Board of Executive Directors

For consideration

On or after 7 December 2015

PR-4360
20 November 2015
Original: Spanish
Public
Simultaneous Disclosure

To:	The Executive Directors
From:	The Secretary
Subject:	El Salvador. Proposal for a loan for the “Integrated Health Program II”
Basic Information:	Loan type .....Specific Investment Operation (ESP) Borrower ..... Republic of El Salvador Amount ..... up to US$170,000,000 Source .....Ordinary Capital
Inquiries to:	Ignacio Astorga (extension 3708) or María Deni Sánchez (telephone Country Office in El Salvador 503-2233-8916)
Remarks:	This operation is not included in Annex III of document GN-2805, “2015 Operational Program Report”, approved by the Board of Executive Directors on 15 April 2015. Therefore, the operation does not qualify for approval by Simplified Procedure. In Addition, its amount exceeds the ceiling established for Group D countries. Therefore, the operation does not qualify for approval by Simplified Procedure.
Reference:	GN-1838-1(7/94), DR-398-17(1/15), GN-2805(3/15), PR-3558-1(8/10), DE-66/10 PR-4208(10/14), DE-146/14, DE-147/14

PUBLIC
SIMULTANEOUS DISCLOSURE

DOCUMENT OF THE INTER-AMERICAN DEVELOPMENT BANK

EL SALVADOR

INTEGRATED HEALTH PROGRAM II

(ES-L1095)

LOAN PROPOSAL

This document was prepared by the project team consisting of: Ignacio Astorga (SCL/SPH) and María Deni Sánchez (SPH/CES) Project Team Co-leaders; José Luis de la Bastida (VPS/ESG); Louis-François Chretien (LEG/SGO); Luis Tejerina (SPH/CHO); Ricardo Pérez Cuevas (SPH/CME); Juan Pablo Severi (SCL/SPH); Pablo Ibarrarán (SCL/SPH); Nadin Fabiola Medellín (SCL/SPH); Nicolas Rosemberg (SCL/SPH); Marco Alemán (FMP/CES); Patricio Crausaz (FMP/CES); Karen Munguía (CID/CES); and Claudia Pévere (SCL/SPH).

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ELECTRONIC LINKS

REQUIRED

1. Development Effectiveness Matrix (DEM)
2. Multiyear execution plan
3. Monitoring and evaluation plan
4. Environmental and social management report (ESMR)
5. Procurement plan

OPTIONAL

1. Project economic analysis
2. PRIDES II institutional capacity analysis
3. Annual work plan (AWP)
4. Technical note on inclusion of the gender perspective
5. Preliminary outcomes of the PRIDES I Integrated Health Program
6. Financial sustainability analysis for PRIDES II
7. Study on mechanisms to facilitate the integration and financial sustainability of the National Health System
8. Structure of the South and North Health Services Network of the Basic Comprehensive Health System
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ABBREVIATIONS

CIHSN	Comprehensive Integrated Health Services Networks
CNCD	Chronic noncommunicable disease
DH	Dirección de Hospitales MINSAL [MINSAL Hospitals Authority]
DPN	Dirección de Primer Nivel MINSAL [MINSAL First Level Authority]
DSS	Department of San Salvador
Ecos	Equipos comunitarios [community health teams]
ESMR	Environmental and social management report
HZN	Hospital zona norte [North zone hospital]
MINSAL	Ministry of Health
PAPTNC	Plan Alianza para la Prosperidad del Triángulo Norte de Centroamérica [Plan of the Alliance for Prosperity in the Northern Triangle of Central America]
PMU	Program management unit
PRIDES	Programa Integrado de Salud [Integrated Health Program]
SAFI	Sistema de Administración Financiera Integrado [Integrated Financial Administration System]
SCRC	Specialized Care Referral Centers
SUIS	Sistema Único de Información en Salud [Master Health Data System]
UCSF	Unidades comunitarias de salud familiar [community family health units]
UIM	Unidad de Infraestructura MINSAL [MINSAL Infrastructure Unit]
WHO	World Health Organization
YPLL	Years of potential life lost

PROJECT SUMMARY

EL SALVADOR
INTEGRATED HEALTH PROGRAM II
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<table>
<tr><th colspan="5">Financial Terms and Conditions</th></tr>
<tr><td colspan="3" rowspan="2">Borrower: Republic of El Salvador</td><td colspan="2">Flexible Financing Facility[a]</td></tr>
<tr><td>Amortization period:</td><td>25 years</td></tr>
<tr><td colspan="3" rowspan="2">Executing agency: Ministry of Health</td><td>Original WAL:</td><td>15.25 years</td></tr>
<tr><td>Disbursement period:</td><td>5 years</td></tr>
<tr><td>Source</td><td>Amount (US$)</td><td>%</td><td>Grace period:</td><td>5.5 years</td></tr>
<tr><td rowspan="2">IDB (Ordinary Capital)</td><td rowspan="2">170 million</td><td rowspan="2">100%</td><td>Inspection and supervision fee:</td><td>[b]</td></tr>
<tr><td>Interest rate:</td><td>LIBOR-based</td></tr>
<tr><td rowspan="2">Total</td><td rowspan="2">170 million</td><td rowspan="2">100%</td><td>Credit fee:</td><td>[b]</td></tr>
<tr><td>Currency of approval:</td><td>U.S. dollars from the Ordinary Capital</td></tr>
<tr><th colspan="5">Project at a Glance</th></tr>
<tr><td colspan="5">Project objective: To improve the population’s health by strengthening health care service delivery at all network levels of care, and to improve the operational efficiency of the public system.</td></tr>
<tr><td colspan="5">Special contractual conditions precedent to the first disbursement:
(i) The executing agency has designated the program management unit, establishing the job descriptions for the technical operations team for program execution, and the Operations Manual has entered into effect (see paragraph 3.3); (ii) the executing agency has created an environmental, social, and occupational health and safety management committee for the program; (iii) the executing agency has designated the principal coordinator of the committee, who will be responsible for direct communication with the Bank in the areas within his or her purview; (iv) the Committee’s operating regulations have entered into effect (see paragraph 2.3); (v) the final version of the program’s environmental and social framework has been submitted for both the construction and operation stages of the program (see paragraph 2.3); and (vi) the Bank has stated its no objection to the site proposed by the executing agency for construction of the specialties hospital (see paragraph 2.3).
Special contractual conditions for execution:
(i) Prior to disbursement of the resources to build each of the hospitals under program Component 2, the executing agency will provide the Bank with: (a) an implementation plan for the measures to allow planned and orderly urban development of the surroundings and immediate area where each hospital is to be built (see paragraph 2.4); and (b) proposals to identify possible job opportunities for vulnerable groups of women in the communities where each hospital is to be located (see paragraph 2.4); (ii) prior to award of the works contract for each of the hospitals under Component 2, the executing agency will provide: (a) evidence of legal possession of the land where the respective works are to be built, easements, or other rights necessary for its construction and use (see paragraph 2.5); and (b) a maintenance plan for the hospital and its mechanism of operation (see paragraph 2.5); and (iii) prior to the start of contracting for construction of the program works, the executing agency will have met the conditions set in section VI.A.c of the environmental and social management report (ESMR) (see paragraph 2.6).
Other execution condition:
The environmental and social conditions of the program’s environmental and social management framework will be satisfied, as an execution condition (see paragraph 2.6).</td></tr>
<tr><td colspan="5">Exceptions to Bank policies: None.</td></tr>
<tr><td colspan="5">Project classified as:[c] SV ☑ PE ☑ CC ☐ CI ☐</td></tr>
</table>

[a] Under the terms of the Flexible Financing Facility (document FN-655-1) the borrower has the option of requesting changes to the amortization schedule, as well as currency and interest rate conversions. The Bank will take operational and risk management considerations into account when reviewing such requests.

[b] The credit fee and inspection and supervision fee will be established periodically by the Board of Executive Directors as part of its review of the Bank’s lending charges, in accordance with the relevant policies.

[c] SV (Small and Vulnerable Countries), PE (Poverty Reduction and Equity Enhancement), CC (Climate Change, Sustainable Energy, and Environmental Sustainability), CI (Regional Cooperation and Integration).

I. DESCRIPTION AND RESULTS MONITORING

A. Background, problem to be addressed, and rationale

1. Socioeconomic conditions

1.1 El Salvador is a densely populated country (306 inhabitants/km^2) with approximately 6.2 million inhabitants. It has a small, dollarized, economy closely tied to the economy of the United States (from which it receives remittance income of 16% of GDP) and it is vulnerable to natural disasters. Average economic growth over the last decade was less than 2% a year, which is below the Central American average of 4%. Traditional exports, particularly maquila manufacturing, have lost ground. Although new productive sectors have emerged, they still lack sufficient scale to catalyze economic activity and create jobs.

1.2 In recent years the country has managed to reduce poverty significantly, with the level dropping from 39% to 30% between 2000 and 2013.[1] This is partly as a result of the social and economic policies implemented.[2] Internal migration has caused growth of the cities, particularly San Salvador, and 66% of the population now lives in urban areas.[3] The San Salvador Metropolitan Area (SSMA) occupies 3% of the national territory and is home to 27% of the population. Within the SSMA, the North zone has grown most, expanding by 26% between 2005 and 2015. This trend is set to accelerate and has triggered a proliferation of unregulated settlements lacking basic infrastructure, public services, and sanitation. Moreover, 13% of SSMA's population lives on land that is highly vulnerable to natural disasters.

1.3 To meet these challenges, the government has drawn up a Five-year Development Plan (2014-2019),[4] which includes interventions in the areas of production, education, and security.

2. Health conditions

1.4 El Salvador is experiencing an epidemiological transition, in which chronic noncommunicable diseases (CNCD) have displaced infectious and perinatal conditions as the main causes of mortality. Between 1990 and 2010 coronary disease rose by 4.1%, and years of potential life lost (YPLL) increased by 8.2%,[5] while diarrheal disease decreased from 14.5% to 1.5%. External causes—interpersonal violence[6] and traffic accidents—remain the main causes of YPLL. The top 10 causes of YPLL account for 58.4% of lost years and include

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1 The Gini coefficient declined from 0.54 in 2003 to 0.40 in 2013.

