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PARAGUAY

PROGRAM TO STRENGTHEN COMPREHENSIVE INTEGRATED HEALTH SERVICES NETWORKS BASED ON PRIMARY CARE

(PR-L1167)

LOAN PROPOSAL

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REQUIRED

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2. Monitoring and evaluation plan
3. Environmental and social management report
4. Procurement plan

OPTIONAL

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3. Work plan for RIISS development in Paraguay
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ABBREVIATIONS

CNCD	Chronic noncommunicable disease
EONC	Essential obstetric and neonatal care
HIV/AIDS	Human immunodeficiency virus/acquired immunodeficiency syndrome
IDB	Inter-American Development Bank
IMR	Infant mortality rate
IPS	Instituto de Previsión Social [Social Security Institute]
MMR	Maternal mortality ratio
MSPBS	Ministry of Public Health and Social Welfare
PAHO	Pan American Health Organization
PHC	Primary health care
PMU	Program Management Unit
PNETDS	Plan Nacional Estratégico de Transformación Digital de la Salud [Strategic National Plan for Digital Health Care Transformation]
RIISS	Redes Integradas e Integrales de Servicios de Salud [Comprehensive, Integrated Health Services Networks]
SIG	Sistema de Información Georreferenciado [Georeferenced Information System]
SSIEV	Subsistema de Información de Estadísticas Vitales [Vital Statistics Information Subsystem]
USF	Unidad de Salud Familiar [Family Health Care Unit]
WHO	World Health Organization

PROJECT SUMMARY

PARAGUAY
PROGRAM TO STRENGTHEN COMPREHENSIVE INTEGRATED HEALTH SERVICES NETWORKS BASED ON PRIMARY CARE
(PR-L1167)

<table>
<tr><th colspan="5">Financial Terms and Conditions</th></tr>
<tr><td colspan="3">Borrower:</td><td colspan="2">Flexible Financing Facility[a]</td></tr>
<tr><td colspan="3">Republic of Paraguay</td><td>Amortization period:</td><td>24 years</td></tr>
<tr><td colspan="3">Executing agency:</td><td>Disbursement period:</td><td>6 years</td></tr>
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<tr><td>Source</td><td>Amount (US$)</td><td>%</td><td>Interest rate:</td><td>LIBOR-based</td></tr>
<tr><td rowspan="2">IDB (Ordinary Capital)</td><td rowspan="2">45,000,000</td><td rowspan="2">100</td><td>Credit fee:</td><td>[c]</td></tr>
<tr><td>Inspection and supervision fee:</td><td>[c]</td></tr>
<tr><td rowspan="2">Total:</td><td rowspan="2">45,000,000</td><td rowspan="2">100</td><td>Weighted average life (WAL):</td><td>15.07 years</td></tr>
<tr><td>Approval currency:</td><td>U.S. dollars</td></tr>
<tr><th colspan="5">Project at a Glance</th></tr>
<tr><td colspan="5">Project objective/description: The overall objective of the program is to help improve the health conditions of Paraguay's most vulnerable population by strengthening the Comprehensive, Integrated Health Services Networks (RIISS) based on primary care. The specific objectives are to: (i) expand and strengthen the care network, and (ii) boost the quality of priority lines of care, including mother and child health; essential obstetrics and neonatal care, particularly diabetes, hypertension, and cancer; and HIV/AIDS and tuberculosis.</td></tr>
<tr><td colspan="5">Special contractual conditions precedent to the first disbursement of the loan proceeds: (i) approval by the MSPBS of the program Operating Regulations; and (ii) creation by the MSPBS of the program management unit (PMU) with the basic composition described in paragraph 3.2 (see paragraph 3.3).
Special contractual conditions for execution: The period for the material start of works will be three years, as from the date the loan contract takes effect. See the Environmental and Social Management Report (ESMR) for other special contractual conditions.</td></tr>
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[a] Under the Flexible Financing Facility (document FN-655-1), the borrower has the option of requesting changes to the amortization schedule, as well as currency, interest rate, and commodity conversions. The Bank will take operational and risk management considerations into account when reviewing such requests.

[b] Under the flexible repayment options of the Flexible Financing Facility, changes to the grace period are permitted provided that they do not entail any extension of the weighted average life of the loan or last payment date as documented in the loan contract.

