San Marcos, Sololá, and Totonicapán. Except for Chiquimula, most of these departments are located in the Northwestern and Western parts of Guatemala.

C. PDO-Level Results Indicators

14. **To monitor progress toward the PDO, the Project will use a core set of indicators:**

- Percentage of children six months old with exclusive breastfeeding in the intervention areas, also a disbursement-linked indicator (DLI) below (Behavior);
- Coverage of growth promotion for children under 24-months old in the intervention areas (Practices and services);
- Number of families being served by new or rehabilitated water systems in the intervention areas (Services); and
- Proportion of municipalities where combined interventions[17] were implemented (Coordinated interventions/services).

15. **In addition, the Project will support the achievement of the following DLIs:**

DLI 1. Increased coverage of prenatal care with at least four visits in the intervention areas (Services and behavior);
DLI 2. The Unique Registry of Beneficiaries receives individual level data on health system usage (Services);
DLI 3. Increased percentage of six months old children who are exclusively breastfed in the intervention areas (Behavior); and
DLI 4. Increased percentage of children under two years old who are beneficiaries of the CCT Program receiving transfers based on compliance with the full verification cycle of health co-responsibilities in the Intervention Areas (Practices and services).

III. PROJECT DESCRIPTION

A. Project Components

16. The proposed Project will finance three Components to be implemented over five years.

Component 1. Providing Inter-sectoral Services to Address Chronic Malnutrition Risk Factors (US$ 81.00 Million – Bank financing)

This Component will support provision of quality nutrition and health services to mothers and children;

[17] PHC services, new or rehabilitated water system, and behavioral change promotion

promotion of behavioral change interventions targeted to families and communities; improving access to safe drinking water and sanitation; and enhancing coordination across sectors. It will finance works for health posts, small water supply and sanitation systems, and select community centers, as well as equipment, medical and nonmedical supplies, health promotion activities, technical assistance, studies and training.

Component 2. Moving the Focus towards Results (US$ 14.75 million – Bank financing)

This Component will introduce results-based financing to: (i) promote the use of health services, including timely prenatal care; (ii) promote behavioral changes, including exclusive breastfeeding during the first six (6) months of life; and (iii) strengthen the CCT Program in the intervention areas.

Component 3. Supporting Project Management, Monitoring and Evaluation (US$ 4 million – Bank financing)

This Component will provide support to the MIDES Social Development Fund (*Fondo de Desarrollo Social*, FODES), or MIDES-FODES, for the carrying out of Project management, coordination and evaluation. It will finance consulting services including consultants to support MIDES-FODES, office equipment, training, and operating costs, and an external entity to evaluate achievement of the DLIs.

B. Project Cost and Financing

17. **The total Project cost is US$100 million, and is complemented by performance-based buy-down grant funds from the GFF.** The GFF is a multi-stakeholder partnership that supports country-led efforts to improve the health of women, children, and adolescents through high-impact evidence-based interventions for measurable and equitable results. Building on the Project's results focus, the GFF Trust Fund will provide Guatemala a US$9 million grant to buy down the interest and/or other IBRD loan charges on the Project loan to more concessional terms when the agreed upon indicators for Years 2 and 4 are achieved, and the Government has showed evidence that the equivalent to twice the buy-down grant amount of public resources has been invested in the CCT Program. The buy-down indicators and targets include: (i) increased percentage of six month old children who are exclusively breastfed in the Intervention Areas; and (ii) increased percentage of children under two years old who are beneficiaries of the CCT Program receiving transfers based on compliance with the full verification cycle of health co-responsibilities in the Intervention Areas (see Annex 4 for targets). The IBRD performance-based buy-down will free up resources from payments on interest and/or other IBRD loan charges that the Government will match and invest in the CCT Program. This allows the country to safeguard resources for the CCT Program and is in line with the GFF objective of supporting countries to increase domestic resources for reproductive, maternal, neonatal, child and adolescent health. In addition to the grant, the GFF will provide technical assistance to mobilize funds for health and nutrition and also support the Government to increase efficiency of public spending on health and nutrition.

Project Components	Project Cost	IBRD Financing	% of IBRD Financing	Grant Funds (GFF*)	% of GFF Financing
Providing Inter-sectoral Services to Address Chronic Malnutrition Risk Factors	81.00	81.00	100	0	0
Moving the Focus towards Results	14.75	14.75	100	0	0
Supporting Project Management, Monitoring and Evaluation	4.00	4.00	100	0	0
Total Costs					
Total Project Costs	99.75	99.75	100	0	0
Front end Fee	0.25	0.25	100		
Buy down (interest and other IBRD Loan Charges)*				9.0	100

C. Lessons Learned and Reflected in the Project Design

18. **The Project builds on lessons learned from Guatemala, and WB-financed projects that successfully addressed malnutrition in other countries.** The Project will employ international best practices in supporting interventions proven to address chronic malnutrition[18] and take into account lessons learned from Guatemala, Peru, Vietnam, and Indonesia:

a. In particular, from Guatemala, lessons from the Zero Hunger Program (2012-2016) and the WB-financed Maternal and Child Health & Nutrition Project (P077756) 2008-2013 include: (i) prioritizing integrated interventions in fewer areas and with fewer implementing agencies; (ii) strengthening monitoring and supervision; (iii) improving reliability and timeliness of funding; and (iv) building complementarity, understanding, and respect among western and Indigenous traditional systems of health care. Lessons from the MIS include: (i) implementing a horizontally coordinated set of interventions targeting individuals, families, and communities; (ii) having a strong management information system combined with regular monitoring and follow up of the target population; and (iii) ensuring interventions build on culturally relevant concepts of health and illness, and employ traditional systems and care providers that the community and families trust.
b. Lessons from Peru, which reduced stunting among children by half in less than a decade (from 28 percent in 2005 to 14 percent by 2013), include: (i) ensuring strong Government commitment at the highest level, as well as MINFIN support; (ii) supporting multisectoral efforts that target the main

[18] The Lancet Maternal and Child Undernutrition Series (2008, vol. 371) and Maternal and Child Nutrition Series (2013, vol. 382).

determinants/risk factors of malnutrition; (iii) promoting strong advocacy of, and communication about, behavioral change; (iv) improving results orientation through results-based financing; (v) strengthening both supply and demand (the importance of the roles of the CCT Program and MSPAS); (vi) increasing local involvement in reducing chronic malnutrition; and (vii) including water and sanitation as part of Project interventions from the beginning.

c. Implementation experience from countries such as Vietnam and Indonesia will be applied to specific health communication interventions, such as behavior change communication and information, education and promotion campaigns.

IV. IMPLEMENTATION

A. Institutional and Implementation Arrangements

19. **MIDES, through FODES, will be responsible for implementation of the Project, with support of additional fiduciary, social and technical consultants.** MIDES-FODES will be responsible for day-to-day management, coordination, and supervision of Project activities through its various line units (complemented by additional technical and fiduciary staff as needed), and its Director will be the General Project Director, entrusted with overall Project oversight. MIDES-FODES will house the Project Implementation Unit (PIU), which is fully integrated in the MIDES-FODES structure (thus it will be referred to as MIDES-FODES/PIU). MIDES-FODES was selected because of its ability to operate with greater independence than other agencies, which is critical given the multisectoral nature of the Project, and because it has the authority to enter into agreements with other institutions. Other entities involved in the Project include MSPAS, SESAN, the Commission to Reduce Chronic Malnutrition, and municipalities in the targeted areas. MIDES-FODES/PIU will sign Inter Institutional agreements with MSPAS and SESAN to define their roles and responsibilities in the Project. In particular, MSPAS and SESAN will provide technical oversight for specific Project activities, with MIDES-FODES performing fiduciary functions, such as procurement and processing of contracts and payments to support these activities (Annex 2). All reporting and oversight relationships are defined in the Operations Manual, to be adopted before Project effectiveness.

20. **MIDES-FODES/PIU will coordinate with local- and community-level actors to strengthen buy-in to and relevance of the Project.** MIDES-FODES/PIU and other participating institutions will coordinate with Community Development Councils (*Consejos Comunitarios de Desarrollo,* COCODES) and Municipal Development Councils (*Consejos Municipales de Desarrollo,* COMUDES) to increase ownership of activities and adjust the interventions to the specific needs of targeted areas. When needed, Indigenous leaders and relevant organizations will be invited to participate in key Project decisions according to specific procedures included in the Operations Manual. In the identification of health, and water and sanitation infrastructure, MIDES-FODES/PIU will seek the agreement of participating municipalities on the works to be financed under the Project, and confirm their commitment to maintain them.

21. **Multisectoral coordination will be overseen by a Steering Committee.** The Steering Committee will provide multisectoral policy oversight and stewardship of the Project, and ensure smooth coordination between the relevant Government agencies, regional authorities and Indigenous representatives from the seven Project-supported departments. The Steering Committee will be chaired

by the Commissioner for Reducing Chronic Malnutrition and made up of representatives of MSPAS, SESAN, MIDES, and MIDES-FODES/PIU. Representatives of other institutions, Indigenous authorities and Government agencies will be invited to join as needed. The Steering Committee will meet at least on a bimonthly basis to review implementation progress and make decisions on intersectoral issues related to the Project. Given that this is a new institutional arrangement, a stocktaking by Project stakeholders and the WB will be conducted after the first six months of implementation to make any necessary adjustments.

B. Results Monitoring and Evaluation

22. **Monitoring and evaluation (M&E) of results and intermediate outcomes will be carried out using mechanisms outlined in detail in Annexes 1 and 4.** MIDES-FODES/PIU will consolidate all Project activity and fiduciary reports, with support from participating institutions and municipalities, as well as independent agencies and consultants, as required. Efforts will be made to ensure that all information systems are inter-operable and communicate with each other. Progress reports will include information on Project indicators, beneficiaries, implementation of social safeguards, procurement, contracts, disbursements, financial management (FM), and other outputs. With respect to beneficiaries, relevant indicators will be disaggregated by gender to track and promote participation of both women and men, as in the case of consultation activities and training. Annual independent audit reports will be prepared to monitor use of funds and physical progress. Reported results under Component 2 will be verified by an independent evaluation entity to be selected competitively and financed under Component 3. If further evaluation is required, the WB retains the right to engage a third party represented by a public organization (for example, the Statistics Department or Controller General). The Steering Committee will review monitoring data during its periodic meetings to assess progress on the PDO and take timely corrective measures as needed. Details on M&E arrangements, including M&E responsibilities, data collection requirements, and reporting frequency are outlined in the Operations Manual.

C. Sustainability

23. **Sustainability of Project activities is supported by several factors.** First, there is strong Government ownership, with: (i) the President of Guatemala requesting WB support for the implementation of the National Strategy to Prevent Chronic Malnutrition 2016-20; and (ii) the presidential appointment of a Commissioner for Reducing Chronic Malnutrition to oversee the process and lead the Steering Committee. Second, the Project will support priority activities of key institutions as part of their institutional work plans as well as the expansion of the MIS to be delivered by MSPAS using its staff rather than contracting services annually. Third, by improving the institutional capacity of the major institutions implementing the National Strategy and contributing to enhancing the coverage, quality, and efficiency of nutrition-related programs, the Project is expected to contribute to overall institutional sustainability. Finally, MIDES-FODES will act as the PIU relying mainly on its own structure and staff with support from a few consultants instead of having an external PIU.

D. Role of Partners

24. **A number of development partners are active in health and nutrition and the WB is coordinating with them**. These partners include BF, CG, IADB, USAID, PAHO, EU, SC, UNICEF, and WFP. Details on areas of support of each development partner are described in Annex 2.

V. KEY RISKS

A. Overall Risk Rating and Explanation of Key Risks

25. **Overall Project risk is assessed as high.** There are six main risk that could affect the achievement of the PDO. The specific high and substantial risks during implementation, and possible impact and mitigation measures are outlined below.

26. **Health sector strategy and policy risk is assessed as high while there is a substantial risk associated with the lack of a clear water resource management policy.** The Government's 2015 decision to discontinue the PEC, without rolling out its own institutional delivery model on time, substantially reduced access of vulnerable populations to PHC services, and likely impacted the demand for services. A new model for the provision of PHC is being introduced, but its effective operationalization could be challenging. The Project will work closely with the MSPAS to support its implementation. With respect to water resources, while MSPAS is responsible for monitoring water quality based on standards and municipalities are responsible for implementing and maintaining water systems, there is limited capacity for the management of water resources in the country. There is also lack of buy-in from some local communities on the importance of water security. To address these issues, the Project will build on lessons learnt from the IADB and SAIDC projects, with MIDES-FODES/PIU responsible for water and sanitation works in consultation with COCODES and COMUDES. The Project will also focus on rehabilitating existing water systems, supporting only a few new water works. Finally, the Project will carry out communication campaigns on the importance of potable water for health and nutrition.

27. **Political and governance, institutional capacity for implementation, and fiduciary risks are all assessed as high**. There is commitment to the National Strategy at the highest level by the President of Guatemala and ministers and/or heads of key institutions with the establishment of the Commission to Reduce Chronic Malnutrition. However, addressing the persistently high rate of chronic malnutrition in Guatemala through the implementation of the National Strategy will also require integrated efforts at national and local levels, and while the National Strategy includes some interventions at the national level, most activities will be carried out in prioritized areas. Fiduciary risk is high due to cumbersome national procedures and recent governance challenges at the country level. In addition, while MIDES-FODES has some experience in managing external funds and coordinating multisectoral projects, it will require further strengthening to properly support a project that includes activities that go beyond civil works and that requires more multisectoral coordination in order to implement central, municipal and community level interventions. To mitigate this risk, an institutional strengthening plan for MIDES-FODES/PIU will be implemented under the Project and management tools will be developed to strengthen coordination, monitoring, and follow up of the National Strategy. MIDES-FODES/PIU will also

be staffed with qualified procurement and FM staff, training will be carried out, and processes and systems will be put in place to ensure that Project implementation is carried out in accordance with the Operations Manual, acceptable to the WB. Moreover, the Steering Committee, which includes representatives of key institutions involved in the National Strategy, is expected to play a key role in resolving any implementation bottlenecks.

28. **Finally, overall environmental and social risk is substantial.** This is due to substantial social risks, although environmental risks are moderate. Many beneficiaries are Indigenous peoples from a wide range of linguistic and ethnic backgrounds. Although the MIS has significantly reduced chronic malnutrition and improved other related indicators among Indigenous peoples, such as use of contraceptives, there is a significant risk that the same level of participation and consultation among Indigenous peoples may not be guaranteed during the scaling up the MIS, hindering respect for traditional and Indigenous practices such as, for example, empowering *comadronas.*[19] To mitigate this, MSPAS will seek to use many of the methods currently being implemented by the MIS on a pilot basis, including individual, family and community level approaches, capacity building, and knowledge exchange. In addition, M&E and the Grievance Redress Mechanism will enable the Project to identify and address community issues and concerns related to service provision.

VI. APPRAISAL SUMMARY

A. Economic and Financial (if applicable) Analysis

29. **The cost-benefit analysis finds a significant positive net present value of Project interventions, under different scenarios.** The net present value of Project interventions is positive (at least US$46 million) and the estimated internal rate of return ranges between 11.4 and 13.6 percent, depending on the discount factor used, clearly showing a positive development impact. These estimates are conservative (see Annex 5) as they do not include the positive effects of improved access to PHC, water and sanitation services for the population at large in Project-supported communities.