2 Social development spending rose from 6% to 12% of GDP between 2000 and 2012. Lustig et al. (2014), the impact being to reduce poverty by almost 6%, and extreme poverty by almost 16%. Tejerina and Muñoz (2015) estimate that growth from 1992-2012 was pro-poor, helping reduce poverty by 18.9 percentage points, from a total of 24 points.

3 Multipurpose Household Survey (EHPM) 2013.

4 http://www.presidencia.gob.sv/wp-content/uploads/2015/01/Plan-Quinquenal-de-Desarrollo.pdf.

5 Institute for Health Metrics and Evaluation, Global Burden of Disease, 2010.

6 The homicide rate is the highest in Latin America.

CNCDs such as ischemic heart disease, diabetes, chronic kidney failure,[7] [8] problems deriving from prematurity, lower respiratory infections, and external causes. Analyzing the top 25 causes of YPLL, cancer is rapidly gaining importance. Men's life expectancy is almost nine years shorter than women's.[9] This is largely explained by the homicide rate (11 times higher among men than women), and deaths associated with high blood pressure, diabetes, and nephropathy (19% higher). The main risk factors associated with the disease burden are alcohol abuse, poor diet, overweight, and obesity.[10]

1.5 The profile of hospital care is changing. Obstetric and neonatal care accounted for 25% of hospital admissions, followed by respiratory and digestive infections, CNCD (diabetes and high blood pressure), and trauma.[11] Analyzing the disease burden from a gender perspective, increasing levels of domestic violence are apparent.[12] Women are the victims of 90% of acts of aggression.[13]

3. Organization of the health sector

1.6 The health sector in El Salvador is mixed, including both public and private service providers. In the public sector there are four systems operating in a segmented fashion: the Salvadoran Social Security Institute (ISSS), which covers the population in formal employment; the Armed Forces and Police system; the Instituto Salvadoreño de Bienestar Magisterial; and the Ministry of Health (MINSAL), which is responsible for the population not contributing to any of the three previous systems. MINSAL covers around 76.4%[14] of the population: 90.6% in rural areas and 67.8% in urban areas. 54% of users belong to nonpoor segments; 95.5% of the poor and very poor use MINSAL hospitals. Private sector service providers are mainly located in higher-income urban areas. MINSAL is responsible for the direction and regulation of the health sector.

1.7 MINSAL's health spending rose from 2.2% of GDP in 2009 to 2.4% in 2014 (US$449 million to US$592 million). Despite this increase in MINSAL's expenditure, the annual per capita level is still below Central American and Latin American averages,[15] at US$169 versus US$218 and US$352, respectively. A high proportion of spending is out of pocket, averaging US$154 per capita annually.

1.8 MINSAL's network is organized into three levels of care. The first level of ambulatory care has territorial coverage and is responsible for preventive activities, health promotion, and general care. The second level comprises

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7 Among the CNCDs, chronic renal failure has increased most, rising by 287% between 1990 and 2010.

8 Herrera R, C. Orantes, M. Almaguer et al. "Clinical characteristics of chronic kidney disease of nontraditional causes in Salvadoran farming communities." MEDICC Review, issue 2, vol. 16, April 2014.

9 http://datos.bancomundial.org/indicador/SP.DYN.LE00.MA.IN.

10 Institute for Health Metrics and Evaluation, Global Burden of Disease, 2010.

11 SIMMOW online morbidity/mortality information system.

12 Among women aged 15 to 49 years, married or living with their partner, 27% had suffered physical or sexual violence from their partner at some point in their life.

13 Encuesta de Salud Reproductiva [Reproductive Health Survey], El Salvador, 2008.

14 Multipurpose Household Survey (EHPM) 2013.

15 Per capita public spending on health in US$ PPP excluding social security. Global Health Observatory, World Health Organization. 2014.

27 low- and medium-complexity hospitals in urban areas, while the third level includes three high-complexity national referral hospitals in San Salvador. These provide services including specialized ambulatory care, surgery, hospitalization, checkups and procedures.

4. Progress of health sector reform and challenges

1.9 In 2009 the Government of El Salvador launched a process of health sector reform pursuing the principles of solidarity, equity, and quality, timely universal coverage, guaranteeing that the system would be free of charge. The reform was inspired by international evidence[16] on the effectiveness of the model of Comprehensive Integrated Health Services Networks (CIHSN) based on primary health care as the gateway to the system, expanding care and helping curb the rate of health spending growth. MINSAL implemented a model of care focusing on family health. The focus is on prevention, health promotion, and providing services through Community Family Health Teams[17] (Ecos F) and Specialized Community Family Health Teams (Ecos E). These teams operate in the Community Family Health Units (UCSF) which may be basic (B), intermediate (I), or specialized (E). The network also includes maternity waiting homes for pregnant women who have difficulty reaching a hospital. The facilities and teams are coordinated geographically by the Basic Comprehensive Health Systems.

1.10 Implementation of the reform has eliminated economic barriers to access at all levels and increased first-level coverage, which has translated into better outcomes. Between 2009 and 2014, preventive consultations increased by 39%, and emergency consultations at the primary care level by 66%; hospital births rose from 40.7% to 80.7%;[18] prenatal enrollments rose from 51.9% to 76.6%, and postnatal checkups rose from 46.9% to 92.3%. In terms of impacts, reductions have been observed in: (a) child undernutrition (from 19% to 14% between 2008 and 2014); (b) maternal mortality (from 71 to 38 per 100,000 live births between 2005 and 2014); and (c) infant mortality (from 20 to 14 per thousand live births between 2005 and 2013).[19] Despite the progress of the reform in terms of service coverage and quality, MINSAL still faces serious challenges.

1.11 **Improving access to information.** Twenty-five percent of the MINSAL target population presenting symptoms for which they believed they needed to consult a medical practitioner[20] did not access health services. Causes relating to service quality or availability of supply (lack of medicines or qualified staff, lack of health facilities nearby) accounted for 70% of these cases, while economic barriers explained only 8% of cases, and the remaining 22% included labor situations (having to work, no time off allowed) and the preference for home remedies.

1.12 **Closing first-level coverage gaps.** At the first level of care,[21] the reform set up 520 Ecos F, giving priority to rural areas (75%), which has had positive results for

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16 Health and Nutrition Sector Framework Document. SPH 2014.

17 The Ecos are teams. The UCSFs are the establishments where the Ecos work. Programs focus on maternal and child care and CNCDs among adults.

18 Memoria de labores del MINSAL [MINSAL activity report] 2013-2014.

19 World Bank.

20 EHPM 2012. This question relates to general morbidity demand, not specialized care.

21 MINSAL 2015.

the health system. However, a 70% gap still exists for Ecos, mainly in urban areas. In the Department of San Salvador there is a deficit of 84% in Ecos F and 60% in Ecos E and maternity waiting homes. The network operates like communicating vessels, such that the deficit on the primary level translated into an increase in hospital emergency consultations of 16% between 2009 and 2014, and a high percentage of avoidable hospitalizations, which could have been resolved at the primary level (19% of hospitalizations nationally in 2014).[22]

1.13 **Responding to the growing demand for specialized care.** The second and third levels of care present significant gaps in specialized medical consultations and hospital beds, creating a bottleneck for continuity of care. The deficit in specialized consultations is bigger in the case of adult CNCDs, where waiting times are in the 172 to 274 day range for endocrinology, neurology, nephrology, and ophthalmology.[23] This supply deficit is also seen in diagnostic procedures such as radiobiology, mammography, endoscopy and electrophotography, among other areas. In relation to hospitalization, in 2014 there was a deficit of 1,095 beds nationally,[24] deriving from the 24% increase in demand for hospital stays between 2009 and 2014. This increased demand is primarily associated with the fact that care is free of charge, as well as the expansion of the primary care network. At the national level, the most serious shortages of beds are observed in adult care, associated with CNCDs and surgery. At the local level, the biggest deficit is in the North zone of the Department of San Salvador, which has a population of 400,000 but no hospital. Additionally, the only third-level hospital devoted to adult care in San Salvador (Rosales Hospital) has dilapidated buildings more than 115 years old that require work. The hospitals suffer from management problems, reflected in lengthy or clinically unjustified hospital stays.[25] [26] In the second-level network, eight departmental hospitals do not have continuous coverage (24/7) by OB/GYN specialists to ensure technical support for obstetric care.

1.14 **Strengthening health network management.** The development of Basic Comprehensive Health Systems has been successful[27] in terms of first-level network management. The network has an organization ensuring coordination between teams and a rapid flow of patients. However, there is no unit in charge of regional and national coordination with the second and third levels, and coordination does not report demand in real time, instead reporting every two or three months.

1.15 **Safeguarding the environment.** In 2014 MINSAL incorporated environmental health as one of the lines of the reform with a view to reducing health risks to the population from environmental factors. MINSAL has technical standards for the

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22 Evolution of preventable hospitalizations in El Salvador's hospitals, IDB 2015.

23 Hospital Rosales, 2014.

24 Sistema de Estadísticas Institucionales [Institutional Statistics System]. MINSAL 2009-2014. Estimates based on 97.1% of occupation.

25 Average hospital stays. 9.7 days for surgery at Rosales, versus a benchmark of 6.7 (Brazil and Chile).

26 According to the nursing department at Rosales, only 17% of hospitalized patients are in a critical or delicate condition; 83% are in stable condition that may not require hospitalization. Similarly, 19% of hospital stays could be avoided.

27 CIHSN management, MINSAL. 2015.

management of wastewater[28] and infectious biomedical wastes[29] that establish minimum conditions for their handling. These standards are not met by 419 UCSFs and two hospitals, which, as well as being a reputational risk, poses a risk to the population from the contamination of soils and watercourses.