[c] 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 relevant policies.

[d] SI (Social Inclusion and Equality); PI (Productivity and Innovation); and EI (Economic Integration).

[e] GD (Gender Equality and Diversity); CC (Climate Change and Environmental Sustainability); and IC (Institutional Capacity and Rule of Law).

I. DESCRIPTION AND RESULTS MONITORING

A. Background, problem addressed, and rationale

1.1 Paraguay has significantly improved the health conditions of its population over the last 15 years, in a context of strong economic expansion and increased social spending.[1] In particular, the maternal mortality ratio (MMR) and neonatal mortality rate have fallen by 61.3% and 23.7% respectively.[2] Part of this improvement can be attributed to a rise in basic health care coverage and the use of services,[3] as well as in the use of family planning methods and institutional deliveries.[4] Moreover, from 2005 to 2016, chronic malnutrition in children under 5 fell from 17.5% to 5.9%.[5] Despite these trends, Paraguay's indicators are still higher than the average for Latin America and similar to those of lesser developed countries like Nicaragua and Honduras.[6] While maternal mortality has gone down, the rate remains high and shows a volatile trend, making it difficult to project a sustained reduction. The headway achieved also masks significant disparities across income levels, ethnicities, and regions.

1.2 In 2017, 78 maternal deaths were reported: a ratio of 67.3 per 100,000 live births,[7] far above the target of the Millennium Development Goals of 37.5 per 100,000 live births by 2015. Out of these deaths, 41% were caused by complications during pregnancy, delivery, and the puerperium; 23% were the result of preeclampsia,[8] and 14% were from hemorrhaging. Due to geographical dispersion, rurality, cultural practices, limited coverage of basic services, and lack of equipment and qualified human resources in Paraguay, the state of maternal mortality can be attributed to the three delays model.[9] Most maternal deaths take place in health care facilities and are avoidable. This reveals that there is limited access and timeliness (first and second delays) and a problem with the quality of care (third delay). Around 20% of the deaths correspond to adolescents.[10] Some of the departments with the highest MMRs are Alto Paraguay, Alto Paraná, Caazapá,

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1 The Paraguayan economy has grown at an annual average of 4.5% over the last 15 years and, in the last 10 years alone, the gross domestic product has expanded by 50% in a context of low inflation.

2 From 2004 to 2018, the MMR per 100,000 live births fell from 153.5 to 67.3, while the neonatal mortality rate per 1,000 live births dropped from 10.7 to 9.

3 The proportion of people who had a medical appointment after falling ill rose from 48.6% to 80.3%. This figure doubled in rural areas from 36.9% to 76.9%. *Paraguay: Distribución del Gasto en Salud y Gastos de Bolsillo. Principales Resultados.* Gerardo Benítez, 2017.

4 From 92.1% in 2008 to 97.9% in 2017. Plan de Acción Nacional en Población y Desarrollo 2018-2019.

5 Permanent Household Survey 2005 and Multiple Indicators Survey 2016.

6 Out of 20 countries in Latin America and the Caribbean, Paraguay ranks 16th in MMR and 14th in the mortality rate for children under 5. "Paraguay, Invertir en Capital Humano," World Bank, 2018.

7 Vital Statistics Information Subsystem (SSIEV), 2018.

8 Preeclampsia is a condition caused by pregnancy-induced hypertension.

9 These can be summarized as: (i) delay in the decision to seek care; (ii) delays in reaching a health care facility due to a lack of adequate transportation or inability to afford it; and (iii) delay in receiving adequate (quality) care. Thaddeus, S. and Maine, D. (1994) *Too Far to Walk, Maternal Mortality in Context*. Social Science & Medicine, 38, 1091-1110.