30. **The Project also seeks to improve the health and nutrition status of the most vulnerable, and mainly Indigenous populations, and enhance the reliability of CCT benefit payments**. The Project will support both supply- and demand-side interventions. It will finance health, nutrition, and water and sanitation services, primarily for the poorest currently lacking access. It will also enhance the CCT Program to increase both financial protection and demand for critical health and nutrition services. Improvements in health and nutrition can have a beneficial economic impact through several channels, including: (i) productivity, as healthier workers are more productive, tend to have higher earnings, and have lower rates of absenteeism; (ii) education, as healthier children are more likely to attend school and have greater cognitive capacity for learning; (iii) investment and savings, as increased earnings

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[19] The *Comadrona* in Indigenous communities is not only a midwife but also a community leader, who is seen as the primary advisor and caregiver to women during their fertile period, pregnancies, at birth and for newborns. Often the *Comadrona* is the first person young women seek out for advice on contraceptives, or when first pregnant. The share of births attended by midwives is still significant for Indigenous women (42.9 percent) compared to non-Indigenous women (14.1 percent).

coupled with longer life expectancy and control of endemic illness could increase national savings rates and, in turn, help catalyze investment and economic growth; and (iv) demographics, as reduced child mortality and lower fertility lead to demographic dividends, facilitating higher labor inputs.

31. **The Project is expected to contribute to generating public goods or positive externalities**. In particular, the Project aims to: (i) enhance coverage and quality of PHC, water and sanitation services, addressing the service gap in rural areas; (ii) improve reliability of CCT benefit payments and strengthen links between payments and fulfillment of health and nutrition co-responsibilities to encourage households to engage in health-promoting behaviors, such as regular growth monitoring and promotion activities and diversification of their diets; and (iii) increase savings from better resource management and overall governance as a result of successful implementation of the National Strategy.

32. **The WB is also adding value by providing complementary support for this agenda through technical assistance for the implementation of the National Strategy and follow up activities to reduce chronic malnutrition as well as a US$250 million Development Policy Financing loan to support nutrition policy reforms.** These reforms include scaling up of a new PHC model prioritizing the seven neediest departments. Investments will be complemented by advisory work on the implementation of the National Strategy, early childhood development, and the CCT Program, which has health and nutrition co-responsibilities. During implementation, the WB will provide capacity development support, through training and sharing of experiences. Finally, the WB will work closely with development partners to ensure synergies between various donor-funded activities.

33. **Given fiscal space limits, the Project does not require counterpart funding and will enable the Government to mobilize funds to sustain key health and nutrition activities.** A GFF grant will reduce the interest and/or other IBRD loan charges through a buy-down based on results, and finance technical assistance to support the Government to mobilize funds for health and nutrition and increase the efficiency of public spending on health and nutrition. In addition, Component 2 aims to protect the availability of public financing for the CCT Program.

B. Technical

34. **The health sector has the prime responsibility for delivering most direct nutrition-specific interventions for children and women, largely through outreach activities.** In 2013, The Lancet identified ten effective interventions that could reduce the burden of stunting by one-fifth if all delivered at 90 percent coverage. Reversal of stunting, a result of chronic malnutrition, requires interventions that focus on improving both maternal and child nutrition and health.

35. **The first 1,000 days of life are the critical period when timely interventions have the most impact.** Maternal stature and nutrition are important predictors of intrauterine growth retardation and size at birth (Ozaltin et al. 2010). Maternal birthweight not only affects the birthweight of the offspring (Ramakrishnan et al. 1999) but also extends to health later in life. For example, birthweight is inversely related with the risk of coronary heart disease and stroke (Barker and Clark 1997; Huxley et al. 2007). Prenatal care, with a focus on maternal nutritional counseling alongside fetal growth monitoring, immunizations, and micronutrient supplements, is a prerequisite for any stunting intervention. Even if a child is born with a low birthweight or length, there is a compensatory period of up to two years of age

when growth can catch up (Victoria et al. 2008). During the first six months after birth, exclusive breastfeeding is one of the most effective ways of reducing infant morbidity (which negatively affects growth) and mortality (Jones et al. 2003; WHO 2000). Therefore, the Project's main interventions include breastfeeding promotion, regular growth promotion (to also identify any need for vitamin supplements), and immunizations. For the 7-24 month age group, complementary feeding, growth promotion, immunizations, and micronutrient interventions (including iron, vitamin A, iodine, and zinc supplementation) are critical. Complementary feeding can increase height by one centimeter up to the age of three years (Bhutta et al. 2008). Zinc supplementation and vitamin A can reduce diarrhea, and iron is known to reduce anemia and improve cognitive ability (Caulfield et al. 2006). Other interventions include deworming and administering anthelminths to reduce the incidence of parasite and bacterial infections among pregnant women, infants, and children (Horton el al. 2008a, Horton et al. 2008b). Sanitation and hygiene also play an important role in the prevention of diarrheal morbidity and mortality. Esrey (1996) found that improvements in sanitation are associated with a 0.8 centimeter to a 1.9 centimeter increase in height. Similarly, ensuring access to clean water is critical to reduce infection from water-borne illnesses. Studies in Bangladesh, Guinea-Bissau, Ghana, and Peru demonstrate that the odds of stunting at the age of two rose by a factor of 1.05 with each diarrheal episode (Black et al. 2008). An intervention as simple as hand washing with soap can reduce diarrhea for children under five by 42 to 46 percent (Fewtrell 2005; Waddington et al. 2009) and can increase newborn survival rates by up to 44 percent when used by birth attendants and mothers (Rhee et al. 2008).

36. **The Project also supports important complementary interventions to increase demand and promote adoption of healthy behaviors.** Community-based interventions, such as promotion of family gardens and husbandry, contribute to improving access to a diverse, quality diet and to animal protein, important for height gain. Safety net programs could be designed to target women and young children, and further refined to be used for preventive nutrition and health services. In the Guatemalan context, for the CCT Program to effectively function as a safety net and support the nutrition strategy, it is critical to improve targeting, reliability and timeliness of benefit payments linked to fulfillment of health and nutrition-related co-responsibilities, and verification/evaluation.

C. Financial Management

37. **Financial Management (FM) functions will be carried out by MIDES-FODES and its fiduciary line units, which will require strengthening.** The multisectoral nature of the Project and the need for central, municipal and community level interventions call for strong operational and FM arrangements. While MIDES-FODES has a basic structure and procedures, it has limited experience with externally-financed operations, and has mainly implemented infrastructure contracts. As a result, its FM arrangements will need to be strengthened in areas such as planning, internal controls, and capacity to provide up-to-date information to properly control and monitor contract execution and arrears. To this end, MIDES-FODES fiduciary line units will be reinforced with qualified and experienced FM staff financed mostly with MIDES-FODES budget funds, under terms of references acceptable to the WB. In addition, the Operations Manual outlines FM processes, procedures and internal controls, including: (i) roles and responsibilities for ensuring technical quality of goods, services and works financed under the Project; (ii) the format and content of financial and disbursement reports; and (iii) the flow of funds and audit arrangements. The Operations Manual will be adopted by the Government prior to Loan

effectiveness. Basic arrangements to ensure proper control, recording, and reporting are further described in Annex 2. These will be reviewed during the first year of Project implementation.

D. Procurement

38. **MIDES-FODES will be responsible for any procurement under the Project.** MIDES-FODES has limited experience and capacity relative to the technical aspects of goods and services to be procured by Project funds, for example, medical equipment. To strengthen its staffing and implementation procedures, MIDES-FODES will recruit additional staff as required to implement this Project and enhance its tools, records and internal controls for different procurement tasks, including contract management. Given the need for close coordination on technical aspects, the Project will also finance technical consultants to support MIDES-FODES and MSPAS, and if needed, MIDES and SESAN for preparing and reviewing technical specifications. Procurement for works, goods, consultant services and non-consulting services will be carried out in accordance with the Procurement Plan and World Bank Procurement Regulations for Borrowers under Investment Policy Financing (July 2016) ("Procurement Regulations"). A Procurement Plan for components 1 and 3 based on the PPSD for the duration of the Project was developed and agreed upon (Annex 2). Component 2 will only finance the provision of CCTs (non-procurable items). Finally, the Operations Manual outlines the roles and responsibilities of different participating entities and units.

E. Social (including Safeguards)

39. **Most Project beneficiaries are Indigenous peoples and therefore, the Project is considered an Indigenous Peoples Project**. The Project meets the criteria for OP/BP4.10. As such, the requirements of the Indigenous Peoples Policy have been complied with both through the Project's design and in the Operations Manual. During Project preparation, a social cultural assessment was carried out to identify Indigenous peoples' aspirations, concepts, concerns, and experiences in relation to chronic malnutrition. The assessment included a desk review of relevant data, policies, programs, and mapping of relevant stakeholders. Based on the latter, participatory workshops, focus groups and interviews were carried out at the national level and within the four departments of the Project's first phase. Actors who participated in consultations included Indigenous community leaders, *comadronas*, Mayan healers, youth, women, and other members of civil society, departmental, regional and national-level agency staff.

40. **A national level workshop was carried out on July 13, 2016 with a group of Indigenous representatives from beneficiary departments.** Based on the results of the social-cultural assessment and in light of the Project's design, workshop participants identified the following: (a) provisions to ensure the effective participation and broad community support of Indigenous leaders, beneficiaries and stakeholders in key Project decisions that could affect or benefit them; and (b) explicit actions to ensure the delivery of culturally pertinent and quality services. These have been integrated in the Operations Manual. Technical assistance under Component 1 will support a social cultural assessment of the current CCT Program to identify potential cultural impacts, barriers to access and measures to improve the effective and culturally appropriate targeting and delivery of cash transfers. The Project's social-cultural assessment and a summary of the key actions integrated into the Operations Manual to

comply with OP/BP 4.10 were published on the websites of the WB, MIDES, SESAN and MSPAS on November 4, 2016.[20]

41. **Activities requiring Involuntary Resettlement, per OP/BP 4.12, will not be eligible for Project financing.** All lands where Project investments will take place are registered under the ownership of the State; in cases where lands or use of lands need to be attained through donation or purchase, the acquisition or usage rights will be attained through voluntary[21] means with the informed consent of the existing proprietors, per the criteria established in the Project's Environmental and Social Management Framework (ESMF). Lands that require the involuntary resettlement of informal occupants will be deemed ineligible for project financing. A Project Grievance Redress Mechanism has also been established where any complaints or issues can be channeled if necessary.

F. Environment (including Safeguards)

42. **The Project is classified as Category B.** Potential environmental impacts associated with Project activities are expected to be minor to moderate, and potential negative impacts will be managed accordingly through the ESMF as discussed in the paragraph below. The Project triggers a) Environmental Assessment Policy (OP/BP 4.01) given potential, albeit small, environmental impacts from anticipated works; and b) Physical and Cultural Resources Policy (OP/BP 4.11) due to Project activity in rural areas and the possibility of Chance Find[22] of artifacts. The Project also triggers Projects on International Waterways Policy (OP/BP 7.50) given that there are shared watersheds with neighboring countries. However, an exception to the notification requirement under Paragraph 7(a) of OP/BP 7.50 was granted on November 7, 2016 given that Project activities consist of additions and alterations to an ongoing scheme that will not adversely change the quality or quantity of water flows to the other riparians, and will not be adversely affected by other riparians' possible water use. The Project will not finance activities involving pesticide use; therefore, the Pest Management Policy (OP/BP 4.09) is not triggered.

43. **The locations of individual works to be financed by the Project are not yet known.** The potential environmental impacts associated with the type and size of works are expected to be relatively minor to moderate. Thus an ESMF was prepared by the Government and approved by the WB to manage the potential environmental and social impacts and risks related to the types of activities to be financed under subcomponent 1.1 and subcomponent 1.3. The ESMF complies with local legislation and international best practices outlined in the WB Environmental Health and Safety Guidelines for health care facilities and water and sanitation. It also includes medical waste management measures for health care facilities. Capacity building under the Project will include occupational health and safety training,

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[20] *http://fodes.gob.gt/bancomundial.html*; *http://www.sesan.gob.gt/index.php/descargas/114--14; http://www.mspas.gob.gt/index.php/en/documentos.html; http://documents.worldbank.org/curated/en/473271478665206070/Marco-de-gestion-ambiental-y-social-Proyecto-crecer-sano.*

[21] Land donations or sales will only be considered "voluntary" when they meet the criteria of informed consent and power of choice.

[22] Chance finds are defined as physical cultural resources encountered unexpectedly during Project implementation. The chance find procedures provide guidance as to what is to be done upon a chance find.

including exposure to diseases, and medical waste. Guatemala is in a hotspot for physical cultural resources, and the ESMF includes Chance Find procedures as reflected in national legislation. Following a national consultation workshop on October 27, 2016, the ESMF was updated and disclosed on the MIDES-FODES and WB websites on November 8, 2016.

G. Other Safeguard Policies (if applicable)

44. No other safeguard policies are triggered for the Project.

H. World Bank Grievance Redress

Communities and individuals who believe that they are adversely affected by a World Bank (WB) supported project may submit complaints to existing project-level grievance redress mechanisms or the WB's Grievance Redress Service (GRS). The GRS ensures that complaints received are promptly reviewed in order to address project-related concerns. Project affected communities and individuals may submit their complaint to the WB's independent Inspection Panel which determines whether harm occurred, or could occur, as a result of WB non-compliance with its policies and procedures. Complaints may be submitted at any time after concerns have been brought directly to the World Bank's attention, and Bank Management has been given an opportunity to respond. For information on how to submit complaints to the World Bank's corporate Grievance Redress Service (GRS), please visit *http://www.worldbank.org/en/projects-operations/products-and-services/grievance-redress-service*. For information on how to submit complaints to the World Bank Inspection Panel, please visit www.inspectionpanel.org.

VII. RESULTS FRAMEWORK AND MONITORING

Results Framework
COUNTRY : Guatemala
Crecer Sano: Guatemala Nutrition and Health Project

Project Development Objectives

The Project Development Objective (PDO) is to improve selected practices, services and behaviors known to be key determinants of chronic malnutrition (with an emphasis on the first 1,000 days of life) in the intervention areas.

Project Development Objective Indicators

Indicator Name	Core	Unit of Measure	Baseline	End Target	Frequency	Data Source/Methodology	Responsibility for Data Collection
Name: Percentage of children six months old with exclusive breastfeeding in the intervention areas (behavior)		Percentage	43.00	65.00	Yearly	MSPAS information system and surveys when needed.	MSPAS
Description: Percentage of children 6 months old with exclusive breastfeeding in the intervention areas. Currently the MSPAS information system collects information on exclusive breastfeeding for children 0-5 months old. The system will be adjusted to collect and report information for children 6 months old. Baseline information is from the preliminary results of the 2014/15 ENMSI which has data for children 4-5 months old so the baseline data cited is likely to be higher than the actual baseline for 6 month old children. Intervention areas are those prioritized by the National Strategy to Prevent Chronic Malnutrition.							
Name: Coverage of growth promotion for children under 24-months old in the		Percentage	19.00	70.00	Yearly	MSPAS information system.	MSPAS

Indicator Name	Core	Unit of Measure	Baseline	End Target	Frequency	Data Source/Methodology	Responsibility for Data Collection
intervention areas (practices and services)							
Description: Percentage of children under 24-months old covered by minimum number of required growth promotion check-ups in the intervention areas. The baseline was calculated based on a minimum number of check-ups that currently includes 4 check-ups in the first year (0-11 months) and 4 check-ups in the second year (12-24 months). However, the minimum number is being increased to at least 8 check-ups for children 0 to 11 months and 6 check-ups for children 12 to 24 months. Targets were calculated for this indicator using new minimum requirements. Intervention areas are those prioritized by the National Strategy to Prevent Chronic Malnutrition.							
Name: Number of families being served by new or rehabilitated water systems in the intervention areas (services)		Number	0.00	80000.00	Yearly	Supervision reports of new and rehabilitated water systems works.	MIDES-FODES/PIU
Description: Number of families being served by new or rehabilitated water systems in the intervention areas. The Project is expected to rehabilitate or build 1,600 water systems (each system would serve approximately 50 families). Intervention areas are those prioritized by the National Strategy to Prevent Chronic Malnutrition.							
Name: Proportion of municipalities where combined interventions were implemented (coordinated interventions/services)		Percentage	0.00	70.00	Yearly	SESAN information system, collecting information from: SIGSA, MIDES, FODES/PIU, municipal dashboard for chronic malnutrition.	SESAN
Description: Number of municipalities that are benefiting from interventions from the three subcomponents of Component 1 (PHC services; new or rehabilitated water system; and behavioral change promotion) divided by the total number of municipalities in the intervention areas (139 municipalities). Intervention areas are those prioritized by the National Strategy to Prevent Chronic Malnutrition.							