5. Evidence and intervention strategy

1.16 The international evidence[30] shows that the success of health systems is based on strengthening primary health care so that it can provide successful treatment[31] and include prevention and promotion activities. Primary health care also needs to be integrated with a network of outpatient and hospital services to ensure continuity of care for more complex problems. This enables wider access to services and better quality of care, while helping slow the rate of cost increases.[32] Studies in Costa Rica, Brazil, and Spain have reported links between experiences in care emphasizing prevention and a reduction in general and infant mortality, reduction in avoidable hospitalizations, and improvements in life expectancy.[33] The Bank has included this strategy in its Health and Nutrition Sector Framework Document (document GN-2735-3) and is applying it throughout the region. MINSAL has adopted the CIHSN strategy (see paragraph 1.9), which has shown itself to be fully applicable and effective in El Salvador (see paragraph 1.10). Its strengthening in the Department of San Salvador could reduce demand for hospitalizations by the equivalent of 160 low-complexity beds.[34] However, it does not eliminate the demand for medium- and high-complexity beds, nor the need to replace old hospitals. A strengthening of the primary level could help identify individuals with problems requiring specialized care (e.g., the effects of diabetes), which could put pressure on demand for this level of care.

1.17 To respond to this set of challenges, MINSAL has given priority to advancing the CIHSN strategy on all levels: (i) strengthening the primary care level by closing coverage gaps in rural and urban areas in the North and South zones of the Department of San Salvador; (ii) strengthening ambulatory care through the Ecos E in the cited zones, as well as the UCSF E in the departments of La Unión, Sonsonate, and Chalatenango, and creation of Specialized Care Referral Centers (SCRCs)[35] in the country's main urban centers, including San Salvador, San Miguel, Santa Ana, and Santa Tecla; (iii) expanding second-level care (general hospital care) in a zone with rapid population growth (the North zone of the Department of San Salvador), integrated with the primary

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28 Código de Salud [Health Code], MINSAL. Chapter II.

29 Salvadoran Standard NSO 13.25.01:07.

30 Kringos et al. 2010; Schoen et al. 2010; WHO 2008; Starfield et al. 2005; Macinko et al. 2003.

31 It is more efficient to resolve demand at the primary level, where consultations are 24% cheaper than the same consultation in a hospital. "Análisis de costos de las RIISS" [CIHSN cost analysis].

32 Pan American Health Organization (PAHO) (2012), Mejora de cuidados crónicos a través de las RIISS de servicios de salud [Improving chronic care with Comprehensive Integrated Health Services Networks]. http://www.paho.org/hq/index.php?option=com_docman&task=doc_view&gid=21400&Itemid , optional link 11.

33 Macinko et al. 2011; Rosero-Bixby 2004; Borkan et al. 2010.

34 Idem.

35 They will provide education, counseling, consultations, and high-demand special procedures mainly relating to CNCDs and adults' problems.

health care network; (iv) strengthening high-complexity specialty care at the national level, concentrating and supplementing the services currently provided by the Rosales Hospital; (v) ensuring continuity of obstetric care (24/7) at the Santiago de María, Jiquilisco, Chalchuapa, Nueva Guadalupe, San Francisco Gotera, La Unión, Suchitoto, and Cojutepeque hospitals; and (vi) improving the management of network facilities so as to ensure timely, high-quality, and efficient services.

1.18 Management of human resources is a key part of the strategy, in order to ensure the availability of specialists (medical and nonmedical) to work at the centers. This will be achieved by tapping existing resources, and hiring and training new staff. This will involve advance collaboration with training centers. Absorbing human resources initially financed by the program, and subsequently supported by the national budget, also poses a fiscal sustainability challenge. The MINSAL's personnel management framework is defined by its Administrative Grade Schedule Law ("Ley de Escalafón"), which establishes significant salary readjustments. Analysis and dialogue on initiatives for long-term sustainability will therefore be promoted.

1.19 Services need to be organized to take into account gender differences in risk profile and behavior.[36] The gender strategy will therefore support: (i) comprehensive training of the staff of Ecos and new services on gender determinants of health, allowing the at-risk population to be identified and risk-reduction actions taken (e.g., early identification of men with CNCDs); (ii) increased access to specialized, integrated care supporting UCSF E; and (iii) bringing Institutional Units for Specialized Women's Care into operation at the two hospitals in the program.

6. Relationship with other Bank operations and lessons learned

1.20 The Bank has actively supported health-care reform. Through the first Integrated Health Program (PRIDES I) (loan 2347/OC-ES), it supported the expansion of primary care coverage in rural areas. The outcomes include the registration of 94% of the program beneficiary families with Community Family Health Units (UCSF), thereby improving mother and child care coverage. The impact indicators show progress: according to the 2014 National Health Survey, maternal mortality declined by 5.7 points (from 57.7 in 2009 to 52 in 2014) and perinatal maternal mortality declined from 19 to 15 deaths per thousand live births. Additionally, PRIDES I contributed through institution-strengthening in: the emergency system, Master Health Data System (SUIS), human resources training, building and equipping the UCSFs, laboratories, and renovating hospitals, etc. The lessons learned from PRIDES I that were drawn upon in the design of this operation include: (i) relevance of the first-level strategy supplemented with interventions at other levels; (ii) success of implementation of SUIS, which was strengthened on all three levels; (iii) strategy for absorption of

[36] WHO, 2007, 2009; Schramm, J. et al., Stevens, A. et al., 2012; Barker, G., C. Ricardo, and M. Nascimento, 2007; Pathania, V. S., 2011; DeVon, H. A., et al., 2008.

human resources by MINSAL;[37] (iv) mechanisms for the selection of technically and environmentally suitable land; and (v) incorporation of a maintenance fund to ensure infrastructure and equipment is kept operational. Additionally, through the Mesoamerican Health Initiative 2015, the Bank supports implementation of the reform in the first-level mother and child care area in 14 of the poorest municipios. Not only did this initiative involve resources (equipment, supplies, and personnel), a great effort was made to improve the business model. More resources increased the number of health units from 0.14 per thousand inhabitants in 2009 to 2.8 in 2014. Coverage indicators have improved, as reflected in the percentage of children under one year of age registered in the system before they are eight days old rising from 51% to 90.1%, and prenatal checkups rising from 5.8 to 6.3. At MINSAL, it has contributed to the design of policies in such areas as the Medicines Law, use of micronutrients, treatment of diarrhea, the supply chain for medicines, and the development of evidence- and results-based operational guidelines. The Mesoamerican Health Initiative 2015 complements the Integrated Health Program by focusing on improving the quality of the first level through improvements in management, innovation in tracking targets and plans for ongoing quality improvement, and the use of results-based pilots.

1.21 Building on the study that gave rise to Technical Note IDB-TN-807 "Guide for the contracting of hospital investment projects," it was recommended that design and construction contracts should be linked, to reduce the risk of cost overruns and missed deadlines. The operation "Modernization of Infrastructure and Management of Hospitals – Western Region" (loan 3306/BL-NI), approved in 2014, takes this approach, and so has served as a model. The Bank's initiatives (PRIDES I and the Mesoamerican Health Initiative 2015) have helped improve conditions in municipios involved in the Plan of the Alliance for Prosperity in the Northern Triangle of Central America (PAPTNC). The Integrated Health Program II (PRIDES II) will continue in the same vein as, through its various components, it will benefit virtually 100% of the municipios involved in the plan. Its coverage is described in Contribution of PRIDES II to PAPTNC.

1.22 **Strategic alignment.** The program is consistent with the Bank's country strategy with El Salvador (2015-2019) (document GN-2828) inasmuch as it contributes to consolidation of the network of health services and the expansion of coverage. Given the country and target sector, this operation is classified automatically with the lending program priority targets of the Ninth General Capital Increase (GCI-9) (document AB-2764) for (i) lending to small and vulnerable countries; and (ii) lending for poverty reduction and equity enhancement. Similarly, the program is aligned with the regional development goals of the Bank's results framework, as it contributes to reducing maternal and infant mortality. The program is aligned with the priority of the Strategy on Social Policy for Equity and Productivity (document GN-2588-4) to strengthen national health systems to meet the double burden of the health transition. It is also aligned with the Health and Nutrition Sector Framework Document (document GN-2735-3) in relation to strengthening

[37] Initially PRIDES I envisaged a gradual strategy for incorporating human resources. This entailed a series of negotiations for incorporation into the budget, and as this was not completed in time, it caused a mismatch in the program budget. The lesson is to submit the budgetary incorporation in just two periods, and not each year.

management and improving service quality, advancing with the consolidation of integrated health service networks. Lastly, it is aligned with the Plan of the Alliance for Prosperity in the Northern Triangle of Central America (PAPTNC),[38] as it includes actions to improve health with priority on child and maternal health in the selected municipios.

B. Objectives, components, and cost

1.23 The objective of this operation is to improve the population's health by strengthening health care service delivery at all network levels of care, and to improve the operational efficiency of the public system. Four components are proposed:

1.24 **Component 1. Strengthening of the ambulatory care network (US$43.9 million).** The objective of this component is to support the consolidation of the ambulatory care network model. This includes: (i) increasing CIHSN first-level coverage in the North and South zones of the Department of San Salvador. This will be done by implementing[39] 33 Ecos, building 30 UCSF B, equipping 32 UCSF B, building and equipping 2 UCSF E and 8 UCSF I. Three maternity waiting homes will also be built and opened, and the infrastructure improved for three Basic Comprehensive Health Systems. This work will cover more than 1.2 million MINSAL beneficiaries; (ii) in order to strengthen care in urban areas, the implementation of an innovative model of four SCRCs is planned in San Salvador, San Miguel, Santa Ana, and Santa Tecla. These will have coverage of 690,000 beneficiaries, and their portfolio of services will relate to CNCDs and high demand services; and (iii) at the national level, work will be done on standardizing the system of wastewater and infectious biomedical waste management at 350 UCSFs, in order to comply with national laws and regulations and reduce the risks to users. PAPTNC municipios will receive 19% of the financing under this component.