10 According to the SSIEV, from 2010 to 2016, there were 142,847 children born to mothers between the ages of 10 and 19. For more information, see "*Paraguay Joven: Informe sobre Juventud*." United Nations Population Fund.

and Concepción.[11] Although considerable progress has been made in recent years, the ability of the health care system to respond to obstetric emergencies outside the capital remains limited, as few hospitals possess the infrastructure, supplies, and skilled human resources needed to address these situations.[12]

1.3 The infant mortality rate (IMR) has followed a clearer downward trend over the last 15 years,[13] though significant deficiencies still exist. The largest proportion of infant deaths takes place during the perinatal period, i.e., from the 28th week of gestation to the 7th day of life. While the IMR reached 12.6 per 1,000 live births in 2017, the neonatal mortality rate was 9 per 1,000 live births, out of which the majority was due to early neonatal mortality (6.8 per 1,000 live births). It can be inferred from this that there are constraints in delivery and neonatal care. In some departments, such as Alto Paraguay, it reached 30.7 per 1,000 live births. Nationwide, 1,041 infants died in the neonatal period in 2017, which accounted for 62% of mortality in children under 5. Approximately 68% of these deaths resulted from premature births. An estimated 40% of neonatal mortality is caused by delivery-related injuries associated with problems coordinating neonatal obstetrics.

1.4 **The nature of maternal and neonatal morbidity and mortality.** The above mortality figures are primarily due to constraints in the public health care system. Evidence of this is the fact that the majority of pregnancies are detected after the 12th week of gestation[14] and, in 15% of cases, the recommended four check-ups performed by qualified personnel are not completed.[15] Additionally, the lack of systematic implementation and periodic verification of protocols and standards of care compromises the quality of care, which is considered deficient by the Ministry of Public Health and Social Welfare (MSPBS) itself.[16] Out of the pregnant women who do attend four check-ups, 17% only receive their first one in the second trimester of gestation and, in the case of the poorest quintile, that figure rises to 28%.[17] Another factor contributing to this situation is the high rate of adolescent pregnancy. Births to mothers in the 10-to-19 age group account for one fifth of all births in the country. These pregnancies carry greater risks and have a higher prevalence in the lower-income strata.[18] From 2004 to 2013, the number of births in the 10-to-14 age group rose by 61.6%. The use of family planning methods continues to grow, but 31.6% of women of childbearing age still do not use any.

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11 For example, 6% of recorded maternal deaths are concentrated in Concepción, which is home to only 3% of the country's population.

12 Plan of Action to Accelerate the Reduction in Maternal Mortality and Severe Maternal Morbidity. MSPBS and Pan American Health Organization (PAHO), 2013.

13 The expansion of services and numerous efforts played a role in fighting the causes of this scourge. For example, the recent campaign "Movilización Nacional para disminuir la mortalidad materna y del Recién Nacido" [National Mobilization to Reduce Maternal and Newborn Mortality], known as #CeroMuertesEvitables [#ZeroAvoidableDeaths].

14 The World Health Organization (WHO) recommends that pregnant women enter the health system before week 12 of gestation for care to begin and, above all, for early detection and treatment of any complications that compromise health.

15 Basic Indicators. Health Situation in the Americas. PAHO, 2018.

16 MSPBS Política Nacional de Calidad en Salud 2017–2030. Page 11.

17 Multiple Indicators Survey by Conglomerates, 2016.

18 Embarazo y Maternidad de Niñas en Paraguay. Centro de Documentación y Estudios, 2018.

1.5 In addition to these health care system limitations, maternal and neonatal mortality are exacerbated by certain comorbidity conditions,[19] such as anemia (affecting 33% of pregnant women[20]), arterial hypertension, and diabetes. Excess weight and obesity in mothers increase pregnancy complications and reduce the likelihood of having a normal birth. Nearly half of pregnant women in Paraguay are overweight or obese, and 35% of births in the country are via Cesarean section, far more than the 15% recommended by the World Health Organization (WHO). This creates the challenge of verifying the technical relevance of this practice by ensuring compliance with the absolute and relative indications for this surgical procedure.

1.6 **Fast epidemiological transition** Paraguay is undergoing an epidemiological transition, in which chronic noncommunicable diseases (CNCDs) have a growing impact (though the prevalence of infectious diseases remains high). Every year, CNCDs lead to approximately 20,000 deaths, out of which 30% are premature.[21] The CNCDs that are leading causes of death are cerebrovascular diseases, tumors, cardiovascular diseases, and diabetes. The latter affects 640,000 people (9.7% of the population),[22] and Paraguay has the region's highest mortality rate from diabetes: 59.9 per 100,000 inhabitants, far above the Southern Cone average of 22.5 per 100,000 inhabitants.[23] As regards infectious diseases, the human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) affects 18,247 people, 30.61% of whom are in the AIDS stage. Out of the newly diagnosed patients in 2017, 53.36% were between the ages of 20 and 34, and 71.1% were male. Access to treatment is limited; in 2017, only 56.2% of people diagnosed with HIV[24] received antiretroviral treatment. Lastly, tuberculosis has gone down, but remains high at a prevalence of 37 per 100,000 inhabitants.