Intermediate Results Indicators

Indicator Name	Core	Unit of Measure	Baseline	End Target	Frequency	Data Source/Methodology	Responsibility for Data Collection
Name: Coverage of prenatal care with at least four visits in the intervention areas (services)		Percentage	18.70	50.00	Yearly	MSPAS information system	MSPAS
Description: Number of pregnant women receiving at least four prenatal care visits in the intervention areas divided by the total number of pregnant women in the intervention areas. Intervention areas are those prioritized by the National Strategy to Prevent Chronic Malnutrition.							
Name: CCT information system tracks and reports compliance with health and nutrition co-responsibilities of individual household members (services)		Yes/No	N	Y	Yearly	MIDES. CCT information system	MIDES
Description: The CCT information system tracks and reports compliance with health and nutrition co-responsibilities of individual household members on an annual basis.							
Name: The Unique Registry of Beneficiaries receives individual level data on health system usage (services)		Text	No	Data is being shared with the CCT Program	Yearly	MIDES/MSPAS	MIDES/MSPAS
Description: The Unique Registry of Beneficiaries receives data from the Health Information Management System (SIGSA) with individual records of usage of each							

Indicator Name	Core	Unit of Measure	Baseline	End Target	Frequency	Data Source/Methodology	Responsibility for Data Collection
component of basic health care services. 50 percent to be disbursed when SIGSA has been updated to include individual records with the information required to confirm if co-responsibilities have been fulfilled, and Unique Registry of Beneficiaries and SIGSA systems are inter-operable. 50 percent to be disbursed once data is being shared with the CCT program for verification of co-responsibilities in the intervention areas.							
Name: Percentage of children under two years old who are beneficiaries of the CCT Program receiving transfers based on compliance with full verification cycle of health co-responsibilities in the interventi		Percentage	0.00	70.00	Yearly	MIDES. CCT information system	MIDES
Description: Number of children under two years old in intervention areas in households enrolled in the CCT Program fulfilling the full verification cycle of health co-responsibilities divided by the total number of children under two years old in intervention areas in households enrolled in the CCT Program. The health co-responsibilities of the CCT Program were adjusted based on basic health services and recommendations of the Social-Cultural Assessment. Intervention areas are those prioritized by the National Strategy to Prevent Chronic Malnutrition.							
Name: Health posts in the intervention areas with updated census of houses and families (services)		Percentage	5.00	90.00	Yearly	MSPAS information system	MSPAS
Description: Number of health posts carrying out annual census of houses and families divided by the total number of health posts in the intervention areas. Intervention areas are those prioritized by the National Strategy to Prevent Chronic Malnutrition.							
Name: Number of women of reproductive age in the		Number	190000.00	230000.00	Yearly	SIGSA. MSPAS Information	MSPAS

Indicator Name	Core	Unit of Measure	Baseline	End Target	Frequency	Data Source/Methodology	Responsibility for Data Collection
intervention areas having access/receiving at least one family planning method (practices and services)						System	
Description: Number of women of reproductive age in the intervention areas having access/receiving at least one family planning method (including family planning counseling) divided by the total number of reproductive age women in the intervention areas. Intervention areas are those prioritized by the National Strategy to Prevent Chronic Malnutrition.							
Name: Percentage of children 12-months old in the intervention areas receiving complete vaccination scheme required for their age (services)		Percentage	74.00	95.00	Yearly	MSPAS information system	MSPAS
Description: Number of children 12 months old in the intervention areas with immunization schedule (Polio virus, pentavalent, pneumococcus and rotavirus) complete for their age group divided by the total number of children 12 months identified in the household survey in the intervention areas. Intervention areas are those prioritized by the National Strategy to Prevent Chronic Malnutrition.							
Name: Percentage of children 12-months old in the intervention areas receiving micronutrients as defined in the protocol (services)		Percentage	5.00	60.00	Yearly	MSPAS information system	MSPAS
Description: Number of children 12-months old in the intervention areas receiving micronutrients as defined in the protocol divided by total number of children 12 months old identified in the household survey in the intervention areas. Intervention areas are those prioritized by the National Strategy to Prevent Chronic Malnutrition.							

Indicator Name	Core	Unit of Measure	Baseline	End Target	Frequency	Data Source/Methodology	Responsibility for Data Collection
Name: Number of families served by new or rehabilitation works for sanitation systems in the intervention areas (services)		Number	0.00	7000.00	Yearly	Project activities. Project Progress report	FODES/PIU
Description: Cumulative number of families in the intervention areas with new or rehabilitated sanitation systems (mainly individual latrines for families). Intervention areas are those prioritized by the National Strategy to Prevent Chronic Malnutrition.							
Name: Surveillance system for safe drinking water in place, and reporting as defined in the protocols (services)		Yes/No	N	Y	Yearly	Information System for Water Quality Surveillance 2 (Sistema de Informacion para la Vigilancia de la Calidad de Agua/SIVIAGUA 2)	MSPAS
Description: The surveillance system is in place and reporting when, in the intervention areas, at least 30 percent of water samples are tested for bacteria and at least 50 percent of positive cases in the intervention areas complete a follow up protocol to fix and re-test the water system. Intervention areas are those prioritized by the National Strategy to Prevent Chronic Malnutrition.							
Name: Participants in consultation activities during project implementation (number)	✔	Number	0.00	40000.00	Yearly	SESAN. Workshop reports. Additional information on description: Number of participants in consultation activities throughout the life	SESAN

Indicator Name	Core	Unit of Measure	Baseline	End Target	Frequency	Data Source/Methodology	Responsibility for Data Collection
						of the Project, disaggregated by gender. This is a WB core indicator.	
Participants in consultation activities during project implementation - female	✔	Number	0.00	28000.00	Yearly	SESAN. Workshop reports Additional description: Additional information on description: Number of participants in consultation activities throughout the life of the Project, disaggregated by gender. This is a World Bank core indicator.	SESAN
Description: This indicator measures the level of community engagement in project implementation.							
Name: Percentage of municipalities in the intervention areas that are using a monitoring dashboard for chronic malnutrition (services)		Percentage	0.00	90.00	Yearly	SESAN information system	SESAN

Indicator Name	Core	Unit of Measure	Baseline	End Target	Frequency	Data Source/Methodology	Responsibility for Data Collection
Description: Number of municipalities that are using a monitoring dashboard for chronic malnutrition divided by the total number of municipalities in the intervention areas. The dashboard provides real-time reports including updated tables and graphs on the incidence and prevalence of risk factors for chronic malnutrition. Intervention areas are those prioritized by he National Strategy to Prevent Chronic Malnutrition.							
Name: Health personnel receiving training (number)	✔	Number	0.00	2400.00	Yearly	Project activities. (Project Progress report). Additional description. Cumulative number of health personnel receiving training through a WB-financed Project, disaggregated by gender. This is a WB core sector indicator.	MSPAS. MIDES-FODES/PIU
Health personnel in the intervention areas receiving training (female health workers)		Number	0.00	1800.00	Yearly	Project activities. Project progress report	MSPAS. MIDES-FODES/PIU
Description: This indicator measures the cumulative number of health personnel receiving training through a Bank-financed project.							

Indicator Name	Core	Unit of Measure	Baseline	End Target	Frequency	Data Source/Methodology	Responsibility for Data Collection
Name: Health facilities constructed, renovated, and/or equipped (number)	✔	Number	0.00	154.00	Yearly	Project activities. Project progress report Additional description. Cumulative number of health facilities constructed, renovated and/or equipped through a WB financed Project. This is a WB core sector indicator.	MIDES-FODES/PIU
Description: This indicator measures the cumulative number of health facilities constructed, renovated and/or equipped through a Bank-financed project.							
Name: People in the intervention areas who have received essential health, nutrition, and population services.		Number	0.00	680000.00	Yearly	MSPAS information system	MSPAS
Number of children in the intervention areas who are immunized		Number	0.00	400000.00	Yearly	MSPAS information system	MSPAS
Number of women and		Number	0.00	280000.00	Yearly	MSPAS information system	MSPAS, SESAN

Indicator Name	Core	Unit of Measure	Baseline	End Target	Frequency	Data Source/Methodology	Responsibility for Data Collection
children in the intervention areas who have received basic nutrition services						and SESAN. Workshop reports	

Description: The sum of the number of 0-5 year old children immunized, the number of women and 0-5 year old children who have received basic nutrition services, and the number of women with access to family planning services in the intervention areas. Intervention areas are those prioritized by the National Strategy to Prevent Chronic Malnutrition. This is a WB core sector indicator.

Target Values

Project Development Objective Indicators

Indicator Name	Baseline	YR1	YR2	YR3	YR4	YR5	End Target
Percentage of children six months old with exclusive breastfeeding in the intervention areas (behavior)	43.00	45.00	50.00	55.00	65.00	65.00	65.00
Coverage of growth promotion for children under 24-months old in the intervention areas (practices and services)	19.00	20.00	30.00	40.00	60.00	70.00	70.00
Number of families being served by new or rehabilitated water systems in the intervention areas (services)	0.00	15000.00	35000.00	50000.00	60000.00	80000.00	80000.00
Proportion of municipalities where combined interventions were implemented (coordinated interventions/services)	0.00	10.00	20.00	40.00	60.00	70.00	70.00

Intermediate Results Indicators

Indicator Name	Baseline	YR1	YR2	YR3	YR4	YR5	End Target
Coverage of prenatal care with at least four visits in the intervention areas (services)	18.70	25.00	30.00	40.00	50.00	50.00	50.00

Indicator Name	Baseline	YR1	YR2	YR3	YR4	YR5	End Target
CCT information system tracks and reports compliance with health and nutrition co-responsibilities of individual household members (services)	N	N	N	Y	Y	Y	Y
The Unique Registry of Beneficiaries receives individual level data on health system usage (services)	No		Implementation has started	Data is being shared with the CCT Program			Data is being shared with the CCT Program
Percentage of children under two years old who are beneficiaries of the CCT Program receiving transfers based on compliance with full verification cycle of health co-responsibilities in the interventi	0.00		30.00	50.00	60.00	70.00	70.00
Health posts in the intervention areas with updated census of houses and families (services)	5.00	70.00	90.00	90.00	90.00	90.00	90.00
Number of women of reproductive age in the intervention areas having access/receiving at least one family planning method (practices and services)	190000.00	190000.00	190000.00	200000.00	220000.00	230000.00	230000.00
Percentage of children 12-months old in the intervention areas receiving complete vaccination scheme required for their age (services)	74.00	80.00	90.00	92.00	95.00	95.00	95.00
Percentage of children 12-months old in the intervention areas receiving	5.00	10.00	30.00	40.00	50.00	60.00	60.00

Indicator Name	Baseline	YR1	YR2	YR3	YR4	YR5	End Target
micronutrients as defined in the protocol (services)							
Number of families served by new or rehabilitation works for sanitation systems in the intervention areas (services)	0.00	600.00	2500.00	4000.00	6000.00	7000.00	7000.00
Surveillance system for safe drinking water in place, and reporting as defined in the protocols (services)	N						Y
Participants in consultation activities during project implementation (number)	0.00	5000.00	10000.00	20000.00	30000.00	40000.00	40000.00
Percentage of municipalities in the intervention areas that are using a monitoring dashboard for chronic malnutrition (services)	0.00	30.00	45.00	70.00	90.00	90.00	90.00
Health personnel receiving training (number)	0.00	500.00	1000.00	1500.00	2000.00	2400.00	2400.00
Health facilities constructed, renovated, and/or equipped (number)	0.00	30.00	70.00	100.00	130.00	154.00	154.00
People in the intervention areas who have received essential health, nutrition, and population services.	0.00						680000.00
Participants in consultation activities	0.00	3500.00	7000.00	14000.00	21000.00	28000.00	28000.00

Indicator Name	Baseline	YR1	YR2	YR3	YR4	YR5	End Target
during project implementation - female							
Health personnel in the intervention areas receiving training (female health workers)	0.00	375.00	750.00	1125.00	1500.00	1800.00	1800.00
Number of children in the intervention areas who are immunized	0.00						400000.00
Number of women and children in the intervention areas who have received basic nutrition services	0.00						280000.00

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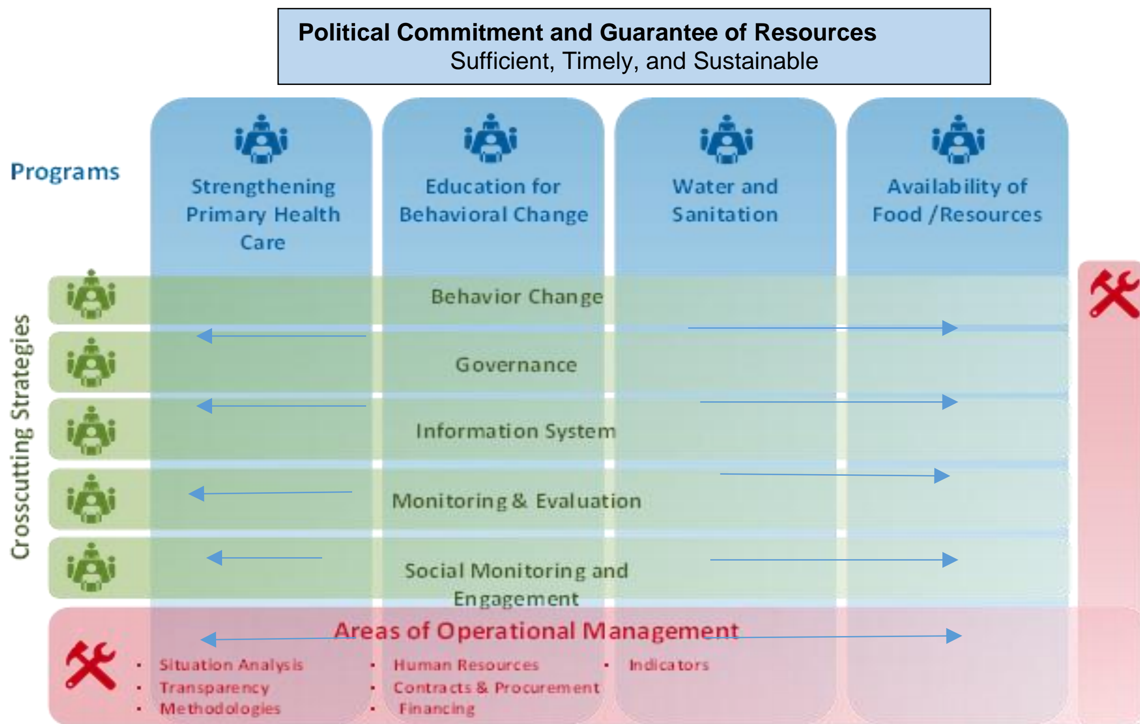
ANNEX 1: DETAILED PROJECT DESCRIPTION

COUNTRY : Guatemala
Crecer Sano: Guatemala Nutrition and Health Project

1. **This five-year Project supports the implementation of the Government's new nutrition strategy, the *National Strategy to Prevent Chronic Malnutrition 2016–2020 and follow up actions to reduce chronic malnutrition,* with special emphasis on the first 1,000 days of life.** Under the new National Strategy, a coordinated set of actions will be implemented in a phased manner in all municipalities in seven departments. Phase I will include the departments of Alta Verapaz, Chiquimula, Huehuetenango, and Quiché, while Phase II will include the departments of San Marcos, Sololá, and Totonicapán. Except for Chiquimula, most of these departments are located in the Northwestern and Western parts of Guatemala. These departments were selected based on high rates of stunting and maternal and child mortality, large numbers of children under five, and a high proportion of rural and Indigenous populations (mainly in the highlands).