1.25 **Component 2. Strengthening of the hospital network (US$111.4 million).** The objective of this component is to improve hospital care offerings by building two new hospitals, which will make more services available and allow subspecialties to be relocated.[40] This component will provide financing to build, equip, and open:[41] (i) a third-level, high-complexity specialties hospital with 400 beds for specialties in which there is a deficit, mainly transferred from the Rosales Hospital. This will be built in the Department of San Salvador and provide nationwide coverage for more than 5.4 million MINSAL beneficiaries; and (ii) a 100-bed general hospital in the North zone of the Department of San Salvador, which will increase the service offerings in the area with the department's fastest population growth[42] and cover more than 350,000 MINSAL beneficiaries. To continue strengthening the mother and child care network, the coverage of OB/GYN care will be expanded at eight hospitals, covering more than 290,000 MINSAL beneficiaries. In addition, wastewater management systems will be built at two second-level hospitals

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38 See Contribution of PRIDES II to PAPTNC.

39 This includes personnel and medicines.

40 Specialties currently offered at the Rosales Hospital will relocate to the new hospital.

41 Idem, note 39.

42 Both hospitals will have an Institutional Unit for Specialized Women's Care.

(Monseñor Oscar Arnulfo Romero y Galdámez National General Hospital in Ciudad Barrios, San Miguel, and Dr. José Antonio Saldaña National Hospital for Pulmonary and Family Medicine in San Salvador), to comply with national laws and regulations and avoid polluting watercourses. PAPTNC municipios will receive 20% of the financing under this component.

1.26 **Component 3. Support to improve the management and efficiency of the health network (US$10.8 million).** The objective of this component is to strengthen the processes and systems contributing to greater efficiency of the health system. The component's resources will finance: (i) development of the model of hospital and network management with the goals of timeliness, quality, and efficiency; (ii) design and implementation of the human resource development model for the health sector, for Ecos, SCRCs, and hospitals,[43] including training on gender determinants of health and differential care;[44] (iii) strengthening of the information systems supporting models of management of primary health care, hospitals, and networks; (iv) upgrading of procurement systems and the logistics chain for supplies and medicines; (v) design and implementation of the medium- and long-term maintenance fund for hospital equipment and infrastructure; and (vi) support for administration of the 2019 National Health Survey, and the midterm and final evaluations of the program.

1.27 **Component 4. Administration and audit (US$3.8 million).** This component will finance the costs of program administration and audits.

1.28 **Program costs.** Table 1 sets out the program costs.

Table 1. Program Costs (US$000s)

Components	IDB	%
Component 1. Strengthening of the ambulatory care network	43,929	26%
Component 2. Strengthening of the hospital network	111,402	66%
Component 3. Support to improve the management and efficiency of the health network	10,824	6%
Component 4. Administration and audit	3,845	2%
Total	**170,000**	**100%**

C. Key results indicators

1.29 The general objective is to improve the population's health, the impact of which will be a reduction in mortality. One nationwide indicator has been established that reflects improvements in care in hemato-oncology at the specialties hospital, and two for the Department of San Salvador, where the improvements in prevention, diagnosis, and treatment activities on the first and second levels of care will enable a reduction in child mortality and mortality due to hypertensive diseases in adults. The outcomes are associated with improvements in standards of service and efficiency in resource management. In the first group, improvements are envisaged

[43] Updating human resource gaps, identification of human resources strategies such as recruitment, training, and skills development for both new and existing personnel. This activity will be supplemented with a World Bank project.

[44] Technical Note on Inclusion of Gender Perspective.

in the following: (i) coverage and timeliness of checkups at the first level of care; (ii) hospital service accessibility and supply; (iii) hospital risks such as infections associated with health care; and (iv) compliance with health and environmental standards. In the second group are improvements in: (i) bed use by shortening stays; (ii) patient flows by managing referrals within the network; and (iii) treatment capacity for obstetric care.

1.30 **Economic analysis.** The strategies promoted by this operation are based on evidence of the effectiveness of the Comprehensive Integrated Health Services Networks (CIHSN) model of care. The project economic analysis quantifies the incremental benefits of the investments using the disability-adjusted life year (DALY) methodology based on World Health Organization (WHO) parameters for El Salvador. In the base-case scenario, with conservative assumptions about the effectiveness of the interventions, a time horizon of five years (2017-2021) and a discount rate of 3%,[45] the ratio of benefits to costs is 1.54. The sensitivity analyses varying the effectiveness and coverage of the interventions and the discount rate yield a cost-benefit ratio greater than unity in most of the least favorable scenarios.

II. Financing Structure and Main Risks

A. Financing instruments

2.1 The cost of the program is US$170 million, to be financed from the Bank's Ordinary Capital resources, with a disbursement period of 60 months. Table 2 shows the annual flow of funds according to the multiyear execution plan.

Table 2. Annual Flow of Funds (US$000s)

	Year 1	Year 2	Year 3	Year 4	Year 5	Total
IDB	1,207	9,934	27,494	120,008	11,357	170,000

B. Environmental and social safeguard risks

2.2 In accordance with the Environment and Safeguards Compliance Policy (Operational Policy OP-703), Directive B.03, "Screening and classification," the operation is classified as category "B", since the potential adverse environmental and associated social impacts and risks are mostly local and short-term, for which effective mitigation measures are readily available. The most significant social and environmental risks are related to the operational phase, particularly as regards increased demand for energy and water; water quality and sewer systems; discharges of hospital effluents; generation of hazardous hospital solid wastes (sharps, infectious biomedical waste, pharmaceuticals, and chemicals); and the occupational health and safety of hospital employees, patients, and visitors. The corresponding environmental and social analysis (ESA) has been submitted, and its results can be found in the environmental and social management report (ESMR). The environmental and social management framework will be used to manage the

[45] As discussed in the project economic analysis, a rate of 3% is recommended by the World Health Organization.

process of considering environmental and social issues for inclusion during the identification, preparation, analysis/evaluation, execution, and monitoring of each of the projects proposed during program implementation, consistent with the phases of identification, construction, and operation of the works, and also defines responsibilities and sets out the instruments and procedures applicable during the socioenvironmental evaluation and management plans. The operation does not anticipate or envisage any resettlement of people economic displacement for the construction of the program works; nevertheless, if this situation should arise, the corresponding Involuntary Resettlement and Compensation Plan must be implemented in line with the Bank's Operational Policy on Involuntary Resettlement (OP-710).

2.3 **Special contractual conditions precedent to the first disbursement of the loan proceeds: (i) the executing agency has created an environmental, social, and occupational health and safety management committee for the program (see ESMR, paragraph 6.1.1); (ii) the executing agency has designated the principal coordinator of the committee, who will be responsible for direct communication with the Bank in the areas within his or her purview (see ESMR, paragraph 6.1.1); (iii) the Committee's operating regulations have entered into effect (see ESMR, paragraph 6.1.1); (iv) the final version of the program's environmental and social framework has been submitted for both the construction and operation stages of the program (see ESMR, paragraph 6.1.2); and (v) the Bank has stated its no objection to the site proposed by the executing agency for construction of the specialties hospital (see ESMR, paragraph 6.1.3).**

2.4 As a special contractual condition for execution, prior to disbursement of the resources to build each of the hospitals under program Component 2, the executing agency will provide the Bank with: (a) an implementation plan for the measures to allow planned and orderly urban development of the surroundings and immediate area where each hospital is to be built (see ESMR, paragraph 6.1.4); and (b) proposals to identify possible job opportunities for vulnerable groups of women in the communities where each hospital is to be located (see ESMR, paragraph 6.1.5).

2.5 As a further special contractual condition for execution, prior to award of the works contract for each of the hospitals under Component 2, the executing agency will provide: (a) evidence of legal possession of the land where the respective works are to be built, easements, or other rights necessary for its construction and use; and (b) a maintenance plan for the hospital and its mechanism of operation.

2.6 As a further special contractual condition for execution, prior to the start of contracting for construction of the program works, the executing agency will have met the conditions set in section VI.A.c of the ESMR. The environmental and social conditions of the program's environmental and social management framework will also be satisfied, as an execution condition (see ESMR, paragraph 6.1.9).

C. Fiduciary risks

2.7 In the PRIDES II Institutional Capacity Analysis, the risk associated with financial management and procurement was estimated as low, given the good performance in the execution of PRIDES I (loan 2347/OC-ES) and the

Mesoamerican Health Initiative 2015 (grants GRT/HE-12982-ES and GRT/HE-14650-ES). The fiduciary risk for procurement has been rated as medium due to complexity and weaknesses in contract administration and procurement procedures and their importance, together with the impact of competitive bidding processes potentially being invalidated for lack of interest. Consequently, the following mitigation measures are planned: (i) strengthening of the program management unit (PMU) with a team directly responsible for program procurement and contract management;[46] (ii) market analysis and wide dissemination of competitive bidding processes, particularly for the hospitals; and (iii) innovative mechanisms for joint tendering of hospital design and construction, to mitigate the risks of cost overruns and execution delays.

D. Other project risks

2.8 **Financial sustainability.** The financial sustainability analysis indicates that budgetary resources of US$0.61 million need to be incorporated for staff, after the three years of IDB financing, rising to US$7.1 million after five years. This is equivalent to 0.09% and 0.96% of health sector spending, and 0.02% and 0.27% of social sector spending (at three and five years, respectively). A scenario of gradual inclusion has been envisaged, to reflect the country's fiscal position. At the end of the program it is envisaged that health spending will rise by 2% due to the increased expenditure on infrastructure, services, operations, and human resources, the latter accounting for 0.8% of this increase.[47] According to the fiscal analysis, in 2020 the Integrated Health Program II (PRIDES II) will represent an increase of 0.03 percentage points of GDP, rising to 0.06 percentage points 10 years after the end of PRIDES II. The Government of El Salvador has undertaken to gradually absorb the incremental current expenses.[48] Additionally, in order to promote more efficient health sector spending, and to mitigate the fiscal impact the incorporation of human resources could have, MINSAL is promoting the following measures: (i) a review of the salary scale;[49] (ii) application of results-based performance review; and (iii) reorganization of human resources according to needs, so as to reduce the wage burden. Additionally, MINSAL will continue to promote measures for the billing of services provided to other institutions.