1. The causes of this situation

1.7 **Coverage and quality of care.** While part of this situation can be attributed to economic, social, and cultural factors,[25] the primary causes of the high rates presented above are limited access to health services and low quality of care. With a view to addressing maternal and neonatal mortality, along with the simultaneous increase in CNCDs, Paraguay set out to achieve universal public health care coverage[26] through the primary health care (PHC) strategy, by installing Family Health Care Units (USF).[27] The objective of this model is to bring health services closer to families and serve as a gateway to the system, while increasing the percentage of issues resolved at the primary care level. Though this model is

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19 Two or more disorders or diseases occurring simultaneously.

20 WHO, 2016.

21 Análisis de la Situación de las ECNT. MSPBS, 2014.

22 PAHO.

23 Basic Indicators. Health Situation in the Americas. PAHO, 2018.

24 The National HIV/AIDS/STI Control Program (PRONASIDA) has set as a target that 90% of people living with HIV should be diagnosed. Out of those, 90% should receive ongoing antiretroviral therapy, and 90% should experience viral suppression. Epidemiological Situation of HIV in Paraguay, 2017.

25 The intercultural and human rights approach has yet to be incorporated sufficiently by health care workers, particularly in hospital care; room for improvement exists in PHC as well.

26 PAHO Directing Council in October 2014. See the MSPBS National Health Policy for 2015-2030.

27 Each USF is responsible for approximately 3,500 to 5,000 people and has a doctor, nurse, nursing assistant, and 3 community health workers. There is one dentist for every three USFs.

expanding rapidly,[28] 60% of the population is still excluded from it.[29] In fact, to ensure universal access to PHC, an estimated gap of 1,194 USFs has to be closed. There is also a duplication of efforts in basic care, in that there are 49 dispensaries and 400 health stations and centers from the traditional model that offer basic services in the same areas as the USFs, with different teams (sometimes assigned to the same facilities). This complicates the management of services.[30] Many USFs and public hospitals also lack adequate infrastructure or basic medical equipment.[31] In the case of USFs, only 11% of the doctors are specialized in family medicine, and most lack community health workers,[32] which limits work outside of health facilities and promotion and protection actions required by the PHC model. These deficiencies are exacerbated at the department level. According to one study, in the department of Caazapá, USFs (primary care) and health stations and centers (medium-complexity facilities) have a 77.4% medical equipment deficit, and, in the department of Concepción, 70.6% lack necessary basic equipment.[33] The same issue exists for high-complexity services. As an example, a survey conducted in the San Estanislao and General Aquino district hospitals, both in the department of San Pedro, shows that 83% and 100% of rooms, respectively, require major repairs and have significant equipment and human resource deficits.[34]

1.8 The still-limited offering is plagued by low quality and resolution rates and weak coordination among the different levels of care, which interferes with the continuity of care for users.[35] There is no portfolio that clearly lays out the full set of public health services organized by levels of care. Clinical guidelines—fundamental tools to promote good practices for care—in many cases, have not been developed or have low rates of ownership and use by health care personnel. Low resolution at the basic-care level impacts hospitals. This is shown by the fact that 40% of initial health visits are conducted in hospitals,[36] which fills up emergency areas, and for

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28 From 2009 to 2018, the number of USFs grew from 176 to 804.

29 Using a coverage parameter of 3,500 people, approximately 4 million Paraguayans do not have access to public basic care.

30 The public network has 9 specialized hospitals, 4 specialized centers, 17 regional hospitals, 11 mother and child hospitals, 37 district hospitals, and 90 health centers.

31 A study performed in seven departments estimates that, on average, USFs are 60% deficient in biomedical equipment, 54% deficient in physical environments, and 40% deficient in the human resources required by sector standards. Centro de Información y Recursos para el Desarrollo (CIRD) 2017.

32 In a sample from seven departments, 85% of USFs lacked the community health workers who should be assigned according to regulations.