Figure A.1.1 *National Strategy to Prevent Chronic Malnutrition 2016–2020:* Overall Approach



Source: Government of Guatemala. *National Strategy to Prevent Chronic Malnutrition 2016–2020.*

2. **Figure A.1.1 illustrates the strategy's overall holistic, multisectoral and culturally relevant approach.** This approach seeks to address the main risk factors associated with chronic malnutrition, by increasing its target population's access to improved PHC, water and sanitation services, as well as information and additional resources to promote and support healthy behaviors. In implementing its National Strategy, the Government will also strengthen intersectoral and interinstitutional governance,

including coordination, monitoring and supervision at central and local administrative levels. The Government's implementation of the new National Strategy will also promote community participation and encourage civil society involvement in monitoring the implementation of the Strategy, for example, through social audits and use of other social feedback mechanisms to enhance accountability.

3. Within the framework of the National Strategy, this Project will support an integrated set of interventions, in specific intervention areas to maximize synergies (Table A.1.1). These include:

(a) Increasing access to, and strengthening the quality of, primary health and nutrition care services;
(b) Promoting health and nutrition promotion and behavioral change at the community level;
(c) Improving access to safe drinking water and sanitation;
(d) Strengthening the Government's CCT Program, which will include improving targeting, reliability of transfers, financing transfers based on performance based indicators, and verification of health and nutrition co-responsibilities;
(e) Supporting coordination across sectors and awareness about stunting; and
(f) Upgrading the information system, creating feedback loops (for tracking progress on nutrition and supporting evidence-based decision-making), and establishing and using a unique registry of beneficiaries.

4. **Significant infrastructure investments are needed to implement the National Strategy in the target communities.** Health infrastructure was destroyed during the Guatemalan Civil War, which lasted from 1960 to 1996, and the Government has been unable to expand health facilities since. To address the lack of health facilities, the Government contracted non-governmental organizations to field mobile teams to provide PHC health and nutrition services on a monthly basis to rural, underserved communities under the PEC. However, in 2015, the Government decided to discontinue the PEC and progressively replace it with its own health facilities and teams in an effort to provide more comprehensive services to these communities on a more frequent basis. As a result of this decision, there is an urgent need to cover the gap in services for at least 4.5 million Guatemalans who were previously covered by the PEC, as well as others who still do not have access to health services. Thus the Project will finance the rebuilding of public infrastructure, including the rehabilitation of approximately 92 health posts and construction of 114 new health posts. These works will be done with a culturally sensitive lens, in order to make the facilities friendlier to Indigenous people. Select community centers and health posts might also be rehabilitated for MSPAS use. Investments are also needed to train human resources, strengthen monitoring and information systems (both of individual programs/services and their interoperability) to track individual level outcomes, and expand coverage of water and sanitation services. The Project will also finance workshops at the community level, technical assistance, and communication campaigns.

5. **In addition, complementary investments to support increased access and use of the strengthened health services by the poor are needed.** Guatemala's CCT targets families with children between 0-15 years and promotes regular health visits for children aged 0-6 years and pregnant women,

and school attendance for children aged 6-15 years.[23] It was launched in 2008 and since then has reached broad coverage (693,936 active households in 2015) and is doing well in reaching the poor (almost 70 percent of its beneficiaries are among the poorest 40 percent of the population).[24] Despite the positive design features, shortages in budget releases and implementation challenges, for example in the verification of conditions, have resulted in lack of predictability of transfers, affecting the cycle of co-responsibilities and program results. Moreover, gaps in coverage of primary health care provision affected the ability of the CCT Program to promote behavior change as vulnerable families were often unable to meet the co-responsibilities because of the lack of supply.

6. **Despite these serious challenges, with Project support the CCT Program has the potential to contribute to the National Strategy in a number of ways**. Early evaluations of the CCT after it was first launched found evidence of an increase in access to health services: the number of check-ups attended by children participating in the Program rose 48 percent compared to 28 percent among those not targeted. In a context in which health and nutrition services are being strengthened, CCTs can catalyze demand and accountability for such services, increasing the overall impact of the intervention. This Project will support the CCT Program in two ways. First, through Component 1, by financing technical assistance to strengthen Program operations (e.g., payments, monitoring of co-responsibilities, outreach and communication, identification of potential cultural barriers to effective and culturally appropriate targeting and delivery of services) and provide options for design that could increase nutrition impact. Second, through Component 2, by providing results-based financing linked to: (i) strengthening of the information systems used in monitoring of health co-responsibilities in order to collect nominal data on individual use of health services for the Unique Registry of Beneficiaries (DLI 2); and (ii) provision of regular, predictable health transfer payments and verification/evaluation of co-responsibilities cycle for children 0-2 years of age (DLI 4). Regular, predictable transfers will provide poor households with higher incomes, while promoting their increased access to health services and behavior change via regular monitoring of co-responsibilities and improved outreach and communication.

7. **The Project will support two technical components and a Project management component**. Component 1 will finance the critical investments mentioned above, while Component 2 focuses on results (a results-based financing component) and acts as a financial tool to protect the reliability of the funding flow to facilitate implementation of the National Strategy. Component 3 will support Project management activities.

[23] In enrolled households, each member is required to comply with co-responsibilities according to his/her age, regardless of whether the household is enrolled under the health or education transfer (though they must have at least one member eligible for the transfer they are receiving).

[24] World Bank Guatemala Social Sector Expenditure and Institutional Review (2016).

Table A.1.1 Main Elements of the Government's Nutrition Strategy: Expected Results Chain

Inputs	Activities	Outputs	Outcomes	Long-term Goals
Technical assistance, training, rehabilitation, equipment, performance-based payments	Actions included in the Program	Project deliverables within the control of the Government	Results achieved that will create conditions for medium- and long-term impact	Improved health and nutrition status of pregnant and lactating women, and children < 2
Government Nutrition Strategy	• Strengthening PHC services in the intervention areas. • Rehabilitation and new health posts. • Medical equipment, medical and nonmedical supplies, and training. • Carrying out a census of houses and families and creating a system for monitoring the demand of health services. • Supporting behavioral change, health promotion, communication (including several innovative communication strategies, including information technology. • Design and implementation of water supply and sanitation works in rural communities. • Technical assistance to strengthen the CCT Program. • Improvement of the information system • Support coordination across sectors to implement the government strategy. The subcomponent will finance a set of tools for monitoring the progress in implementing the strategy, and promote the links among the user registries in different sectors. • Communication campaigns (local, health workers, stakeholders, and general population). • Protection of critical budget lines.	Program intermediate indicators	• Increased coverage of the rural population having regular access to updated PHC services, growth promotion, and early childhood development. • Increased coverage of prenatal care with at least four prenatal care visits. • Increased coverage of growth promotion for children under 24 months old. • Increased immunization coverage among 12 month old children (emphasis on rotavirus and pneumococcal). • Increased percentage of children six months old and younger who are exclusively breastfed. • Increased percentage of families receiving information and having access to family planning services. • Increased percentage of children under 2 years old who are CCT Program beneficiaries receiving transfers based on compliance with full verification cycle of health co-responsibilities. • Improvement of the nutrition and health information system. • Increased coverage of rural population having regular access to safe drinking water. • Municipalities implementing monitoring dashboard for chronic malnutrition surveillance system for safe drinking water, and reporting as defined in the protocols. • The Unique Registry of Beneficiaries receives individual level data on health system usage.	• Reduce prevalence of chronic malnutrition among children 24 months old. • Reduce infant and maternal morbidity and mortality.
Investments				**Results**

8. **Component 1. Providing Inter-sectoral Services to Address Chronic Malnutrition Risk Factors (US$81 million).** This Component will finance four subcomponents:

a. **<u>Subcomponent 1</u>. Strengthening PHC services in the intervention areas.** This subcomponent will strengthen PHC service delivery in areas without access to integrated health care services by providing PHC services interventions of nutrition and health services to mothers and children, with special emphasis on the first 1,000 days; and increasing the access to, and the quality of, said health care interventions, through, *inter alia*: (i) the carrying out of selected health infrastructure investments, which consists of, *inter alia*, rehabilitation or construction of health posts in the intervention areas; (ii) the rehabilitation of selected community centers; (iii) the purchase of medical equipment, and medical and non-medical supplies; (iv) the carrying out health promotion activities; and (v) the carrying out of studies and training on the primary health care package to relevant stakeholders. PHC services includes prenatal care, immunization, growth promotion, early stimulation and other early childhood activities, counseling, and family planning. Each health center will conduct a census of houses and families in their areas and create a system for monitoring the demand and utilization of health services. The subcomponent will finance works, the design and implementation of which will be carried out in accordance with social and environmental safeguards. It will also finance the purchase of medical equipment, medical and nonmedical supplies, technical assistance, and training.

b. **<u>Subcomponent 2.</u> Promoting behavioral change.** This subcomponent seeks to reduce behavioral-related risk factors for chronic malnutrition, including increasing exclusive breastfeeding, improving feeding practices for children over six months, improving hygiene practices, increasing the demand for PHC, and increasing iron/folate supplementation. It will do so by promoting behavior change interventions through, *inter alia*: (i) the carrying out of health promotion activities, including workshops; (ii) fostering interpersonal communication and culturally appropriate local communication strategies; and (iii) providing technical assistance to improve the CCT Program, which could include reviewing and improving targeting, conditionalities, communication protocols, and outreach strategies, and the development of municipal-level monitoring dashboards.

c. **<u>Subcomponent 3</u>. Improving access to safe drinking water and sanitation.** This subcomponent supports improving access to safe drinking water and sanitation in the intervention areas through, *inter alia*: (i) the design, construction and/or rehabilitation of small water and sanitation systems in the intervention areas, including rural communities in participating municipalities;[25] (ii) the provision of water filters for households in prioritized areas; (iii) the carrying out of tests of water systems to be rehabilitated; and (iv) strengthening the water quality monitoring system and follow up mechanisms to promote compliance with water quality standards. The Project will coordinate with local municipalities through the COMUDES to identify potential water and sanitation works (in consultation with their respective communities, represented by their COCODES).

d. **<u>Subcomponent 4.</u> Improving cross-sectoral coordination.** This subcomponent will support

[25] The design and implementation plan for these works will be supported by a social and environmental management plan. The activities envisaged are small works mainly rehabilitation and improvement of existing water systems, such as protecting water sources, laying pipes to deliver water to rural communities from upstream water sources, and small rural sanitation systems such as outhouses.

interinstitutional coordination for the implementation of the National Strategy to Prevent Chronic Malnutrition 2016-2020 and follow up activities to reduce chronic malnutrition, through *inter alia*: (i) the improvement of existing information systems (MSPAS and MIDES information systems) to ensure interoperability, through the Unique Registry of Beneficiaries and the existence of tools to monitor implementation progress of said strategy; (ii) the carrying out of studies on the causes and roles of risk factors in the development of chronic malnutrition; (iii) the evaluation of interventions to address chronic malnutrition; and (iv) the preparation and implementation of a nationwide communication strategy for health and social workers, relevant stakeholders and the general population.

9. **The construction and/or rehabilitation of small water and sanitation works will consider climate change in their designs in order to reduce current climate change vulnerability.** This will ensure the sustainability of health infrastructure assets, as well as ensuring the sustainable and adequate drinking water, sanitation, and hygiene, which are essential to human health. The estimated cost of these works is US$25 million.

10. **Component 2. Moving the Focus toward Results (US$14.75 million).** This Component will support provision of CCTs to: (i) promote the use of health services, including timely prenatal care; (ii) promote behavioral changes, including exclusive breastfeeding during the first six (6) months of life; and (iii) strengthen the CCT Program in the intervention areas. This Component is expected to increase the focus on results by disbursing funds to finance CCT transfers related to health and nutrition conditionalities against (i) the achievement of a subset of key results in the expected result chain; and (ii) verified documentation of pre-financing of CCT transfers for an amount equivalent to the funds to be reimbursed. DLIs were selected to reflect key program results of the National Strategy to promote synergy and coordination with the Government’s efforts and seek to be both achievable and challenging, combining ambition and feasibility so that the financial risk attached to each DLI has the right impact. Intermediate and end-of-Project targets for all DLIs were chosen to allow for adequate disbursement flow (with 50 percent allocated for achieving the intermediate target), while maintaining incentives to achieve end-of-Project targets for subsequent disbursements. The CCT is part of the demand side approach to improving nutrition and health outcomes. The adjusted CCT Program will include improved prioritization of families with pregnant women and children under two years and selected co-responsibilities related to health and nutrition, which are linked with preventing and reducing chronic malnutrition. Box A.1.1 below provides information on CCTs’ role in reducing malnutrition.

11. **Building on the Project’s results focus, the GFF Trust Fund will buy down the interest and/or other IBRD loan charges on the Project loan to more concessional terms when the agreed upon indicators for Years 2 and 4 are achieved.** The buy-down indicators and targets include: (i) increased percentage of six month old children who are Exclusively Breastfed in the Intervention Areas; and (ii) increased percentage of children under two years old who are beneficiaries of the CCT Program receiving transfers based on compliance with the full verification cycle of health co-responsibilities in the Intervention Areas (see Annex 4 for targets).

12. ***Eligible expenditures to be financed under Component 2.*** **This Component will also contribute to the National Strategy as a financial tool to protect reliability of funding flows for key recurrent activities in the intervention areas.** To trigger disbursements under this Component, the Government

will submit evidence to the WB of achievement of the results (DLIs for the Project and for the GFF), together with proof that eligible expenditures were made to finance the National Strategy. For the GFF buy-down to be triggered, in addition to meeting the DLIs, the Government needs to submit evidence that the equivalent of twice the buy-down amount[26] of public resources was invested in the CCT Program. The budget line selected and protected by this mechanism are benefit payments for the adjusted health and nutrition component of the CCT Program in the intervention areas. The Government has also committed to matching (1:2) and reinvesting the buy-down amount in the CCT Program and will present evidence to the WB accordingly. The WB has agreed to reimburse the Government an equivalent amount in United States Dollars from the Loan account for said pre-financed Eligible Expenditures in accordance with paragraph 2.2 of the Disbursement Guidelines, and as provided in Sections IV and V of Schedule 2 of the Loan Agreement. Funds reimbursed by the WB under Category 2 will be deposited into a specific secondary account within the Treasury Single Account, as indicated by the Borrower in the respective withdrawal application and will thereafter be registered by the Government in its corresponding annual budget, and be used in conformity with the Government's budgetary laws. No retroactive financing is planned under the Project. The DLIs are as follows (see Annex 4 for details about the DLIs and targets:

- DLI 1. Coverage of prenatal care visits with at least four visits in the intervention areas;
- DLI 2. The Unique Registry of Beneficiaries receives individual level data on health system usage;
- DLI 3. Percentage of six month old children who are exclusively breastfed in the intervention areas; and
- DLI 4. Percentage of children under two years old who are beneficiaries of the CCT Program receiving transfers based on compliance with the full verification cycle of health co-responsibilities in the intervention areas.

Box A.1.1 CCT Programs and their Contribution to Reducing Malnutrition

CCTs are among the most evaluated programs in the world, with the evidence showing that they can lead to positive changes in service utilization. CCTs not only boost demand for health, nutrition, and education, but can also that demand to compel governments to improve quality and coordinate across sectors to increase the overall impact of the interventions. Between 2005 and 2015, for example, the *Juntos* CCT Program in Peru contributed to more than doubling regular health and growth check-ups for children in their first three years, and school attendance for older children, in return for a *monthly cash payment of about US$30* to the female head of the household for beneficiary families. An evaluation showed that it also had a significant impact on nutritional status of the most malnourished children.[27]

Design matters.[28] To allow households to purchase more and better goods, thereby improving food security and dietary quality, transfers should be predictable, timed appropriately and adequate in size. To maximize the impact of transfers, directing transfers to women, targeting the poorest and children under two, or adding a culturally appropriate nutrition education or micronutrient supplementation component, can play an essential role in generating impact.