2.9 **Insufficient human resources and resistance to change.** The program will add 977 new public sector employees to the MINSAL payroll, equivalent to 3.2% of the total. Of these human resources, the scarcest are medical staff, totaling 191 posts. Within the subcomponents, the specialty hospital is the largest and requires staff with more years of training. The following actions are proposed in order to mitigate the corresponding risks: (i) training of medical staff through agreements with

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46 Contract management will include specialized technical assistance and support in contract monitoring.

47 The cases used are: recurrent costs: maintenance; staff; supplies; annual increase in flows: expenditure on maintenance and assets, 2.5% the first two years and 5% in subsequent years; medicines, 2% fixed. Two scenarios are envisaged for staff payments, the first with the current salary scale (increase of between 5% and 8%) and the other with a maximum salary increment rule based on nominal GDP growth. The Bank will support dialogue for the approval of the reform of the Administrative Grade Schedule Law with technical cooperation resources (see paragraph 3.13).

48 Aide-mémoire, identification mission, June 2015.

49 MINSAL is currently preparing a preliminary draft amendment to the Law Establishing the Administrative Grade Schedule, set for passage in 2016. If it is not passed, the effect on MINSAL spending would be to create a need for US$8.4 million as of 2024.

academic institutions; (ii) transfer of specialties and their associated staff from the Rosales Hospital to the new hospital, which will meet approximately 60% of the new hospital's demand; and (iii) hiring of existing specialists to provide duty physicians. It is anticipated that the transfer may cause some degree of resistance, so technical cooperation resources will be provided to support the design of a change management plan (HO-T1246) (see paragraph 3.11).

2.10 **Availability of hospital maintenance.** One risk is the lack of maintenance of works and equipment, which may limit hospital operation. An infrastructure and equipment maintenance plan will therefore be prepared, and the management mechanism defined, to ensure long-term continuity. The initial design will be executed with technical cooperation resources (see paragraph 3.11), and the resources provided for its implementation through Component 3.

III. Implementation and Management Plan

A. Summary of implementation arrangements

3.1 The program executing agency will be the Ministry of Health (MINSAL). The program will report directly to the minister, under the technical responsibility of the Office of the Deputy Minister for Health Services, which will be tasked with setting technical standards for care in the integrated health services network through the MINSAL First Level Authority (DPN) (primary care) and MINSAL Hospitals Authority (DH) (national hospital). Also involved will be the offices of planning, health monitoring, information and communication technologies, health infrastructure development, human resources development, environmental sanitation, as well as the procurement department and others. The Office of the Deputy Minister for Health Policies and the General Operations Division will be involved in coordination.

3.2 At local level, execution will depend on regional Basic Comprehensive Health System departments. The Basic Comprehensive Health Systems are responsible for planning, managing human resources, and monitoring service network activities in a geographically delimited area, and have a network of first- and second-level health facilities. The roles and responsibilities will be defined in the program Operations Manual.

3.3 For program execution there will be a program management unit (PMU), which will report directly to the Minister for Health (at MINSAL). As well as general coordination of execution, the PMU will be directly responsible for procurement procedures and coordination with MINSAL's Institutional Financial Unit, which will be in charge of financial management. The points set out in these agreements, fiduciary requirements (see Annex III), and execution procedures will be defined in the program Operations Manual. **As special contractual conditions precedent to the first disbursement, the executing agency will have designated the program management unit, establishing the job descriptions for the technical operations team for program execution, and the Operations Manual will have entered into effect.** The program Operations Manual will include the details of the program's activities, roles, and responsibilities, as well as process flows.

3.4 The PMU will be responsible for the preparation and refinement of project management and monitoring tools, such as the multiyear execution plan, procurement plan, and financial plan. On the basis of these, it will prepare status reports and project the disbursement plan.

3.5 Progress reports will be six-monthly and will have the objective of presenting the outcomes and outputs achieved in the execution of the annual work plan (AWP) and the procurement plan. These reports will be delivered within 60 days after the end of the corresponding six-month period and will constitute the main source of information for the progress monitoring report (PMR).

3.6 Financial management will be performed by the Institutional Financial Unit, and procurements conducted through the PMU. The program's accounting records and supporting documentation will be kept by the Institutional Financial Unit using the SAFI Integrated Financial Administration System.

3.7 MINSAL will deliver to the Bank, within 120 days after the close of each fiscal year during the operation's disbursement period, the annual financial statements, duly certified by an independent audit firm acceptable to the Bank. Annex III describes the financial management arrangements.

3.8 Program procurements financed in whole or part with the loan proceeds will be conducted in accordance with the IDB policies for the procurement of goods and works (document GN-2349-9) and for the selection and contracting of consultants (document GN-2350-9). The Procurement Plan Execution System (SEPA) will be used for procurement planning and monitoring. Annex III provides more details on procurement management.

B. Summary of arrangements for monitoring results

3.9 MINSAL, acting through the PMU, will be responsible for operational and administrative coordination and supervision of the program monitoring system, using the Results Matrix, outcome/output and cost indicators defined in the PMR, and the monitoring tools identified in the monitoring and evaluation plan.

3.10 In order to measure change in the program's impact indicators, a reflexive evaluation is proposed, in which the changes in the Results Matrix indicators before and after implementation of the operation are analyzed, based on the sources of information identified in the monitoring and evaluation plan. The evaluation exercise will be commissioned by the executing agency and performed in two stages, midterm and final, in the last year of implementation. The operation will also support administration of the 2019 National Health Survey, to ensure that it continues to represent all the country's departments, and the data will be used as input for the final evaluation of the operation.

C. Design activities post-approval

3.11 A nonreimbursable technical-cooperation operation (HO-T1246) is expected to be processed in the first quarter of 2016. This will be used to: (i) prepare the bidding documents for the design and construction of the two hospitals; (ii) design a change management program, including a communication (internal/external) and training strategy for the personnel moving from the Rosales Hospital; (iii) promote investment initiatives, informing the market about the competitive bidding processes; (iv) analyze contracting alternatives for the maintenance of equipment

and infrastructure and nonmedical service delivery; and (v) support dialogue on the Administrative Grade Schedule Law.

Development Effectiveness Matrix			
Summary			
I. Strategic Alignment			
1. IDB Strategic Development Objectives	Aligned		
Lending Program	-Lending to small and vulnerable countries -Lending for poverty reduction and equity enhancement		
Regional Development Goals	-Maternal mortality ratio -Infant mortality ratio		
Bank Output Contribution (as defined in Results Framework of IDB-9)	-Individuals receiving a basic package of health services		
2. Country Strategy Development Objectives	Aligned		
Country Strategy Results Matrix	GN-2828	Consolidate the network of healthcare services.	
Country Program Results Matrix		The intervention is not included in the 2015 Operational Program.	
Relevance of this project to country development challenges (If not aligned to country strategy or country program)			
II. Development Outcomes - Evaluability	Evaluable	Weight	Maximum Score
	8.6		10
3. Evidence-based Assessment & Solution	10.0	33.33%	10
3.1 Program Diagnosis	3.0		
3.2 Proposed Interventions or Solutions	4.0		
3.3 Results Matrix Quality	3.0		
4. Ex ante Economic Analysis	10.0	33.33%	10
4.1 The program has an ERR/NPV, a Cost-Effectiveness Analysis or a General Economic Analysis	4.0		
4.2 Identified and Quantified Benefits	1.5		
4.3 Identified and Quantified Costs	1.5		
4.4 Reasonable Assumptions	1.5		
4.5 Sensitivity Analysis	1.5		
5. Monitoring and Evaluation	5.7	33.33%	10
5.1 Monitoring Mechanisms	2.5		
5.2 Evaluation Plan	3.2		
III. Risks & Mitigation Monitoring Matrix			
Overall risks rate = magnitude of risks*likelihood	Medium		
Identified risks have been rated for magnitude and likelihood	Yes		
Mitigation measures have been identified for major risks	Yes		
Mitigation measures have indicators for tracking their implementation	Yes		
Environmental & social risk classification	B		
IV. IDB´s Role - Additionality			
The project relies on the use of country systems			
Fiduciary (VPC/FMP Criteria)	Yes	Financial Management: Budget, Treasury, Internal Audit. Procurement: Information System, Shopping Method, National Public Bidding.	
Non-Fiduciary	Yes	Strategic Planning National System, Monitoring and Evaluation National System.	
The IDB's involvement promotes additional improvements of the intended beneficiaries and/or public sector entity in the following dimensions:			
Gender Equality	Yes	One of the products of the project is the implementation of special units within health centers to address domestc violence.	
Labor			
Environment			
Additional (to project preparation) technical assistance was provided to the public sector entity prior to approval to increase the likelihood of success of the project	Yes	The Bank has provided technical support for the consolidation of the reform through studies to improve quality of healthcare and the financial sustainability of the health sector.	
The ex-post impact evaluation of the project will produce evidence to close knowledge gaps in the sector that were identified in the project document and/or in the evaluation plan			

The project's objective is to improve the health conditions of the population by strengthening the public health system at all levels of care and improving the efficiency of the public network.

The project document provides an informed diagnosis of the challenges that the health sector faces in El Salvador that justify the program implementation. The project presents some references about the effectiveness of the proposed solutions implemented in contexts outside of El Salvador. Notwithstanding that the document presents a descriptive analysis of improvements associated with reforms and similar programs previously implemented in the country, causal evidence of the effectiveness of such programs in the country is not included. The target population is clearly established, with minimal details about its health profile.

The results matrix includes SMART indicators suitable for measuring results and products.