33 Estimate of essential obstetric and neonatal care gaps at the first and second levels of care in seven departments. IDB, 2017.

34 The General Aquino Hospital has just one out of eight necessary larger pieces of equipment (it lacks an X-ray machine, ultrasound scanner, diagnostic equipment, electrocardiograph, and incubator) and under 50% of the recommended human resources. The San Estanislao Hospital lacks 50% of required equipment in the emergency room and has 33% fewer health care professionals than the district IPS hospital. Análisis de la oferta de servicios de salud en Paraguay, II Red departamental de salud de San Pedro, 2014.

35 MSPBS with RISS Salud. 2017. Panorama Regional: Sistemas de Salud de Latinoamérica y Estado de Situación del Modelo RISS. Asunción, Paraguay.

36 Paraguay, Policy notes. World Bank, 2018.

18% of hospital discharges, the issue could have been addressed through basic care. As there are no centers to triage and schedule appointments, the units treat patients by spontaneous demand. This causes inefficiencies in the system and average wait times of 79 minutes, three times longer than in the private health system.[37] The fragility of basic care contributes, for example, to high rates of mortality from breast and cervical cancer in Paraguay because health promotion and periodic screening is limited.[38] Early diagnosis can prevent the spread of these types of cancer, and timely treatment can help extend years of life.

1.9 To address the supply and quality constraints described above, Paraguay has put forth a sustained effort to boost health care funding. Over the 2004-2014 period, public spending in this area nearly doubled from 2.4% to 4.5% of gross domestic product. Although it currently accounts for 11.2% of the total budget, it is still far below other countries like Uruguay (21.8%) and Argentina (21.7%) and has high levels of inefficiency. While out-of-pocket and private spending have been declining in the region, they remain high in Paraguay and account for 65% of total health care spending, the highest in the region. Most spending inefficiency is the result of quality problems and the duplication of services in some regions. This is compounded by the allocation of resources based on demographic or historical criteria, instead of current demand or health outcomes. This prevents the prioritization of district networks with the worst health care outcomes and the reduction of inefficiencies.

1.10 **Weak institutional structure of the MSPBS.** Another factor contributing to the current situation is that the MSPBS exhibits fragile administration and delivery of services, with uncoordinated institutional management and serious governance issues. The fragmentation of programs, budgets, and information systems hinders strategic planning.[39] Administrative and clinical standards and regulations are also weak. The two areas below, both key to improving the quality of health care, pose significant challenges.

a. **Human resources.** The public health system has a complex and dysfunctional structure. The average density of health workers is 23.3 per 10,000 inhabitants, far below the regional average (84.6) and below the threshold of 25 established by the WHO to provide essential maternal and child care. Moreover, the territorial distribution of the health work force is inequitable: 60% of doctors and nurses are concentrated in the capital city and Central department, though it is home to just 37% of the population.[40] Some of the factors that complicate human resources management are: (i) excessive centralization (managed by the MSPBS); (ii) a lack of incentives for personnel to reside outside the capital; (iii) the variety of contracts with different hourly workloads, low wages, and moonlighting; and (iv) training skewed towards hospital specializations, generating a large deficit to comply

[37] "Paraguay, Invertir en Capital Humano," World Bank, 2018.

[38] For women, breast cancer has the highest incidence, causing 13.2 deaths per 100,000 women. Paraguay also presents the highest incidence of and mortality from cervical cancer in the region, with a mortality rate of 10.5 per 1,000 women under the age of 70.

[39] Plan Estratégico Institucional 2013-2018. MSPBS, 2013.

[40] Estudio sobre disponibilidad y distribución de RRHH en salud en los paises partes del Mercosur. Hugo Mercer and María Pozzio.

with the PHC policy. There is also scant development of personnel with training in public and family health.[41] The MSPBS estimates that only 11% of primary care doctors are specialized in family medicine,[42] and a total of 266 doctors are certified in this specialization nationwide.[43] This is a constraint for the consolidation of the health care model and expansion of the number of USFs, and specific strategies are required to address it.