[26] This is in addition to eligible expenditures that the Government needs to show to IBRD.
[27] Jaramillo, M. and A. Sanchez. 2011. Impacto del Programa Juntos sobre nutrición temprana, GRADE Documento de Investigación 61, Lima, Perú.
[28] World Bank. 2013. Improving Nutrition Through Multisectoral Approaches.

13. **Component 3. Supporting Project Management, Monitoring and Evaluation (US$4 million).** This Component will finance provision of support to MIDES-FODES for the carrying out of Project management, coordination and evaluation, including, *inter alia*: (a) the carrying out of the Project audits; (b) the provision of office equipment; (c) the carrying out of training on project management, coordination and evaluation; (d) the provision of technical support on procurement, safeguards and financial management requirements, including the hiring of MIDES-FODES' staff; (e) the financing of Operating Costs; and (f) the carrying out of an independent evaluation of DLI achievement.

ANNEX 2: IMPLEMENTATION ARRANGEMENTS

COUNTRY : Guatemala
Crecer Sano: Guatemala Nutrition and Health Project

Project Institutional and Implementation Arrangements

1. **The new National Strategy involves the participation of several institutions across multiple sectors (health, nutrition and food security, and social protection) directly linked to the objective of reducing chronic malnutrition.** The involvement of several institutions requires effective governance mechanisms to promote inter-sectoral and interagency coordination. Key stakeholders in the implementation of the Project will be guided at all levels through a specific set of guidelines outlined in the Operations Manual that defines their respective roles together with mechanisms for coordination, communication and monitoring.

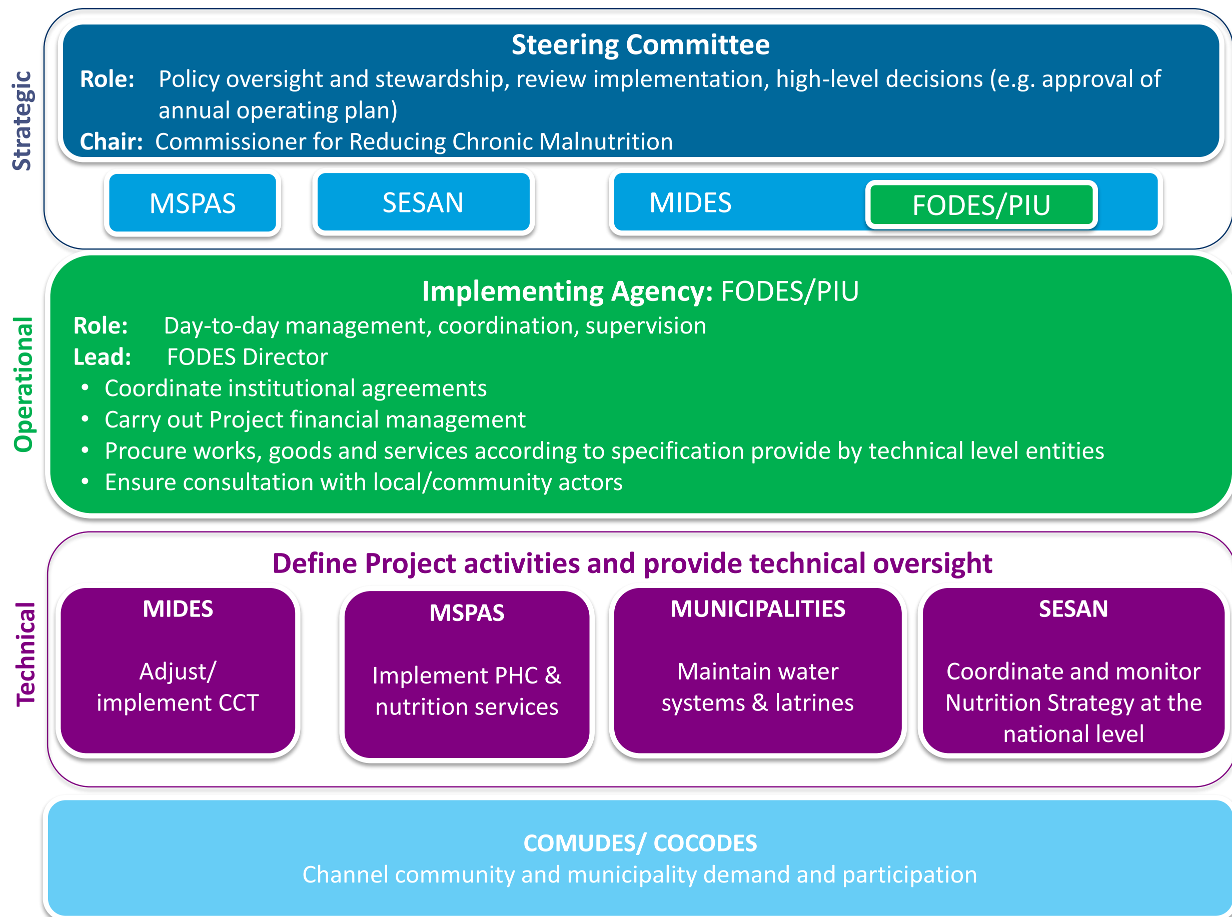
Project administration mechanisms

2. **MIDES, through FODES, will be responsible for implementation of the Project, with support of additional fiduciary and technical consultants**. As agreed with participating institutions in the Project, MIDES-FODES will be responsible for day-to-day management, coordination, and supervision of Project activities through its various line units (complemented by additional technical and fiduciary staff as needed), and its Director will be the General Project Director, entrusted with overall Project implementation oversight. MIDES-FODES will house the PIU for the Project, which is fully integrated in the MIDES-FODES structure (thus it will be referred to as MIDES-FODES/PIU). MIDES-FODES was selected because of its ability to operate with greater independence than other agencies, which is critical given the multisectoral nature of the Project, and because it has the authority to enter into agreements with other institutions. Other entities involved in Project implementation include MSPAS, SESAN, the Commission to Reduce Chronic Malnutrition, and municipalities in the targeted areas. Figure A.2.1 provides an overview of each participating entity's main responsibilities. MIDES-FODES/PIU will sign Inter Institutional agreements with MSPAS and SESAN to define their roles and responsibilities and guarantee their assistance in implementing the Project. For example, MSPAS and SESAN will be responsible for the technical oversight of specific activities under the Project (e.g., MSPAS will decide the location and technical design of health posts, as well as develop technical specifications for medical equipment and health related training, while SESAN will be responsible for the content of national and local level advocacy messages on reducing and preventing chronic malnutrition), with MIDES-FODES performing fiduciary functions and coordinating safeguards management in collaboration with MSPAS, MIDES, SESAN, and the Ministry of Environment and Natural Resources (Ministerio de Ambiente y Recursos Naturales). All reporting and oversight relationships are defined in the Operations Manual, to be adopted before Loan effectiveness.

3. **MIDES-FODES/PIU will coordinate with local- and community-level actors to strengthen buy-in to and relevance of the Project.** Specifically, MIDES-FODES/PIU and the other institutions involved in Project implementation will coordinate with, the COCODES and the COMUDES to increase ownership of activities and adjust the interventions to the specific needs of targeted areas. In particular, MIDES-

FODES/PIU will seek the agreement of participating municipalities on the water and sanitation works to be financed under the Project, and confirm their commitment to maintain them. Each water and sanitation subproject will also include the necessary technical assistance to train and strengthen water committees and build community ownership for the long-term operational and maintenance of the system. The Operations Manual explicitly requires that when Indigenous communities and traditional leaders are not adequately represented by the COCODES and/or COMUDES, additional efforts will be made to ensure the effective participation of Indigenous peoples, traditional leaders and traditional health care providers.

Figure A.2.1 Implementation Arrangements under the Project*



*Operations Manual and Inter Institutional agreements provide additional information

4. **Multisectoral coordination will be overseen by a Steering Committee.** The Steering Committee will provide multisectoral policy oversight and stewardship of the Project, and ensure smooth coordination between the relevant Government agencies, regional authorities and Indigenous representatives from the seven Project-supported departments. The Steering Committee will be chaired by the Commissioner for Reducing Chronic Malnutrition and made up of representatives of MSPAS, SESAN, MIDES, and MIDES-FODES/PIU. Representatives of other institutions, Indigenous authorities and

Government agencies will be invited to join as needed. The Steering Committee will meet at least on a bimonthly basis to review implementation progress and take decisions on intersectoral issues related to the Project. Given that this is a new institutional arrangement, a stocktaking of this arrangement by Project stakeholders and the WB will be conducted after the first six months of Project implementation to make any necessary adjustments.

5. **Given the heavy routine workload of the Steering Committee members, full-time Project implementation and management will be carried out by MIDES-FODES/PIU.** Meetings to be chaired by the General Project Director will be conducted on a regular basis to review and coordinate Project implementation. All reporting and oversight relationships are outlined in the Operations Manual to be adopted before Loan effectiveness.

6. **Technical staff, FM specialist and procurement specialists will be hired as consultants to support FODES, but will not have authorizing signatures.** The relevant FODES line units (Planning, Financial Sub-directorate, Administrative Sub-directorate and Technical Sub-directorate) will be further strengthened by technical and professional staff while FM and procurement consultants will support MIDES-FODES/PIU. MIDES-FODES/PIU consultants will act as liaisons between FODES, the other institutions involved in the Project and the WB.

7. **While SESAN and the Commissioner for Reducing Chronic Malnutrition will focus on coordination, communication at the national level, advocacy, and monitoring of the National Strategy, MIDES-FODES/PIU will coordinate Project interventions with the various institutions in charge of implementing activities.** These agencies include MSPAS, MIDES (through the Vice-Minister of Social Protection) and participating municipalities (through COMUDES and COCODES) (Figure A.2.1). MSPAS will focus on the implementation of PHC and nutrition services; MIDES will adjust and implement the CCT Program; and participating municipalities will be involved in the maintenance and treatment of water systems as well as identification and provision of land to build new health posts and small water and sanitation systems. MIDES-FODES/PIU will be responsible for technical specifications for small works related to the rehabilitation and construction of water systems and sanitation (latrines). Detailed roles of these institutions are summarized in Table A.2.1. At local and community levels, MIDES-FODES/PIU and the other Project implementation institutions will coordinate with COCODES and COMUDES to increase ownership and adjust the interventions to the specific needs of each area.

8. **As part of M&E, regular visits will be carried out by the MIDES-FODES/PIU Social Specialist to meet with local counterparts, conduct focus groups, and participate in community meetings to generate community-level feedback.** This will be complemented by a bi-annual department level meeting and national annual meeting with key stakeholders to allow for systematic feedback and exchange among Indigenous leaders, official and traditional health care providers, beneficiaries, involved implementing agencies and the Steering Committee.

9. **COCODES are active in communities with at least 250 inhabitants and are each made up of a group of community members**. The main functions of the COCODES are to:

- Promote economic, social and cultural development of their community;
- Promote effective public participation in identifying and solving community problems;
- Identify the needs of the community and determine priorities for the formulation of programs

and projects;
- Request support from the COMUDES to implement programs and projects when they cannot be resolved within the community;
- Coordinate activities promoted or performed by community groups to avoid duplication of efforts; and
- Manage economic and financial resources required for its programs and local development projects.

Table A.2.1 Roles and Responsibilities of Participating Institutions*

Area	Intervention/activity	Institution
Primary health care	Integrated health care at individual, households and community level that includes vaccination, growth promotion, health and nutrition promotion, PHC maternal and infant health services, and information system	MSPAS Coordinator at district level
Behavioral change	Local level	MSPAS/SESAN/COCODES/ COMUDES
	National level	SESAN
Water and sanitation	Access (new water pipes and rehabilitation)	MIDES-FODES (department level) in consultation with the municipality
	Maintenance and water treatment	Municipality/COCODES
	Surveillance of water quality	MSPAS Coordinator at district level
	Sanitation	MIDES-FODES/COCODES
Communication	National and local	SESAN
Information	Situation room	Municipalities/SESAN
	Monitoring and evaluation	SESAN
CCT	Adjustment (improve targeting, conditionality and verification/evaluation) and implementation	MIDES – Vice Ministry of Social Protection
Project management	Coordination of activities implemented by other institutions participating in the Project	MIDES-FODES/PIU

*More specific roles (decision-making, technical, consultative, implementation) are defined in the Operations Manual, the Inter-Institutional agreements and the Loan Agreement.

10. **The COMUDES are municipal-level councils for development.** Each COMUDES is represented by the mayor who has a coordination role and members include representatives of the COCODES, members of the municipal council body, representatives of public entities with a presence in the town, and representatives of local civil entities responsible for specific issues. The COMUDES promote, facilitate and support the operation of the COCODES and have similar roles, except at the municipal level.

Financial Management

11. **FM will be carried out by MIDES-FODES.** A FM assessment conducted by the WB to evaluate the adequacy of the FM arrangements of MIDES-FODES found these to be largely satisfactory. The assessment focused on the unit's arrangements to ensure proper control, recording, and reporting of Project expenditures. The basic staffing structure, financial recording system and financial reporting, cash flow, audit arrangements, internal control system and asset management of MIDES-FODES were

reviewed as part of the assessment. Mitigation measures have been put in place to address bottlenecks that could impact Project implementation.

12. **MIDES-FODES was created on June 13, 2013 through *Acuerdo Gubernativo* No. 236-2013 as a Special Executing Unit (*Unidad Especial de Ejecución*) of MIDES in charge of the execution of projects, programs and activities of the Social Development Fund financed through a Trust Fund (*Fideicomiso*).** Since FODES, as a special executing unit, is overseeing the implementation of projects financed by different sources of funds, its duration has been extended until October 18, 2031 through *Acuerdo Gubernativo* No. 56-2016 dated October 18, 2016. MIDES-FODES inherited the portfolio, assets and liabilities of its predecessor, the National Peace Fund.[29] Staffing of MIDES-FODES in regional offices has been considerably reduced since last year, and its organizational structure currently includes technical and administrative/finance units at the central level that operate following Guatemala's public sector regulations and a set of basic FM procedures approved in 2015.

13. **Project design involves a number of different activities that require multisectoral coordination and interaction at central, local and community levels.** Such design features call for strong operational arrangements, including the availability of qualified and experienced staff. While MIDES-FODES has a basic structure and procedures, it has limited experience with externally-financed operations (for example, only having managed some IADB supported projects), and has mainly implemented infrastructure contracts. As a result, it will need strengthening in areas such as planning, internal controls, and capacity to provide up-to-date information to properly control and monitor contract execution and arrears. Moreover, given the high volume of transactions expected under the Project, the use of Excel for the preparation of financial and disbursement reports, as well as for contract monitoring, may affect the timeliness and reliability of financial information for Project monitoring.

14. **Based on the above factors, fiduciary risk is considered high.** Key mitigating measures agreed with MIDES-FODES include: (i) hiring of qualified and experienced FM staff to strengthen MIDES-FODES fiduciary line units under terms of reference acceptable to the WB; (ii) securing availability of local funds for the life of the Project to attract and maintain qualified staff; (iii) strengthening of both technical and financial processes and procedures; and (iv) defining arrangements for keeping supplemental records for the preparation of financial and disbursement reports, as well as for contract management. Points (i) and (ii) relate to having the proper staffing and adequate budget for MIDES-FODES/PIU to function and as such, are legal covenants in the Loan Agreement, and points (iii) and (iv) are outlined in the Operations Manual.

[29] The National Peace Fund was a Government institution responsible for designing and implementing projects to eradicate poverty and extreme poverty in Guatemala. It operated between 1991 and 2013.

15. ***Organization and Staffing*. Within MIDES-FODES, FM related tasks fall within the responsibility of the Financial Sub-Directorate that reports to the Executive Sub-Director.** The Financial Sub-Directorate is made up of budgeting, accounting, and treasury units, each staffed with only one professional. While all FM tasks are delegated to this Sub-Directorate, there are some that require the approval of the finance unit of MIDES (e.g., budget modifications). Most staff within the Financial Sub-Directorate are new and, while they are familiar with local requirements, they have limited exposure to the requirements of externally financed operations or investment projects.