The project has a cost-benefit analysis supporting the economic viability of the proposed activities. Monitoring activities and products have been identified with their particular costs. On the other hand, the evaluation plan discards the methodology of synthetic controls, suggesting instead a before-after comparison methodology. The questions to be tested and the data to be analyzed are described in the Monitoring and Evaluation Plan.

RESULTS MATRIX

Project objective	The operation's objective is to improve the population's health by strengthening health care service delivery at all network levels of care, and to improve the operational efficiency of the public system.

EXPECTED IMPACTS

Indicators	Unit	Baseline		Intermediate target (2021)		Final target (2026)		Means of verification	Remarks
		Value	Year	Value	Year	Value	Year		
Expected impact									
1. Mortality rate (18-70 years of age) due hypertensive diseases in the Department of San Salvador (DSS).	Rate	**11 X 100,000 inhabitants**	2014			**9.9 X 100,000 inhabitants**	2026	SIMMOW morbidity/ mortality information system (admissions + vital statistics)	Deaths from hypertensive diseases (ICD-10 from l10 to l15) in 18-70 age group in DSS/18-70 Population of DSS x 100,000 There is evidence from Uruguay (Health Technical Note, 2015, SCL/SPH) that proper management of risk factors and high blood pressure can reduce mortality from this cause.
2. Mortality rate from hematological cancer in the over-18 age group nationwide	Rate	**7.38 X 100,000 inhabitants**	2014			**6.6 X 100,000 inhabitants**	2026	SIMMOW (admissions + vital statistics)	Numerator: Number of deaths from hematological cancer (ICD 10: C81-86, C90-96) in the population over 18 years old nationwide. Denominator: population over 18 years old nationwide projected by DIGESTIC (Planning Department)

									To the extent that the project strengthens the detection and treatment of this type of cancer, it is estimated that it should reduce the mortality rate by 10% by 2026.
3. Child mortality rate in the Department of San Salvador.	Rate	**9.98 per 1,000 live births**	2014	9.5	2021	**8.9 per 1,000 live births**	2026	SIMMOW (admissions + vital statistics)	No. deaths in children aged under one year in DSS / Live births in DSS x 1,000 Downward trend in the child mortality rate. The targeting of primary level interventions should contribute to reducing mortality by 10% by 2026.

EXPECTED OUTCOMES

Expected outcomes	Unit	Baseline		Targets		Means of verification	Remarks
		Value	Year	Value	Year		
(i) coverage and timeliness of actions at the first level of care							
1. Health service beneficiaries in the 10 prioritized municipios.[1]	People	52,835	2015	131,104	2021	Family Record Information System (SIFF)	Corresponds to persons registered with community family health teams (Ecos F) in the 10 prioritized municipios Source: calculation of expected coverage of one Ecos F of 600 families or 3,000 individuals. The annual targets will be calculated at the launch workshop.
2. Percentage of children under one year of age who were registered with the health system in the first seven days after birth, in the 10 prioritized municipios.	Percentage	51%	2014	80%	2021	SIMMOW	No. of children under one year of age who were registered in the first seven days after birth, in the 10 prioritized municipios. / Total children under one year of age from the 10 prioritized municipios who were registered. X 100 The target was estimated based on experience from the Mesoamerican Health Initiative 2015.
(ii) hospital service accessibility and supply							
3. Nonhospital births in municipios of the North zone of the DSS.[2]	%	7	2015	3	2021	SIMMOW	Total nonhospital births by residents of municipios in the North zone of DSS / total births registered by MINSAL x 100, residents of municipios in the North zone of DSS A nonhospital birth is a birth taking place outside of the hospital setting. Strengthening primary health care and creation of maternity waiting homes to improve this indicator.

[1] The 10 prioritized municipios are: Apopa, Nejapa, Tonacatepeque, Guazapa, Aguilares, El Paisnal, Panchimalco, Rosario de Mora, Santiago Texacuangos, and Santo Tomas.

[2] Municipios in North zone of San Salvador: Apopa, Nejapa, Tonacatepeque, Guazapa, Aguilares, and El Paisnal.

Expected outcomes	Unit	Baseline		Targets		Means of verification	Remarks
		Value	Year	Value	Year		
4. Average availability of essential drugs at the project hospitals (specialties and North zone)	Percentage	80%	2014	85%	2021	Sistema Nacional de Abastecimiento [National supply system] (SINAB)	No. items on the list of essential drugs available in hospitals / total items on the list of essential drugs for hospitals x 100 The baseline was established based on MINSAL hospitals.
5. Average physical accessibility (distance) from municipios in the North zone of DSS to the service area of the North zone hospital (HZN).	Km	25.7	2015	18	2021	Google maps	Average distance from seat of the municipal government of municipios in the North zone of DSS to HZN.
(iii) hospital risks							
6. Surgical site infection rate at HZN a. Cesarean b. Appendectomy	Rate	a. 3.4 b. 10.7	Study 2012 – 2014 Dirección Vigilancia Sanitaria [Health Surveillance Department]	a. 2.7 b. 3.8	2021	Comité Hospitalario de Infecciones Asociadas a la Atención Sanitaria [Hospital Committee on Health Care Associated Infections] (IAAS) at each hospital	No. cases of infections of surgical site following cesareans at HZN / Total no. cesareans at HZN x 100 No. cases of infections of surgical site following appendectomies at HZN / Total no. appendectomies at HZN x 100 Baseline taken from the reports by the health surveillance departments of hospitals operated in the Department of San Salvador.
(iv) compliance with health and environmental standards							
7. Percentage of Community Family Health Units (UCSF) nationwide complying with legislation on wastewater and infectious biomedical wastes.	Percentage	21.3%	2014	70.7%	2021	Environmental form ANDA permit	No. UCSF complying with the national sanitary legal framework / Total no. UCSF Verification: i Infectious biomedical waste inspections by the health authority ii Administración Nacional de Acueductos y Alcantarillados [National Water and Sewer Authority] (ANDA) permit for wastewater

Expected outcomes	Unit	Baseline		Targets		Means of verification	Remarks
		Value	Year	Value	Year		
(v) hospital and first level efficiency							
8. Average hemato-oncology stay in specialties hospital	Days	8.6	2014	4	2021	SIMMOW	Number of beds occupied in hemato-oncology / number of hospital admissions in hemato-oncology. The baseline is the Rosales hospital Benchmark: same service in Chile and Brazil
9. Facilities reporting their production information by electronic means in the 10 prioritized municipios	Health facilities	78	2015	108	2021	SIMMOW	Number of units in the project target area that report using the MINSAL information system.
(vi) network operation							
10. Returns by referral and consultation in DSS North zone.	%	29% (12,669/ 45,203)	2014	80%	2021	SIMMOW	No. returns received / No. referrals made x 100 Municipios in North zone of San Salvador.
11. CRAE treatment effectiveness in selected cities[3]	%	0	2014	TBD	2021	SIMMOW	No. referrals made / No. referrals received Referral made: patient sent to other facility Referral received: patient received from other facility
12. Capacity for hospital childbirth with strengthened OB/GYN care in selected municipios[4]	% Births	72.2%	2013	85%	2021	SIMMOW	Numerator: Number of births by residents of selected municipios in targeted hospital. Denominator: Number of births by residents of selected municipios in all MINSAL hospitals.

[3] Selected cities: San Salvador, San Miguel, Santa Ana, and Santa Tecla.

[4] Selected municipios: Santiago de Maria, Jiquilisco, Chalchuapa, Nueva Guadalupe, San Francisco Gotera, La Union, Suchitoto, Cojutepeque.

OUTPUTS

Outputs	Unit	Baseline	Year 1	Year 2	Year 3	Year 4	Year 5	Final Target	Means of verification / Remarks
Component 1. Strengthening of the ambulatory care network									
1.1 Basic UCSF (B) built in 10 prioritized municipios	No. UCSF B	0		4	10	10	6	30	Record of acceptance of the works from UIM[5]
1.2 Community family health teams (Ecos) set up in 10 prioritized municipios	No. Ecos	0		4	19	29	29	29	HRs report confirming the hiring of 1 physician, 1 nurse, 1 all-rounder, and 3 promoters. [6]
1.3 Basic UCSFs (B) equipped in 10 prioritized municipios	No. UCSF B	0		6	10	10	6	32	Report on the list of needs of each UCSF B and acceptance certificates of equipment from DPN.[7]
1.4 Intermediate UCSFs (I) built in the 10 prioritized municipios.	No. UCSF I	0		2	3	3		8	Record of acceptance of the works from UIM
1.5 UCSF Is equipped in 10 prioritized municipios	No. UCSF I	0		2	3	3		8	Report on the list of needs of each UCSF I and acceptance certificates of equipment from DPN.
1.6 Specialized UCSFs (E) built in 10 prioritized municipios	No. UCSF E	0			1	1		2	Record of acceptance of the works from UIM
1.7 UCSF (E) equipped in 10 prioritized municipios	No. UCSF E	0			1	1		2	Report on the list of needs of each UCSF E and acceptance certificates of equipment from DPN.

[5] This unit has standards for the acceptance of works.

[6] The final target is not equal to the sum of each of the years, since in each year community teams (human resources) from previous years and new teams are financed.

[7] The DPN has standards establishing the quantity and type of equipment that each UCSF (Basic, Intermediate, or Specialized), maternity waiting home, and Basic Comprehensive Health System should have. These needs will be verified prior to solicitation.