b. **Health information systems.** In terms of systems, while there has not been a recent assessment,[44] several analyses point out that health information systems are excessively fragmented, with little to no coordination between systems and subsystems and deficiencies related to information quality and timeliness.[45] There more than 30 disconnected databases and 200 forms, the use of which amounts to a considerable burden for health care personnel and does not permit a strategic analysis of information. Since 2008, the National Health Care Information System has been utilized, mainly for vital statistics and health and environmental surveillance. To strengthen service management with a network approach, the MSPBS has launched pilot experiments, such as the Georeferenced Information System (SIG) for essential obstetric and neonatal care (EONC) and early childhood development (ECD). This system is currently in use in six departments. Paraguay also has pharmaceutical and pathology information systems, but not laboratory or medical imaging systems, which are critical to increase primary care resolution rates.[46] Currently, there is no information system for electronic clinical history and health care interoperability standards, which are essential to ensure that information flows between the MSPBS, the Instituto de Previsión Social [Social Security Institute] (IPS), and other health care actors. There is a unique patient identifier, which is the national identity number, used by both the IPS and the MSPBS. Lastly, laws and regulations need to be reviewed and updated to promote a digital health care transformation.

1.11 The health care system is also fragmented between the MSPBS subsystem, which covers 73% of the population, and the IPS subsystem for salaried workers (around 19% of Paraguayans).[47] Each subsystem has its own care network, leading to pronounced segmentation and lack of coordination. This translates into barriers to

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41 Sistemas de Salud en Sudamérica: Paraguay, Desafíos Hacia la Integralidad y Equidad. MSPBS, 2011. Cómo y por cuánto reformar el mercado de trabajo de los RRHH en salud en el Paraguay. PAHO consultancy in Paraguay. Dr. Antonio Sánchez, 2011.

42 In all, 72 out of a total of 722 doctors. Presentation “Consolidación de la Atención Primaria de la Salud.” Dr. María Alicia Macedo. Director of Primary Care, MSPBS, Paraguay. October 2018.

43 Roster of doctors certified in family medicine, Sociedad de Medicina Familiar de Paraguay, available at: http://www.spmf.org.py/index.php/quienes-somos/resena-historica.

44 The diagnoses available from MSPBS information systems are from 2006-2008. http://portal.mspbs.gov.py/digies/publicaciones/documentaciones-del-sinais/

45 *Measure Evaluation, 2009.*

46 PAHO eHealth country profile, 2015.

47 The remaining population receives services from private providers (7%), police and military health services, and other entities. Permanent Household Survey, 2017.

access, greater inequality,[48] disparities in quality, and lack of continuity in patient care.

1.12 **Network of services based on PHC to face the challenge.** To improve the quality and continuity of care and increase efficiency, since 2015, Paraguay has been implementing a deep overhaul of the health system to structure Comprehensive, Integrated Health Services Networks (RIISS) based on PHC. Under the RIISS approach, services are managed and delivered in a way that ensures people receive a continuum of health promotion, disease prevention, diagnosis, treatment, disease management, rehabilitation, and palliative care according to their needs, throughout their life (WHO, 2015). This model assesses and stratifies the population according to social health risks and defines a portfolio of services based on the particularities of each region. International evidence shows that, by delivering services through integrated PHC with an emphasis on promoting health and resolving the majority of the morbidity burden at this level, hospitalizations can be avoided. Organizing services in primary care-based integrated networks increases efficiency in the use of resources and improves health outcomes by promoting the continuity of care.[49] In practice, implementation of the network approach in Paraguay is still rather limited, and there is no clear flow of care in each district-level network. This contributes to the quality issues described in paragraph 1.8.[50] The MSPBS transfers resources to Local Health Committees to manage local micronetworks; however, these resources are not linked to health outcomes and rarely support coordination between services at the three levels of care. The MSPBS is currently developing a new services organization manual and RIISS implementation plan to identify the specific needs of each region and meet current and future health care demands.

1.13 Paraguay has also been enhancing the quality of care by incorporating priority care lines into its services portfolio, since they have a greater impact on health indicators. By strengthening the RIISS, Paraguay aims to deliver the full array of services for a specific health condition or disease, including health promotion, disease prevention, timely detection and treatment, and rehabilitation. Currently, the main priority line is EONC,[51] in order to accelerate the reduction of the IMR and MMR. This is the only line of care with a standard in accordance with the new RIISS model based on PHC. The CNCD line is also being promoted, namely, the treatment of hypertension, diabetes, and prevalent cancers, such as cervical and breast cancer. The implementation of these lines requires close coordination among the different levels to ensure the continuity of care, development of care protocols, and establishment of triage centers and referral and counter-referral systems.