16. **For Project purposes, MIDES-FODES will establish a PIU under the International Cooperation Unit, that will include a FM Specialist.** MIDES-FODES/PIU consultants are expected to play a liaison role, both with the WB and the other entities, while day-to-day FM tasks will be the responsibility of the MIDES-FODES Financial Sub-Directorate, which will retain signing authority (*cuentadancia*) for finance related tasks. In order to respond to Project needs, the Financial Sub-Directorate and the Planning Unit will be strengthened with additional staff in the areas of planning, budgeting, accounting, treasury, and contract management. MIDES-FODES/PIU consultants will be financed out of Loan proceeds, and the six FM staff to strengthen fiduciary line units will be financed with MIDES-FODES's own funds, and therefore, will be selected and hired following local rules. Terms of reference for the six FM positions to be hired, regardless of the source of financing, have been agreed with the WB, and are included in the Operations Manual, including roles and responsibilities, qualifications and experience requirements. The selection and contracting of key FM staff is a dated covenant in the Loan Agreement.

17. ***Programming and Budgeting*. Project programming and budget will be governed by public sector regulations, and specific procedures adopted by MIDES.** Accordingly, MINFIN will ensure that Loan proceeds allocated to different Components are included in the annual National Plan and Budget**.** Accordingly, the Operations Manual includes detailed procedures for the preparation of the annual operational plan and budget for the Project, which requires inputs from MSPAS and SESAN, and approval by the Steering Committee. This process needs to be strengthened by differentiating the responsibilities of the Planning Unit from those assigned to the Project. Programing and budgeting processes also need to be significantly strengthened, by ensuring the availability of reliable information on the status of on-going contracts and needs of different participating entities for the upcoming year, as the basis for preparing a robust annual operational plan and budget.

18. **The annual Project budget will be submitted to the Financial Sub-Directorate to be incorporated into MIDES-FODES' budget and later, into the MIDES budget proposal for approval by MINFIN and the National Assembly.** Budget modifications will also be approved by MIDES. The Project budget will be processed, recorded and executed through the country's Integrated FM System (*Sistema de Contabilidad Integrada,* SICOIN). However, based on the programmatic structure used by MIDES-FODES, given the budget for the first year has already been formulated, MIDES-FODES will define how the Project budget will be reflected and identified[30] within the institutional budget.

19. ***Accounting*. Project transactions will be accounted for in SICOIN following government accounting policies and practices.** Overall, SICOIN has basic controls over budget execution, by

[30] MIDES-FODES will need to prepare a budget programmatic structure that will allow it to identify which budget lines belong to the Project.

effectively limiting commitments to actual cash availability and approved budget allocations, and is able to ensure the timely availability of budget execution reports. At the time of recording the Project's budget for the first year of implementation, there will be a need to confirm whether the budget classification used by SICOIN allows for Project Components/cost categories to be included, as this would facilitate the preparation of financial reports. The use of SICOIN will be complemented with Excel Spreadsheets to record Project transactions by Component/subcomponent and in United States Dollars. Those auxiliary records will be used for the preparation of financial and disbursement reports. The recording and maintenance of up-to-date Excel records will be one of the responsibilities assigned to the Accounting Unit within the Finance Sub-Directorate and MIDES-FODES/PIU will be in charge of preparing financial reports using those auxiliary records. The Operations Manual includes the internal controls mechanisms required to ensure integrity of the information, as well as specific content and format of the financial reports.

20. ***Processes and procedures (including internal controls).*** **In compliance with local regulations, MIDES-FODES has basic FM procedures for budget execution, modification and payments, but mainly for SICOIN.** Overall, MIDES-FODES internal control system needs to be significantly strengthened. For Project purposes, MIDES-FODES has prepared detailed flow charts that cover the budget execution process (commitment, accrual and payment) for different transactions. Those procedures have been complemented with specific arrangements for the review and approval of a product/service or progress certificate for civil works. The Technical Sub-Directorate will be responsible for infrastructure contracts and the technical quality of products and civil works, in collaboration with other parties such as MSPAS and SESAN, as needed. Procedures for the transfer of goods and supplies financed out of Loan proceeds to other participating entities such as MSPAS have also been agreed.

21. **Overall, those specific procedures provide for clear roles and responsibilities and an adequate segregation of duties within MIDES-FODES, involving the technical, administrative and finance units, as well as the PIU.** However**,** close follow up will be required to avoid overlap between MIDES-FODES and MSPAS, as well as to seek further simplification of certain approvals and reviews to limit implementations delays. Contract management will be strengthened by: (i) putting in place a single and comprehensive record of contracts, including amount, terms, amendments, amount paid, outstanding balances; and (ii) ensuring clear roles and responsibilities for the timely update of this record to be done as part of the PIU's M&E function. All processes, procedures and related internal controls should be assessed during the first year of Project implementation.

22. ***Internal Audit*.** **MIDES-FODES has an Internal Audit Unit staffed with seven professionals, including a unit head, a supervisor and five financial auditors**. The Internal Audit Unit carries out different types of audits according to an annual program approved by the *Contraloría General de Cuentas,* and audit reviews are performed following the standards and regulations issued by the *Contraloría*. Reviews are focused on transactional issues, and the results are limited to providing information rather than analyzing systemic structural issues in the internal control system.

23. ***Financial Reporting.*** **MIDES-FODES/PIU will submit to the WB semi-annual Interim Unaudited Financial Reports.** These will be submitted to the WB no later than 45 days after the end of each semester and will contain: (i) the sources and uses of funds, reconciling items, and cash balances, with expenditures classified by Project Component/cost category; and (ii) a statement of uses of funds

reporting the current semester and the accumulated operations against ongoing plans, as well as footnotes explaining the important variances. Since Project reports will be prepared using Excel supplementary records (based on the information available in SICOIN), the Operations Manual includes the required internal controls to ensure that transactions processed in SICOIN are timely and systematically updated in the Excel records. In addition, monthly reconciliation will be carried out.

24. **On an annual basis, MIDES-FODES/PIU will prepare Project financial statements, including cumulative figures, for the year and as of the end of the fiscal year (December 31).** All documentation for a consolidated Statement of Expenditures will be maintained for post review and audit purposes for up to three years after the closing date of the Project, or for 18 months after receipt by the WB of an acceptable final financial audit, whichever is the later.

25. ***External Audit*. An external, independent, private audit firm, acceptable to the WB, will be contracted by MIDES-FODES for the entire life of the Project no later than six months after the Loan's effectiveness.** The audited financial statements shall be furnished to the WB not later than six months after the end of the fiscal period. According to the WB's policy on access to information, audited financial statements shall be made public. Component 2 has separate requirements related to financial reporting and auditing, given that funds will be disbursed upon achievement of DLIs and based on eligible expenditure lines. Specifically the audit of the Budget Execution Report of the CCT Program will need to verify that the amount shown as paid to CCT Program beneficiaries in the areas of intervention corresponds to actual payments made to beneficiaries who complied with the co-responsibilities defined in the Program. Specific audit requirements and due dates are shown in Table A.2.2.

Table A.2.2 Audit Requirements and Due Dates

Audit type	Due date
Components 1 and 3	
Project financial statements	June 30
Statement of Expenditures	June 30
Management Letter	June 30
Component 2	
Budget Execution Report for Component 2 (CCT)	June 30

26. **An Action Plan to ensure that adequate FM systems are in place before Project implementation is currently being undertaken by MIDES-FODES/PIU**. Table A.2.3 outlines the key actions.

Table A.2.3 Action Plan for FODES

Action	Responsible Entity	Completion Date[31]
1. Define the budget structure to be used to record the Project budget in SICOIN	FODES	At the time of recording Project budget for Year 1
2. Contract individual external audit based on terms of reference and short list satisfactory to the WB for the entire implementation period	FODES/PIU	Six months after effectiveness

[31] This column presents the estimated completion date, and is not an indication of legal conditions.

	Action	Responsible Entity	Completion Date[31]
	of the Project		
3.	Provide specific training in FM & disbursements for Project FM staff once the key team is appointed	WB	Three months after effectiveness

Disbursements

27. ***Flow of Funds.*** **Disbursement methods that may be used to withdraw funds under Components 1 and 3, including reimbursement, advances, and direct payments.** Under the advance method, a Designated Account will be opened as a Secondary Account (*Cuenta Secundaria),* under the Multilaterals' Single Treasury Account in MINFIN in United States Dollars, to be used exclusively for deposits and withdrawals of Loan proceeds for eligible expenditures. Funds deposited into the Designated Account as advances will follow the WB's disbursement policies and procedures, described in the Loan Agreement and Disbursement Letter. Following current practices, advances made to the Designated Account will be documented through use of Statements of Expenditures and supporting documents defined in the Disbursement Letter. Documentation of eligible expenditures paid out of the Designated Account is expected to be carried out on a quarterly basis. Supporting documentation requirements for Project expenditures (thresholds for the use of Statements of Expenditures) as well as the minimum value for direct payments and reimbursements are defined in the Disbursement Letter.

Figure A.2.2 Funds Flow for the Financing of DLIs related to the CCT Program

WORLD BANK

8. Disbursement $

MINISTRY OF FINANCE

$ 2. Advance of funds to the Trust Fund FPS based on approved "cuota"

1. Request of advance to FPS based on programming

7. Withdrawal application based on verification of DLIs and financial execution of Eligible budget lines

BANRURAL
Trust Fund Social Protection Fund (SPF)

3. Payment payroll based on verified co-responsibilities

MIDES

Vice Ministry. SOCIAL PROTECTION - Executing agency SPF

MIDES-FODES PIU – CRECER SANO PROJECT

$ 4. Deposit of funds into individual bank accounts

BANRURAL – INDIVIDUAL BENEFICIARIES BANK ACCOUNTS

B1 Bn Bnn

5. Evidence of CCT payment

6. Evidence on DLIs/Execution of eligible budget lines eligible

Flow of funds

Flow of information

Note: Implementation of CCT program (light gray); Component 2 (dark gray)

28. ***Specific Flow of Funds for Component 2.*** **Given the use of DLIs for disbursement purposes for Component 2, the flow of funds and information for the implementation of the CCT Program is presented in Figure A.2.2.** Based on the budget allocation approved for the CCT Program, MINFIN will disburse the funds needed to process payments to CCT beneficiaries through Bank of Rural Development (Banco de Desarrollo Rural/BANRURAL). Once payments to eligible beneficiaries have been made and duly recorded in SICOIN, the Executing Unit of the Social Protection Fund within MIDES will provide MIDES-FODES with a budget execution report for the eligible budget lines agreed with the WB reflecting expenditures (CCT Program cash transfers) in the seven Project-supported departments.

The format and content of the budget execution report have been agreed with the WB and periodicity is defined in the Disbursement Letter. Said budget execution reports will be subject to a special audit under terms of references approved by the WB, as described in the external audit section. Said audit review will be financed with Loan proceeds and will be procured together with the financial audit of Component 1 and 3. The WB shall reimburse the Borrower an equivalent amount in United States Dollars from the Loan account for pre-financed eligible expenditures in accordance with paragraph 2.2 of the Disbursement Guidelines, and as provided in Sections IV and V of Schedule 2 of the Legal Agreement. Funds reimbursed by the WB under Category 2 will be deposited into a specific secondary account within the Treasury Single Account, as indicated by the Borrower in the respective withdrawal application, and will thereafter be registered by the Government in its corresponding annual budget, and be used in in conformity with the Borrower's budgetary laws. No retroactive financing is planned under the Project.

29. **The WB will closely work with MIDES-FODES FM staff during the first year of the Project to support the effective implementation of all required arrangements, and assess their adequacy.** The WB will also review the annual audit report, the semi-annual Interim Unaudited Financial Reports, and carry out at least two complete supervision missions per year. This supervision strategy will be reviewed periodically and adjusted based on performance and risk.

Procurement

30. **MIDES-FODES will be responsible for any procurement under the Project, which will be carried out in accordance with World Bank Procurement Regulations for Borrowers under Investment Policy Financing (July 2016) ("Procurement Regulations").** A Project Procurement Strategy for Development (PPSD), prepared by the Borrower, describes how procurement in this operation will support the PDO and deliver value for money under a risk-based approach. Procurement for works, goods, consultant services and non-consulting services will be implemented based on Mandatory Procurement Prior Review Thresholds detailed in Annex I of the WB's Procurement Procedures. A Procurement Plan for Components 1 and 3 was prepared based on the PPSD, which provides adequate supporting market analysis for the selection methods detailed in the Plan. As indicated in the PPSD, Component 2 will only finance the provision of CCTs (non-procurable items). All procurement procedures, including roles and responsibilities of different participating entities and units, are defined in the Operations Manual. A summary of PPSD, including recommended procurement approach for higher value contracts, is detailed in Table A.2.4.

31. ***Procurement Plan*. The Procurement Plan was prepared by the Borrower based on the PPSD and agreed with the WB.** In accordance with paragraph 5.9 of the Procurement Regulations, the WB's Systematic Tracking and Exchanges in Procurement system will be used to prepare, clear and update the Procurement Plan and conduct all procurement transactions for the Project. The Borrower has already been trained on how to use the system.

32. ***Civil Works*. The Project will finance small-scale infrastructure.** This includes refurbishments of health posts and community centers, improving water drainage, rehabilitation/construction of small water systems, installing water supply and sanitation connections for households, construction of health posts, etc.

33. ***Goods.*** **Goods to be financed under this Project include medical equipment and materials, communication and technology equipment, software, etc.**

34. ***Non-consulting Services.*** **The Project will finance services such as printing, data collection, communications, publicity services, and other services.**

35. ***Consulting Services*****. Consulting services to be financed under the Project will be focused on M&E services, supervision of civil works, and external auditing, among other services.**

36. ***Standard Procurement Documents.*** **Standard procurement documents shall be used for all contracts subject to international competitive procurement and those contracts as specified in the Procurement Plan tables in the Systematic Tracking and Exchanges in Procurement system.**

37. ***Operating Costs*****. Operating costs refer to reasonable recurrent expenditures that would not have been incurred by the implementing agency in the absence of the Project.** The Project will finance operating costs, such as office supplies, communication and advertising costs, computers and equipment maintenance, per diems for local and international staff, among others. The Project will also finance costs of training, travel and per diem of trainers and trainees, and rental of facilities.

38. ***Capacity Assessment.*** **A procurement capacity assessment was carried out to evaluate the adequacy of procurement arrangements of MIDES-FODES.** It focused on how the entity was organized to procure using external funds or their own national funds. The basic staffing structure, procurement record system, internal controls, evaluation committees roles and responsibilities, contract signing, contract administration were reviewed with each entity as part of the assessment.

39. **While MIDES-FODES has a basic structure and procedures, it has limited experience with externally-financed operations.** For example, thus far, MIDES-FODES has only carried out two externally financed procurement processes and has limited knowledge of the WB's Procurement Regulations. Moreover, MIDES-FODES has been affected by budget restrictions and procurement processes have been of lesser value and/or delayed due to national constraints. Therefore, it will need to strengthen its procurement staffing and implementation procedures. As such, MIDES-FODES will recruit additional staff as required to implement this Project and enhance its tools, records and internal controls for different procurement tasks, including contract management. Mitigation measures have been incorporated in Operations Manual and agreed with the WB accordingly.

40. **Technical aspects of envisaged procurement activities will require coordination amongst all institutions.** MIDES-FODES has limited knowledge and capacity regarding technical aspects of goods and services to be procured by Project funds, for example, medical equipment. The Project will finance technical consultants to support MIDES-FODES and MSPAS, and if needed, MIDES and SESAN for preparing and reviewing technical specifications. Detailed roles and responsibilities of different entities are outlined in the Operations Manual.

41. ***Frequency of Procurement Supervision.*** **In addition to prior review supervision to be carried out by the WB office, annual supervision missions will be carried out to visit the field and conduct post**

review of a sample of 20 percent of procurement actions.