Outputs	Unit	Baseline	Year 1	Year 2	Year 3	Year 4	Year 5	Final Target	Means of verification / Remarks
1.8 UCSF E established in Apopa, La Union, Sonsonate, and Chalatenando	No. Ecos E	0		1	2	1		4	Considered set up when they have 1 internist, 1 obstetrician/ gynecologist, 1 pediatrician, 1 nutritionist, 1 psychologist, 1 physiotherapist, 1 health educator. Source: Human Resources System report.
1.9 Specialized Care Reference Centers (CRAE) built in selected cities	No. CRAE	0			2	2		4	Record of acceptance of the works from UIM.
1.10 CRAE in selected cities equipped	No. CRAE	0			2	2		4	Report on the list of needs of each CRAE and acceptance certificates of equipment from DH.
1.11 Health teams in CRAE in selected cities set up	Number of health teams	0			2	4		6	A CRAE health team comprises approximately 60 posts. Source: Human Resources System report. .
1.12 Maternity waiting homes (HEM) built.	No. HEM	0		1	2			3	Record of acceptance of the works from UIM.
1.13 HEMs equipped	No. HEM	0		1	2			3	Report on the list of needs of each HEM and acceptance certificates of equipment from DPN.
1.14 Health teams in HEMs constituted	Number of health teams	2			1			3	Human Resources System report.
1.15 Regional Basic Comprehensive Health System offices built	No. offices	0		1	2			3	Record of acceptance of the works from UIM.
1.16 Regional Basic Comprehensive Health System offices equipped	No. offices	0		1	2			3	Report on the list of Basic Comprehensive Health System needs and acceptance certificates of equipment from DPN.

Outputs	Unit	Baseline	Year 1	Year 2	Year 3	Year 4	Year 5	Final Target	Means of verification / Remarks
1.17 UCSF with waste management systems built	No. UCSF	0			100	100	150	350	Standards exist for wastewater and infectious biomedical waste. Verification: Health authority and/or ANDA certificate, as applicable.
1.18 Project target area vehicles	No. vehicles	0	0	17	0	0	0	17	Verification: vehicle acceptance certificate.
1.19 UCSF with supplies and medications	No. UCSF	0	0	2	30	0	0	32	Verification: Acceptance certificates for medications and supplies, compared with list of medications and supplies established in operations manual issued by each UCSF.
Component 2. Strengthening of the hospital network									
2.1 North zone hospital (HZN) built	No. hospitals	0				1		1	Record of acceptance of the works from UIM
Milestone: Design and construction permits finalized	No. reports	0		1				1	Report includes design and permits. Technical file approved and construction permits obtained
2.2 HZN equipped	No. hospitals	0						1	The project will include a list of equipment to be purchased. DH will verify delivery from acceptance certificates.
Milestone: Fixed equipment in works purchased.	No. reports					1		1	Generally includes large and heavy equipment. This group includes steam autoclaves, fixed X-ray equipment, in particular.
Milestone: Non-fixed equipment in works purchased.	No. reports						1	1	This group includes 100% mobile equipment, such as monitors, endoscopes, ultrasound scanners, etc.
2.3 Staff hired for HZN	Number Hospitals	0					1	1	Verification: Human Resources System

Outputs	Unit	Baseline	Year 1	Year 2	Year 3	Year 4	Year 5	Final Target	Means of verification / Remarks
Milestone: Staff hired	No. hospitals						1	1	The effective hiring of staff defined on the new staff list will be verified.
2.4 Specialty hospital built	No. hospitals	0				1		1	Record of acceptance of the works from UIM.
Milestone: Design and construction permits finalized	No. reports	0			1			1	Technical file approved and construction permits obtained.
2.5 Specialty hospital equipped	No. hospitals	0					1	1	The project will include a list of equipment to be purchased. DH will verify delivery from acceptance certificates.
Milestone: Fixed equipment in works purchased.	No. reports					1		1	Idem HZN
Milestone: Non-fixed equipment in works purchased.	No. reports						1	1	Idem HZN
2.6 Staff hired for specialty hospital	Number Hospitals	0					1	1	Verification: Human Resources System
Milestone: Staff hired	Number Report						1	1	The effective hiring of staff defined on the new staff list will be verified.
2.7 OB/GYNs hired for the 8 hospitals in selected municipios	No. OB/GYN contracts	0		36	36	36		36	Human Resources System report. 36 OB/GYNs will be financed to ensure their presence for 3 years. The annual targets are not cumulative.
2.8 Hospitals with a standards-compliant wastewater management system	No. hospitals	0			2			2	Saldaña hospital and San Miguel general hospital certified by ANDA.

Outputs	Unit	Baseline	Year 1	Year 2	Year 3	Year 4	Year 5	Final Target	Means of verification / Remarks
Component 3. Support to improve the management and efficiency of the health network									
3.1 Number of public involvement activities	No. activities	0		2	6	6	6	20	The activities are events with members of the community for feedback and to provide services. Records of activities run with list of participants provided by the first level authority.
3.2 Health units with computer hardware and internet connections.	No. UCSF	78		11	10	17	2	108	Units with primary health care information system module operating (hardware and Internet connection operational) Report: IT Department.
3.3 Storage facilities built and equipped	No. storage facilities	0		4	1			5	Verification: Minutes of works accepted and equipment delivered Report: Storage Department
3.4 Maintenance plan prepared	Number	0	0			1	1	2	HZN and HE hospital maintenance plans approved with their management mechanism. Operations Department report.
3.5 National Health Survey.	No. surveys	0				1		1	Survey final report
3.6 Midterm project evaluation	No. evaluations	0				1		1	Midterm evaluation report
3.7 Final project evaluation	No. evaluations	0					1	1	Final evaluation report
3.8 Audits commissioned	No. audits	0	1	1	1	1	1	5	Program audit reports

FIDUCIARY AGREEMENTS AND REQUIREMENTS

Country:	El Salvador
Name:	Integrated Health Program (PRIDES II) (ES-L1095)
Executing agency:	Ministry of Health of El Salvador (MINSAL)
Prepared by:	Marco Alemán, Senior Fiduciary Specialist in Procurement (FMP/CES) and Patricio Crausaz, Financial Specialist (FMP/CES)

I. SUMMARY

1.1 The Ministry of Health (MINSAL), as executing agency, will be in charge of running the project through a program management unit (PMU) comprising staff from the program coordination unit that executed loan 2347/OC-ES. The PMU will be strengthened with additional human resources hired to meet the extra workload represented by the complexity and scale of the new project. MINSAL's Institutional Financial Unit will be responsible for the project's financial management in coordination with the PMU. Procurement management will be the direct responsibility of the PMU.

1.2 Financial management will be in accordance with country laws and regulations, as established in the Integrated Financial Administration Act and annual budget laws, supplemented by the Financial Management Guidelines for IDB-financed Projects (document GN-2811). Bank policies and procedures (documents GN-2349-9 and GN-2350-9) will be applied for procurement management. The PMU will use the "free management" approach envisaged in national legislation, as approved by the Bank's Board of Executive Directors in September 2013.

II. FIDUCIARY CONTEXT OF THE EXECUTING AGENCY

2.1 Financial management will be conducted by MINSAL's Institutional Financial Unit. This includes budgeting, cash management, and accounting within the framework of the Finance Ministry's processes and standards, using its SAFI Integrated Financial Administration System. The Institutional Financial Unit has qualified staff with the technical capability to perform its tasks and responsibilities. Nevertheless, it will be supplemented with additional staff, so that it can take on the extra workload in the budget, accounting, and cash management areas. The coordination between the Institutional Financial Unit and the PMU as part of the management of the new project will be via process flows and functional and administrative reporting lines between them.

2.2 Institutional procurement will be conducted by the MINSAL Institutional Contracting and Procurement Unit (UACI). The UACI does not currently have the

capacity to take on new responsibilities,[1] so a procurement work group will be set up devoted exclusively to the project. This work group will report to the head of the PMU on administrative and functional matters.

2.3 The regulatory framework for public procurement is established by the Government Procurement and Contracting Law (LACAP) and its supplemental rules and regulations. Bank policies and procedures (documents GN-2349-9 and GN-2350-9) will be applied for project procurement management.

III. FIDUCIARY RISK ASSESSMENT AND MITIGATION ACTIONS

3.1 The project's fiduciary risk is estimated to be medium, and the following mitigation actions are to be taken.

Risk type	Risk	Probability rating	Impact rating	Risk classification (high, medium, or low)	Mitigation action[2]	Fulfillment indicator
Fiduciary/ Procurement	Weak management of the initial phase of the procurement cycle in critical processes	Medium	Medium	Medium	- Team dedicated exclusively to procurement - Technical assistance from expert consultants in design, construction, and equipment. - Promoting investment, market identification; actively informing stakeholders about process characteristics; preparation of bidding processes enabling bidders' technical capacity to be evaluated, and reasonable time frames.	- Team hired and trained. - Consultants hired. - Market studies conducted. - Preliminary publications and information meetings held. - High quality bidding documents prepared.

[1] See institutional capacity analysis report.

[2] Includes main mitigation actions agreed upon with the client.

Risk type	Risk	Probability rating	Impact rating	Risk classification (high, medium, or low)	Mitigation action[2]	Fulfillment indicator
Fiduciary/ Procurement	Weakness of administration of contracts signed that have a high impact on the project	Medium	Medium	Medium	- Technical assistance from specialist consultants - Implementation of supervision tools; contract monitoring and oversight. - Establishing the RACI matrix. - Preparation of reports on contract status. - Establishing a procedure to respond in a timely manner to situations arising during contract execution.	- International consultants hired. - Contract administration tools implemented. - RACI matrix implemented for each contract. - Procedure established and implemented.

IV. CONSIDERATIONS FOR THE SPECIAL PROVISIONS OF THE LOAN CONTRACT

4.1 The following agreements and requirements are to be included in the Special Provisions of the contract:

- Appointment of the PMU and establishment of job descriptions for the technical/operational team for program implementation.
- Submission of the project Operations Manual to the Bank for approval.
- Clause enabling contracting of works and acquisition of durable goods to be implemented over more than one fiscal year according to the availability of loan proceeds and in compliance with the stipulations of the Act on the Financial Administration of the State and annual budget laws.
- Clause permitting use of the national “free management” approach for project procurement.