Table A.2.4. Summary of PPSD (for higher value contracts)

Description	Est cost (US$)	Review	Market approach	Procurement method
CIVIL WORKS				
Renovation and rehabilitation of health posts	901,316	Post	National - open	RFB - post-qualification
Construction of new health posts (to be procured in 2018 & 2019)	13,727,211.73	Prior	National - open	RFB - post-qualification
Construction of water systems (to be procured in 2017, 2018 & 2019)	8,630,000	Post	National - open	RFB - post-qualification
Construction of latrines (to be procured in 2017, 2018 & 2019)	3,470,000	Post	National - open	RFB - post-qualification
GOODS				
Procurement of motorcycles and vehicles for MSPAS	5,436,751	Prior	National - open	RFB - post-qualification
IT equipment	2,031,506	Prior	International - open	RFB - post-qualification
Office equipment for health centers	8,208,942.91	Prior	International - open	RFB - post-qualification
Water quality	2,000,000	Prior	National - open	RFB - post-qualification
Chlorinators	2,150,000	Prior	National - open	RFB - post-qualification
Equipment for water quality vigilance	1,313,872	Prior	National - open	RFB - post-qualification
Anthropometric and cold chain equipment; stethoscopes	1,210,192.20	Prior	International - open	RFB - post-qualification
Household filters for water purification	550,000	Prior	National- open	RFB - post-qualification
Micronutrients	909,090.90	Prior	National – open	RFB - post-qualification
Incentive goods	1,278,595	Prior	National - open	RFB - post-qualification
Kits for behavior change	2,668,203	Prior	National - open	RFB - post-qualification
NON-CONSULTING SERVICES				
Printing of educational material	682,015	Prior	National - Open	RFB - post-qualification
Logistic services for training MSPAS	2,040,534	Prior	National - open	RFB - post-qualification
Logistic services for training SESAN	1,459,892	Prior	National - open	RFB - post-qualification
Logistic services for training on behavior change (SESAN)	3,911,295	Prior	National - open	RFB - post-qualification
Logistic services for training civil servants (SESAN)	300,000	Post	National - open	RFB - post-qualification
Printing materials	2,862,612	Prior	National - open	RFB - post-qualification
CONSULTING SERVICES				
Supervision of civil works (latrines)	347,000	Post	National, Limited	Short list, QCBS
Supervision of civil works (rehabilitation)	90,131.60	Post	National, Limited	Short list, QCBS
Supervision of civil works (new premises)	1,372,721.17	Prior	International, Limited	Short list, QCBS

Description	Est cost (US$)	Review	Market approach	Procurement method
Communication strategy	2,176,000	Prior	National, Limited	Short list, QCBS
Supervision of civil works (water introduction)	863,000	Prior	International, Limited	Short list, QCBS
Communication campaign	599,000	Prior	National, Limited	Short list, QCBS
Baseline, mid-term and final term evaluation	1,000,000	Prior	International, Limited	Short list, QCBS

(*) Procurement packages and WB prior review as defined in procurement plan accordingly.

Environmental and Social (including safeguards)

42. **Most Project beneficiaries are Indigenous peoples and therefore, the Project is considered an Indigenous Peoples Project**. A socio cultural assessment was carried out to identify Indigenous peoples' aspirations, concepts, concerns, and experiences in relation to chronic malnutrition and inform Project design. Based on the results of the socio cultural assessment and a consultation process at national and department levels, specific Project actions and provisions for community level participation in relevant Project decisions have been incorporated into the Operations Manual. MIDES-FODES/PIU will hire a social specialist to supervise implementation of these actions and provisions, elaborate and implement a culturally appropriate communications strategy, and ensure any concerns or issues that arise during Project implementation at a community level are adequately addressed.

43. **The socio cultural assessment was carried out in different steps.** These included: (i) a stakeholder mapping at both the national and departmental levels for the first four participating departments; (ii) interviews with key stakeholders at national, departmental and community level, including government actors, non-governmental organizations, and Indigenous organizations; (iii) focus groups in 12 municipalities from the four departments prioritized under the first phase, with Indigenous leaders, traditional health care providers, youth and Indigenous women; and (iv) a desk analysis of barriers to access, and both unsuccessful and successful past experiences in reducing chronic malnutrition, infant mortality, maternal mortality, and increasing adoption of family planning methods. Table A.2.5 summarizes the key findings of the social cultural assessment that was published on the WB's, MSPAS, MIDES, and SESAN's websites:

Table A.2.5 Summary of Socio Cultural Assessment

Access	1. **Official Health Services and Posts:** There is very little presence of primary health care in Indigenous communities in the Project's beneficiary departments. When health posts do exist, they often are lacking medical personnel, medicine, updated equipment and adequate infrastructure. Whereas community infrastructure does exist, due to legal limitations, MSPAS cannot utilize this infrastructure to provide any official health service. 2. **Transportation:** Transportation costs are also another major barrier for Indigenous families to access health posts for primary care needs such as vaccinations and emergency situations. 3. **Official vs. Traditional health Systems:** Most Indigenous individuals and families seek care first via their traditional health systems that include healers, *comadronas*, different specialists such as "bone healers", and spiritual guides. When this system does not resolve their issues, they then tend to seek out care from the official health service, often at moments that are very late to effectively address their health issue. 4. **Births:** In Guatemala, the share of births attended by *comadronas* in the case of Indigenous women are significantly higher (at least 46.5 percent) compared to births by non-Indigenous

	women (14 percent). 5. **Food:** Many women lack access to sufficient resources to provide their children with a healthy and balanced diet. Most Indigenous communities' primary diet is consumption of beans and corn produced through subsistence farming and compliment this with junk food. Whereas some vegetables are produced they are mostly sold to external markets. Consumption of meat products is limited as this surpasses the budgetary possibilities of most families, especially larger ones. Whereas most families have from four to six children, some families have as many as 17 children. This is exacerbated by frequent pregnancies where babies who could be breastfed are not as the women stop breast feeding once pregnant. 6. **Water and Sanitation:** Most Indigenous families have access to untreated piped water to their homes and to latrines without drainage systems. Since water is used for washing, cooking, food preparation, and hygiene, this is clearly a barrier to achieving good health outcomes. In rural Indigenous communities there are few systems for drainage, disposal and treatment of sewage, waste water and solid waste.
Cultural Aspects & Pertinence	1. **Traditional health systems:** Traditional health care goes beyond the purely physical realm, to also include emotional and spiritual health. Health and illness are most often viewed as an integral dynamic between the individual, family and community and their relationships with each other and their natural environment. 2. **Role of the *comadrona***: The *comadrona* is considered the primary health service professional at the community level. *Comadronas* are born with the gift and cannot be "trained". They serve as the guardians over traditional medicinal plants and treatments for the community. Their role goes far beyond that of a midwife as they also serve as the gynecologist, obstetrician, family planning consultant, and pediatrician. *Comadronas* have a critical role in regards to family planning and other critical behaviors for chronic malnutrition and infant and maternal mortality as they are the community, family and individual's primary point of reference for health care advice and hold high levels of trust within their communities. 3. ***Comadronas* & the official system:** Past efforts to "integrate" the *comadrona* into the official medical system have been known for diminishing their role within the health posts to cleaning, making beds, bringing food, and other assistant type tasks, limiting their role in the actual care for their patients. This treatment of such important community figures has led to a heightened level of mistrust for the official system among Indigenous communities and *comadronas*. In other cases, the official system has been known for blaming *comadronas* for women's choices to not seek out official medical services in a timely fashion or for promoting inadequate or detrimental practices. *Comadronas* and traditional healers have also been called "witch doctors".
Practices	1. **Family planning:** Due to religious beliefs or *machista* norms and domestic violence, girls and women often seek out birth control methods without their husband's knowledge at health posts or in communities that are not their own. At the same time, it was found that many women are using the Depo Vera method of birth control as it only requires an injection once every three months and thus is easier to hide from their partners. 2. **Breast feeding**: Although it was found that most women breast feed if they can, it was also found that women believe that once they are pregnant they can or should not continue breast feeding. Poor nutritional practices, where women are the last to eat or rely on a very unbalanced and limited diet have also influenced their capacity to produce milk. In some cases women had the perception that giving their newborns formula or even Coca Cola was better for their newborn than breast milk as it cost money and was considered a "luxury product". 3. **Nutritional Supplements**: Past efforts to complement dietary practices with nutritional supplements have largely failed as Indigenous women did not understand the purpose of the supplements, or know how to integrate them within their cooking practices and diet. 4. **Education & Literacy:** It was found that there is a high correlation between a woman's level of

	education and levels of chronic malnutrition. The departments to be supported by the Project have a very diverse range of linguistic groups and levels of mono and bilingual capacity. The effective delivery of capacity building and primary service care, especially around behavioral changes, needs to be tailored specifically to the levels of education, literacy and linguistic situation of the communities in each region 5. **Emergencies & Seeking Care in the official health system:** It was found that most women only seek out medical attention from the official health care system when their families, and most importantly their husbands and mother in laws authorize this choice. Lack of resources, *machista* behaviors, and high levels of mistrust for the official system have led to many infant and maternal deaths as the choice to seek out official medical assistance if often far too late to access proper care in a timely fashion. 6. **Water and Sanitation:** There is an overwhelming rejection of the use of chlorine to treat water. People complain of the smell and how the chlorine affects the taste and others have complained of getting sick, most likely due to an excess amount of chlorine being used. In regards to waste water and solid waste, in rural Indigenous communities there are no services so waste water is disposed without treatment and garbage is buried and burned.
Oppor-tunities	**1. Inclusive Health Model:** The Inclusive Health Model that has been piloted by the *Instituto de Salud Incluyente* in several municipalities in Guatemala has demonstrated the most impressive results in regards to reducing chronic malnutrition, child mortality and maternal mortality, improving family planning practices. This model builds and strengthens both the traditional and western systems to work in complementary manners, in respect for the beliefs, practices and services that each provide. This model is the basis for the MSPAS PHC model that will be supported by the Project. **2. Comadrona Policy:** A National Policy for *comadrona*s was recently approved this year and outlines measures to adequately recognize, strengthen and support the role of *comadronas* in Guatemalan health care.

44. **A national level workshop was carried out on July 13, 2016 with a group of Indigenous representatives from the beneficiary departments.** Based on the results of the social cultural assessment and in light of the Project's design, workshop participants identified the following: (a) provisions to ensure the effective participation and broad community support of Indigenous leaders, beneficiaries and stakeholders in key Project decisions that could affect or benefit them; and (b) explicit actions to ensure the delivery of a culturally pertinent and quality service delivery. The Inclusive Health Model that the Project will expand responds directly to most of the issues raised in the socio cultural assessment. To ensure that adequate consultation, participation and prioritization of Indigenous and other beneficiary communities is carried out for other key Project decisions that go beyond the service delivery model, the Operations Manual addresses a number of key areas. These include: (i) identification and targeting of key communities or *comunidades sedes* for the organization of health service provision, including where infrastructure will be financed; (ii) ensuring adequate design and adaptation of health post infrastructure for effective inclusion of critical cultural preferences and contextual design elements; (iii) recruiting and training of local auxiliary health personnel that will be providing health services and facilitating the interface between the official and traditional health systems, using local norms such as language requirements; (iv) training, sensitizing, and building capacity of health post staff to ensure respectful and quality service delivery for Indigenous patients; (v) supporting and strengthening traditional health providers; (vi) promoting intercultural exchange and sensitization to strengthen the interface and understanding among the official and traditional Indigenous health systems; (vii) ensuring adequate planning and technical assistance to accompany water and sanitation; (ix) including traditional, local and Indigenous illnesses and service provision in official information systems; and (x)

implementing specific measures to ensure ongoing community and Indigenous leadership participation in Project monitoring and evaluation processes. The social cultural assessment and a summary of the key actions integrated into the Operations Manual to comply with OP/BP 4.10 were published on the WB, MIDES, SESAN and MSPAS websites on November 4, 2016.

45. **In non-Indigenous communities, the Inclusive Health Model is also relevant as it builds on local community concepts and practices around health, regardless if they are based on Indigenous traditional systems.** The Model has been implemented successfully in both Indigenous and non-Indigenous communities in Guatemala. At the same time, participatory processes for all communities will be respected through the participation of the COCODES and COMUDES.

46. **Activities requiring Involuntary Resettlement per OP/BP 4.12 will not be eligible for Project financing.** Screening criteria to ensure that land donations are voluntary are included in the Project's ESMF. A Grievance Redress Mechanism is also outlined in the ESMF that builds on national systems and MSPAS's existing system for information and complaints.

47. **At the operational level, the responsibility for Project environmental due diligence will rest with assigned staff at the MIDES-FODES/PIU.** These staff will collect, analyze, and report environmental data from MIDES, MSPAS, the Ministry of Environment, and the WB as part of MIDES-FODES/PIU quarterly and annual implementation progress reports. The ESMF provides guidelines on how to proceed with mitigating any potential environmental impact of the anticipated works. The environmental assessment for each individual subproject will be undertaken by a consultant hired by MIDES-FODES/PIU and whose terms of reference will closely follow that stipulated in the ESMF.

Monitoring and Evaluation

48. **Given that Project interventions will contribute to the National Strategy to Prevent Chronic Malnutrition 2016–2020*,* MIDES-FODES/PIU will monitor and evaluate the progress and outcomes of reforms supported by the Project in the context of overall monitoring of the National Strategy.** In order to track progress toward achieving the PDO, the Project's Results Framework includes four PDO-level results indicators and four DLIs. The four DLIs will contribute to demonstrating progress made toward the achievement of the four PDO-level indicators, while other indicators will be used for tracking health outcomes across WB-financed projects (WB core sector indicators), and will serve as intermediate results indicators. The DLIs matrix is included in Annex 4.

49. **At the operational level, the responsibility for Project M&E will rest with assigned staff at the MIDES-FODES/PIU.** Results included in the DLI matrix of Component 2 (DLIs 1, 2 and 4) will be verified through an external entity selected through a competitive process and financed by Component 3. The Steering Committee will review monitoring data during its periodic meetings to assess progress on the PDOs and take timely corrective measures as needed. Project M&E data will also be used in analytical reports on the progress and impact of the National Strategy. To strengthen the long-term M&E capacity of MSPAS and SESAN, the Project will support adjustments/improvements and scale-up of health information systems currently in use in the intervention areas. In addition, MIDES-FODES/PIU, MSPAS, and SESAN staff and local workers will receive necessary in-service and external training. Independent M&E services will also be engaged, including for mid-term and final evaluation of the Project.

50. **To the extent possible, progress on results will be monitored using routine data sources.** This includes data from the information systems and administrative records of MIDES, MSPAS, SESAN, municipalities, and MINFIN. In addition, as mentioned, the Project will support adjustment and scaling up of the local health information systems. Some indicators, such as those related to breastfeeding, might require special surveys.

51. **Data on most Project indicators will be reported on annual basis.** Progress reports will include data on grievances and resolution to allow for timely corrective action. Indicators generated through citizen engagement mechanisms will be reported on annually following the citizen monitoring and feedback process. Evaluation of Project implementation will be done at mid-term and Project closing.

52. **The WB will provide implementation support based on the detailed Implementation Support Plan** (Annex 3). The focus of this support will be on timely implementation of agreed activities and the Procurement Plan, and will include provision of necessary technical support, carrying out of fiduciary reviews, and M&E activities. These will be done as part of regular implementation support visits and through reviews of data and documents, discussions with governmental and nongovernmental counterparts and relevant partners, and visits to Program sites and facilities, as needed. With regard to M&E, the WB will pay particular attention to reviewing the monitoring data and verification/evaluation documentation for the Program's results and DLIs submitted by MSPAS, retaining the right to make the final decision, for disbursement purposes, on whether the agreed DLIs have been achieved.

Role of Partners (if applicable)

53. **The BF, CG, EU, IADB, PAHO, SC, UNICEF, USAID, and WFP are providing support in health and nutrition in Guatemala.** In particular, the BF is supporting food security including smart agroforestry systems, CG is financing actions to reduce child and maternal mortality, IADB has projects supporting primary health care and water and sanitation. The EU, mainly through the SAIDC, is supporting water and sanitation, and governance in food security and nutrition, and SC is supporting livelihood activities. In terms of technical assistance, PAHO is supporting health systems strengthening; USAID is assisting on certain aspects of health system strengthening and food security and nutrition; WFP is providing support in food security; and UNICEF is providing technical assistance on maternal and child nutrition. In the Project intervention areas, the main partners are: BF, CG, IADB, EU mainly through SAIDC, SC, and USAID.

ANNEX 3: IMPLEMENTATION SUPPORT PLAN

COUNTRY : Guatemala
Crecer Sano: Guatemala Nutrition and Health Project

Strategy and Approach for Implementation Support

1. **The Implementation Support Plan includes frequent supervision by WB, regular dialogue with the Government, recurrent joint reviews of Project implementation, and regular supervision of Project implementation and fiduciary activities.** Day-to-day supervision by WB will contribute to supporting Project implementation and identifying situations that might require specific reviews or meetings. Regular dialogue will facilitate early identification of problems, the involvement of key stakeholders, and timely provision of technical advice and support to remove obstacles. Reviews will take place at least twice a year, aimed at reviewing progress and achievement of agreed DLIs and Results Framework indicators. During each of the reviews, the type of implementation support needed will be identified, followed by joint decisions on specific necessary assistance.

Implementation Support Plan and Resource Requirements

Time	Focus	Skills Needed	Resource Estimate	Partner Role
First 12 months	Technical Assistance CCT Adjustments of PHC services, nutrition, and early childhood development training Communication behavioral change at community level Adjustment of information system First phase of civil works (health post and water and sanitation and equipment)	Task Team Leader Senior Operations Officer Procurement Specialist Social Specialist Social Protection Specialist FM Specialist Medical Equipment Specialist – Short-term Consultant Environmental Specialist Architect/Civil Works Specialist	100 staff weeks	
12–48 months	Scaling up of the interventions Implementation of the updated information system	Task Team Leader Senior Operations Officer Procurement Specialist Social Specialist FM Specialist Medical Equipment Specialist – Short-term Consultant Environmental Specialist Architect/Civil Works Specialist	300 staff weeks	

49–60 months	Completion of all pending activities Project evaluation	Task Team Leader Senior Operations Officer Procurement Specialist Social Specialist FM Specialist Medical Equipment Specialist – Short-term Consultant Environmental Specialist Architect/Civil Works Specialist	150 staff weeks

ANNEX 4: DISBURSEMENT-LINKED INDICATORS MATRIX

	Total Financing Allocated	*As % of Total Financing Amount*	*DLI Baseline*	*Indicative Timeline for DLI Achievement*				
				Year 1	***Year 2***	***Year 3***	***Year 4***	***Year 5***
DLI 1. Coverage of prenatal care with at least four visits in the intervention areas.	US$4 million	4%	18.7 (2015)		30%		50%	
Definition/Description of Achievement: 30 percent and 50 percent of all pregnant women in the intervention areas[32] receiving at least four prenatal care visits. Scalable disbursement proportional to the progress toward achievement of this DLI will be applied to the second 50 percent portion of the DLI financing based on a formula specified in the Disbursement Table.								
DLI 2. The Unique Registry of Beneficiaries receives individual level data on health system usage.	US$3 million	3%	No (2015)		Implementation has started	Data is being shared with the CCT Program		
Definition/Description of Achievement: The Unique Registry of Beneficiaries receives data from SIGSA with individual records of usage of each component of the basic health care services. 50 percent to be disbursed when SIGSA has been updated to include individual records with the information required to confirm if co-responsibilities have been fulfilled and Unique Registry of Beneficiaries and SIGSA are inter-operable; and 50 percent to be disbursed once data is being shared with the CCT Program for verification of co-responsibilities.								

[32]Project intervention areas were selected based on high rates of stunting and child mortality, high maternal mortality ratios, a large share of population represented by children under five years old, and a high proportion of rural and Indigenous populations (mainly in the highlands).

DLI 3. Percentage of six month old children who are exclusively breastfed in the intervention areas.	US$4 million	4%	43% (2015)		50%*		65%*	
Definition/Description of Achievement: 50 percent and 65 percent of all 6 months old children are exclusively breastfed (infant receives only breast milk. No other liquids or solids are given—not even water—with the exception of oral rehydration solution, or drops/syrups of vitamins, minerals, or medicines). Scalable disbursement proportional to the progress toward achievement of this DLI will be applied to the second 50 percent portion of the DLI financing based on a formula specified in the Disbursement Table. Currently the MSPAS information system collects information regarding exclusive breastfeeding for children 0-5 months old. The system will be adjusted to collect and report information for 6 months old children. Baseline information is based on the results of the last ENSMI, which includes children 4-5 months, so the actual baseline figure for 6 months old children is expected to be lower than the ENSMI figure. ** GFF disbursement targets*								
DLI 4. Percentage of children under two years old who are beneficiaries of the CCT Program receiving transfers based on compliance with the full verification cycle of health co-responsibilities in the intervention areas.	US$3.75 million	4%	0% (2015)	CCT adjusted and implementati on started	30%*		70%*	
Definition/Description of Achievement: First portion (US$2M) to be disbursed based on achieving the following indicator: CCT Program is adjusted to include the components of basic health care services as health co-responsibilities. Second portion (US$1.75M) to be disbursed based on meeting target (70%) for this indicator. Numerator: number of children under two years old whose household is enrolled in the CCT Program fulfilling the full verification cycle of health co-responsibilities (and associated payments) as defined in CCT Program Operation Manual. Denominator: number of children under two whose household is enrolled in the CCT Program. ** GFF disbursement targets.*								

DLI Verification Protocol Table

	DLI	*Scalability of Disbursements (Yes/No)*	*Protocol to Evaluate Achievement of the DLI and Data/Result Verification*		
			Data Source/Agency	*Verification Entity*	*Procedure*
1	Coverage of prenatal care with at least four visits in the intervention areas.	Yes	MSPAS information system	Independent evaluation	An Independent Evaluation Entity will conduct a survey to validate the data.
2	The Unique Registry of Beneficiaries receives individual level data on health system usage.	No	MIDES/MSPAS	MIDES/WB	Plan approved by all involved agencies (/MIDES/MSPAS). The WB will conduct a visit to verify that the Unique Registry of Beneficiaries is in place and that it receives individual level data from SIGSA on health system usage, and that MIDES is using it for verification of co-responsibilities.
3	Percentage of six month old children who are exclusively breastfed in the intervention areas.	Yes	MSPAS information system; ENSMI; and knowledge, practice, attitude behavioral surveys.	Independent evaluation	An Independent Evaluation Entity will conduct a survey to validate the data.
4	Percentage of children under two years old who are beneficiaries of the CCT Program receiving transfers based on compliance with the full verification cycle of health co-responsibilities in the intervention areas.	No	MIDES – CCT information system	Independent evaluation	An Independent Evaluation Entity will review CCT administrative records.

DLI Disbursement Table

#	*Disbursement-Linked Indicator (DLI)*	*Bank Financing Allocated to the DLI*	*Of which Financing Available for Prior Results*	*Deadline for DLI Achieve-ment*	*Minimum DLI Value to be Achieved to Trigger Disbursement of Bank Financing*	*Maximum DLI Value(s) Expected to be Achieved for Bank Disbursement Purposes*	*Determination of Financing Amount to be Disbursed against Achieved and Verified DLI Value(s)*
1	Coverage of prenatal care with at least four visits in the intervention areas.	US$4 million	N/A	Dec-31-2021	30%	50%	First 50 percent portion to be disbursed once coverage or early prenatal care of 30 percent is verified. Second 50 percent portion to be disbursed proportionate to the verified progress toward achievement of the target value of 60 percent based on the following formula: US$2 million / (20) X additional percentage points achieved after first portion.
2	The Unique Registry of Beneficiaries receives individual level data on health system usage.	US$3 million	N/A	Dec-31-2021	Implemen tation has started	Data is being shared with the CCT Program for verification of co-responsibilities	First 50 percent portion to be disbursed once SIGSA has been updated to: (a) include individual records with the information required to confirm if co-responsibilities have been fulfilled; and (b) the Unique Registry of Beneficiaries and SIGSA are inter-operable. Second 50 percent to be disbursed once data is being shared with the CCT Program for verification of co-responsibilities.
3	Percentage of children six months old with exclusive breastfeeding in the intervention areas.	US$4 million	N/A	Dec-31-2021	50%	65%	First 50 percent portion to be disbursed once prevalence of children six months old with exclusive breastfeeding of 50 percent is verified. Second 50 percent portion to be disbursed proportionate to the verified progress toward achievement of the target value of 65 percent based on the following formula: US$2 million / (15) X additional percentage points achieved after first portion.

#	*Disbursement-Linked Indicator (DLI)*	*Bank Financing Allocated to the DLI*	*Of which Financing Available for Prior Results*	*Deadline for DLI Achieve-ment*	*Minimum DLI Value to be Achieved to Trigger Disbursement of Bank Financing*	*Maximum DLI Value(s) Expected to be Achieved for Bank Disbursement Purposes*	*Determination of Financing Amount to be Disbursed against Achieved and Verified DLI Value(s)*
4	Percentage of children under two years old who are beneficiaries of the CCT Program receiving transfers based on compliance with the full verification cycle of health co-responsibilities in the intervention areas.	US$3.75 million	N/A	Dec-31-2021	CCT adjusted and implementation started	70	First portion (US$2M) to be disbursed once the CCT Program is adjusted and has started implementation based on health co-responsibilities that include the components of basic health care services. Second portion (US$1.75M) to be disbursed once target value of 70 percent is verified.

ANNEX 5: COST-BENEFIT ANALYSIS OF THE PROJECT-SUMMARY

1. **The PDO is to improve practices, services and behaviors known to contribute to reducing chronic malnutrition (with an emphasis on the first 1,000 days of life) in the intervention areas.** The economic analysis estimates the economic benefits of reaching this PDO for the country, as measured by the defined PDO indicators. The Project not only supports interventions to ensure that newborns are better nourished (i.e., by promoting exclusive breastfeeding during the first six months of life and extending the coverage of growth promotion), but also takes a comprehensive approach to improving early childhood living conditions by promoting early prenatal care, immunization coverage (rotavirus and pneumococcal), and access to safe drinking water.

2. **While the Project prioritizes interventions for children 0-24 months, others will benefit from the interventions, such as the populations of municipalities with access to rehabilitated water systems.** Given that the purely economic benefits of such interventions, which mainly come in the form of reduced healthcare costs, are hard to quantify using the available data (e.g., on waterborne diseases), and in order to provide a conservative estimate, the cost-benefit analysis only monetizes benefits accruing to the cohorts of newborns that are the most immediate beneficiaries of the Project. The economic benefits from interventions tackling malnutrition have been shown to be the largest when targeted at newborns, because early childhood is the key phase for neural development,[33] which is a critical determinant of a person's income potential.

3. ***Benefits.* There is robust evidence for the considerable economic returns of reducing chronic malnutrition among newborn children and improving their access to water and sanitation.** The evidence comes from countries in Africa, Southeast Asia and Central America. The exact magnitude of the economic returns, however, varies considerably with the regional and local context. Therefore, it is key to employ the right data when estimating benefits of these interventions. One of the most compelling analyses of the long-term economic benefits of improving nutritional status of young children is actually based on a randomized controlled trial from Guatemala. Children in the treatment group received *atole* (a high-in-proteins drink) from age 0-2 years on a daily basis, whereas children from the control group received a low-in-proteins drink. This relatively limited intervention led to an estimated average income increase of at least 10 percent (lower bound of the confidence interval), though for a relatively small sample (Hoddinott et al. 2008). Most studies do not pay attention to the question of whether the benefits (of increased productivity/economic activity) from such small-scale interventions are attainable at scale. The main reason why there might be decreasing returns to scale is that such interventions tackle mainly hindrances on the demand side of labor markets, but not on the supply side. Conservatively estimating that the benefits might not be fully scalable to a large-scale intervention, the analysis estimates the benefits from improved early neural development to yield wage increases (applied to the minimum wage) of 10 percent (and 5 percent in an alternative scenario).

4. ***Costs.* The analysis considers the entire Project cost of US$100 million, but not the funds provided by the Government for the CCT Program.** The CCT Program focuses on other interventions

[33] Additional potential benefits, such as savings in healthcare costs associated with coronary heart disease, non-insulin dependent diabetes, and high blood pressure—conditions for which there is evidence of increased susceptibility due to undernutrition in early life, manifested as low birth weight.

that go beyond the improvement of nutrition outcomes. The expected benefits of this program are thus not accounted for in the analysis.

Table A.5.1 Assumptions to Quantify Additional Realized Human Capital due to Better Nutrition

Hours worked per year	2,000
Years worked in a life time	45
Wage increase (real) per hour in USD	0.1/0.05
Wage increase (real) per year in USD	200/100
Wage increase (real) as % of minimum wage	5%/2.5%

- **Basic discount rate.** Costs/benefits are discounted taking into account both inflation (2 percent) and the time value of money (5 percent). A higher discount rate of 12 percent (reflecting a 10 percent time value of money) is also applied to verify the sensitivity[34] of the results.
- **Period of time considered**. The analysis considers benefits for the cohorts of children born between 2016 and 2021 (duration of Project implementation) that will start accruing in 2036 (approximately when the first cohort of Project beneficiaries will be starting to work).
- **Beneficiary population.** The Project's main target population is located in seven departments (Alta Verapaz, Chiquimula, Huehuetenango, Quiché, San Marcos, Sololá, and Totonicapán). There are about 400,000 newborn children per year in the targeted areas.
- **Financial measures.** The overall economic benefits of the interventions are estimated using two standard measures of investment project analysis: (i) the net present value; and (ii) the estimated internal rate of return of the considered interventions.

5. ***Results.*** **Considering all Project costs and benefits from interventions during the first 1,000 days of life (i.e., improved human capital), the analysis finds a largely positive net present value (difference between benefits and costs), independently of the different scenarios considered.** The net present value of the interventions is largely positive (at least US$46.04 million) and the estimated internal rate of return ranges between 11.43 percent and 13.61 percent.

Table A.5.2 Estimated Net Present Values and Internal Rate of Returns: Scenarios

Time Value of Money Discount Factor	Baseline Productivity Increase[35] (5%)		Low Productivity Increase[35] (2.5%)	
	Net present value	Internal rate of return[36]	Net present value	Internal rate of return[36]
5%	1,467.30	13.61%	690.58	11.43 %
10%	169.60		46.04	

[34] A sensitivity analysis with respect to inflation was not conducted, given that the expected benefits are productivity gains and, hence, are measured in real wage gains.

[35] Productivity measured by hourly wages.

[36] Net of inflation.

ANNEX 6: MAP

GUATEMALA
CRECER SANO NUTRITION AND HEALTH PROJECT

PROJECT DEPARTMENTS
RIVER SUB-BASIN BOUNDARIES
RIVER SUB-BASINS IN PROJECT DEPARTMENTS
RIVERS
SELECTED CITIES AND TOWNS
DEPARTMENT CAPITALS
NATIONAL CAPITAL
DEPARTMENT BOUNDARIES
INTERNATIONAL BOUNDARIES

MEXICO
BELIZE
HONDURAS
EL SALVADOR
Gulf of Honduras
PACIFIC OCEAN
GUATEMALA

PETÉN
HUEHUETENANGO
QUICHÉ
ALTA VERAPAZ
BAJA VERAPAZ
SAN MARCOS
TOTONICAPAN
SOLOLÁ
QUETZALTENANGO
CHIMALTENANGO
SACATEPÉQUEZ
GUATEMALA
EL PROGRESO
ZACAPA
IZABAL
CHIQUIMULA
JALAPA
JUTIAPA
SANTA ROSA
ESCUINTLA
SUCHITEPÉQUEZ
RETALHULEU

0 30 60 Miles
0 30 60 Kilometers

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