V. PROCUREMENT EXECUTION

5.1 The project involves the procurement of works, goods and services, and the contracting of consultants, in accordance with the framework established in policy documents GN-2349-9 and GN-2350-9, respectively. The procurements to be conducted during the project execution period will be established in the project procurement plan. The procurement plan will state: (i) category; (ii) types and/or

methods; and (iii) type of supervision. Executing agencies must keep the procurement plan updated and consistent with the annual work plan (AWP). Any changes or modifications to the procurement plan must be made through the Procurement Plan Execution System (SEPA). The IDB's Project Team Leader (PTL) is responsible for approving the procurement plan and keeping it updated during the project execution period, with the support of the procurement specialist.

5.2 **Procurement of works, goods, and nonconsulting services.** Alternatives are being considered for procurement of the hospital construction work (Specialties and North zone hospitals) that are geared toward efficiently distributing risk between the contracting entity and contractor. Experience on several similar projects has shown that unit price contracts are not the most appropriate for this type of complex construction project, particularly given that the owner, rather than the designer and builder, retains the largest share of the risk.[3] Various mechanisms for the procurement of medications will be studied, from among those used by MINSAL, including the joint negotiation mechanism administered by COMISCA. This complies fully with the principles established in document GN-2349-9. Other agreements entered into by MINSAL may be considered with the Bank's no objection. For the contracting of minor works: In the case of goods and nonconsulting services, any of the methods described in the procurement policies may be used, provided that such method has been identified for the respective procurement in the procurement plan agreed upon with the Bank. The threshold for the use of international competitive bidding[4] will be made available to the executing agency online at: www.iadb.org/procurement. Below this threshold, the selection method will be determined on the basis of the complexity and features of the procurement, which must be reflected in the procurement plan.

5.3 **Contracting of consulting services.** For consulting services, any of the methods described in the policies for the contracting of consulting services may be used, provided that such method has been identified for the respective procurement in the procurement plan. The thresholds for the inclusion of international consultants[5] on the shortlist will be made available to the executing agency online at www.iadb.org/procurement. Below this threshold, the shortlist may comprise entirely consultants from the borrowing country.

5.4 **Initial procurement plan.** The initial procurement plan is included as an annex to the proposal for operation development (POD). Additionally, the SEPA will be used for planning and monitoring procurements financed with the loan proceeds.

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[3] A consulting engagement commissioned by the IDB's SPH Division is now under way for the bidding documents and contract type to be used for works of this kind.

[4] In the case of works, the threshold for international competitive bidding (ICB) is applicable to amounts of US$5 million or more; and for goods and nonconsulting services, ICB is applicable for amounts of US$250,000 or more.

[5] The threshold for the contracting of consulting firms is currently set at amounts of US$200,000 or more; for smaller amounts, the short list may comprise entirely national consultants.

Works	Cost estimate (in US$)	Type of process	Type of supervision
Specialties hospital	53,586,142	ICB	Ex ante
General hospital	19,481,814	ICB	Ex ante

Goods	Cost estimate (in US$)	Type of process	Type of supervision
Purchase of highly specialized medical equipment	24,113,678	ICB	Ex ante

Consulting services	Cost estimate (in US$)	Selection method	Type of supervision
Works supervision for specialties hospital	2,479,307	QBS	Ex ante
Works supervision for general hospital	909,091	QBS	Ex ante

5.5 **Procurement supervision.** The Bank will supervise the procurement of goods and works and contracting of consulting services with project resources in accordance with the procurement plan.

5.6 **Records and files.** The documentation for the project-financed operations will be kept by the Institutional Financial Unit and the PMU, according to their areas of jurisdiction.

VI. FINANCIAL MANAGEMENT

6.1 **Programming and budget.** The country system will be used. In coordination with the PMU, the Institutional Financial Unit will manage the annual budgetary allocation with the Ministry of Finance. This will identify the project, and include sufficient budgetary appropriations to cover payment commitments deriving from execution in each year. The budget will include the necessary breakdown for each of the project components, assigning budget lines to work to ensure the periodic monitoring of the sums committed, obligated, and disbursed for each component. Additionally, the project will include a specific public investment code within the Ministry of Finance Public Investment Information System (SIIP). For the procurement of works and goods and services to be financed with the loan proceeds, including the award and signature of the respective contracts, MINSAL may solicit and contract on the basis of the availability of funds in the loan contract, and must program within its institutional budget for each fiscal year the

amounts necessary to meet its payment commitments according to the annual execution programming of the aforementioned contracts for works, goods and services.

6.2 **Accounts and financial reports.** The country system will be used. The project's accounting books, and the corresponding supporting documentation, will be kept by MINSAL's Institutional Financial Unit, using the SAFI Integrated Financial Administration System, and additional manual processes to prepare financial reports on a cash basis in the formats required by the Bank, and to process requests for advances.

6.3 **Disbursements and cash flow.** The country's cash management subsystem will be used to process payments and disbursements. MINSAL will request the opening of a special account at the Central Reserve Bank of El Salvador. The Ministry of Finance Department of Cash Management will be given instructions to pay suppliers and contractors, supported by the SAFI cash management subsystem from this account. This mechanism will be reviewed or adjusted if the General Treasury Account of the Ministry of Finance is considered acceptable to the Bank. In accordance with the provisions of the Financial Management Guidelines for IDB-financed Projects (document OP-273-6), the Bank will make disbursements in the form of advances of funds charged to the loan contract. The monetary value of each advance will be calculated based on the Institutional Financial Unit's cash flow programming in conjunction with the PMU for the execution of the project activities and procurements scheduled for periods of up to six months. Cash flow programming must be consistent with the AWP and procurement plan to which the Bank has given its no objection, and must cover a moving horizon of at least 12 months. The Institutional Financial Unit, acting through the designated project payer, will be responsible for updating and controlling cash flow programming execution, in coordination with the head of the PMU and other relevant members of the project management team. The payer will also be responsible for preparing disbursement requests for the IDB and their "bank account reconciliation" annex in coordination with the PMU finance technical specialist. IDB disbursements will be paid into the designated account opened with the Central Reserve Bank for exclusive project use.

6.4 **Internal control.** The technical standards on internal control issued by the Corte de Cuentas de la República [Audit Office of the Republic] will be applied.[6] The internal control authority will comprise MINSAL officials involved in project execution, according to their area of work. MINSAL's internal audit unit will perform controls of the project on an annual basis.

6.5 **External control and reports.**[7] External control will be performed by an external audit firm acceptable to the Bank, contracted with loan proceeds through a competitive procedure and on terms of reference subject to the IDB's no objection pursuant to Guide AF-200. Annual audit reports will be delivered to the IDB by MINSAL no later than 120 days after the close of the corresponding fiscal

[6] The legislation establishes public officials' responsibility in the performance of their functions, such that noncompliance can result in legal action against them. Title III "Civil service responsibility," Articles 52-61 of the Law on the Audit Office of the Republic.

[7] At least the financial audit must be planned. It may include procurement and/or technical procedures, as deemed necessary.

period. As of the second year of execution, the same audit firm may be engaged by single-source selection on the principle of continuity of service, provided that the quality of the audit work done in the first year was deemed acceptable to the Bank and MINSAL. The Institutional Financial Unit, in coordination with the PMU, will prepare annual reports for auditing in accordance with the Bank's Guidance on Financial Reports and Auditing.

Fiduciary Supervision Plan

Supervision activity	Supervision plan			
	Nature and scope	Frequency	Responsibility	
			Bank	Other
Operational	Review of progress report	Six-monthly	Fiduciary and sectoral team	MINSAL
	Review of portfolio with executing agency	According to the schedule agreed by MH and the Bank.	Head of Operations, Fiduciary and Sector Team	MH/MINSAL/IDB
Financial	Update to cash flow and disbursement schedule	With each request for an advance When project circumstances so require.	Fiduciary and operational specialists	MINSAL
	Supervision visits	First year: Six-monthly: Following years; Annual	Fiduciary specialist	Consultant.
	Financial auditing and ex post review	Annual	Fiduciary specialist	MINSAL/external auditor
Procurement	Ex ante procurement review	During program execution	PTL/executing agency	MINSAL
	Procurement Plan updating	Annual or when circumstances require	PTL/executing agency	MINSAL
Compliance	Compliance with conditions precedent	Once; 2016 Q2	Fiduciary team / Operations analyst	MINSAL/MH/IDB
	Prioritization and budgetary allocation	Annual, June and January of each year	Fiduciary specialist	MINSAL/MH
	Delivery of audited financial statements	Annual	Fiduciary specialist	MINSAL/Auditor

6.6 **Execution mechanism.** The borrower will be the Republic of El Salvador, and the executing agency will be MINSAL. A PMU will be established, reporting directly to the minister's office. In addition to general coordination of project execution, the PMU will conduct the procurement and contracting procedures. The Institutional Financial Unit will be responsible for the project's financial management in coordination with the PMU. The PMU will incorporate the staff of the PMU of project ES-L1027, and will be strengthened with additional staff to address the extra workload and specialization of project ES-L1095. The PMU will act in coordination with all MINSAL institutional units and complement their functions. The organization chart, authority and duties, roles, and responsibilities of the PMU will be specified in the program Operations Manual.

DOCUMENT OF THE INTER-AMERICAN DEVELOPMENT BANK

PROPOSED RESOLUTION DE-___/15

El Salvador. Loan ____/OC-ES to the Republic of El Salvador
Integrated Health Program II

The Board of Executive Directors

RESOLVES:

That the President of the Bank, or such representative as he shall designate, is authorized, in the name and on behalf of the Bank, to enter into such contract or contracts as may be necessary with the Republic of El Salvador, as Borrower, for the purpose of granting it a financing to cooperate in the execution of the Integrated Health Program II. Such financing will be for the amount of up to US$170,000,000 from the resources of the Bank's Ordinary Capital, and will be subject to the Financial Terms and Conditions and the Special Contractual Conditions of the Project Summary of the Loan Proposal.

(Adopted on ___ _____ 2015)

LEG/SGO/CID/IDBDOCS#39932304
ES-L1095