1.14 The Bank supports the MSPBS in the implementation of RIISSs through the Early Childhood Development Program (loan 2667/OC-PR), which is financing the integration of ECD care in the RIISS portfolio. This program emphasizes the timely

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48 For example, in the department of Caazapá, the IPS has 20 times more human resources relative to its assigned population, and 5.5 times more beds than the public health care services.

49 Health and Nutrition Sector Framework Document 2016, (document GN-2735-7), IDB.

50 For more information on the current state of the RIISS model in Paraguay, see optional link 3.

51 Set of services to which pregnant women, postpartum women, and newborns should have access, which are essential to save their lives and prevent long-term morbidity.

detection and treatment of developmental delays in children. It has also promoted the strengthening of PHC, which has involved rebuilding and equipping 81 USFs, hiring community agents, and training health teams as part of a strategy to implement the ECD care model. Additionally, the program is improving care in second-level hospitals by installing early intervention services and strengthening the Acosta Ñu specialized reference hospital. The program is being implemented in 10 health regions, focusing investments on Alto Paraná, Caazapá, Concepción, and San Pedro. These departments are where the MSPBS has established the base of operations to strengthen the RIISS, by activating micronetworks to boost the coordination and referral of services.[52] The basis for this progress was a pilot experiment in Alto Paraná executed by the MSPBS with technical cooperation financing from the Bank. The objective was to integrate the RIISS, prioritizing the EONC line with a focus on the quality of services and results-based financing.[53] This experiment supported the installation of the SIG in 10 departments to help manage the RIISS in the EONC and ECD lines of care. It will serve as a platform to add other lines of care and implement a national results-based financing model.[54]

1.15 To obtain quality and timely information for these strategies, the Bank is also supporting the digital transformation agenda by providing technical cooperation resources for a Strategic National Plan for Digital Health Care Transformation (PNETDS) based on the future state of the sector.[55] This plan will estimate the budget required to close gaps and will support the governance structure and present a single work plan to align the various external partners. As part of this process, the Bank will finance a diagnostic study on information and communication technology (ICT) in health care and the identification of critical inputs for the strategic plan. This will ensure that technology is aligned with the needs of the sector and regional best practices. The PNETDS will guide the financing of the health component envisaged in the Digital Agenda Support Program (loan 4650/OC-PR), which, among other activities, supports the development and installation of a health information system to streamline RIISS integration. To do this, partnerships will be sought with the Pan American Health Organization (PAHO) under its Information Systems for Health program (IS4H), which can assist the government in guiding its various donors (Taiwan and South Korea, the World Bank), thus optimizing resources and aligning efforts.

1.16 Despite the major reforms underway, the current system is not in conditions to face persistently high maternal and neonatal mortality or the growing prevalence of NCDs. A supply and demand study[56] on health services based on the current use of the public health system projected future demand and estimated that, by 2025, there would be a gap of 9.5 million medical appointments per year if the current

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52 This progress includes: (i) the implementation of the SIG of the RIISS/EONC/ECD, which helps manage care for women during pregnancy and children under 5 in the RIISSs; (ii) the localized RIISS/EONC/ECD proposal; (iii) the medium-term plan to implement the RIISS/EONC/ECD; and (iv) the proposal to set up RIISS management units.

53 RIISS with an emphasis on EONC in the north of the department of Alto Paraná (ATN/OC-14374-PR).

54 The EONC line seeks to ensure access to integrated services during pregnancy, delivery, and the postpartum and neonatal periods longitudinally from the home of a pregnant woman to the hospital or maternity ward.

55 Paraguay Digital Agenda Support Program (ATN/OC-16802-PR).

56 See optional link 5.

services structure were maintained. Given that the most frequent users of services are newborns and older adults, those populations would be the most affected if the system's production did not increase. In terms of diagnostic support services like laboratories and imaging, the study projected that, through 2025, there would be an unmet demand of 7.8 million exams per year. Under current conditions, an additional 84 laboratories would be needed to meet the future demand stemming from increased production at the first level of care.

1.17 Paraguay needs to develop its network of services using an activities planning model based on the production capacity of its health care system. Using care protocols or disease burden studies, this model should estimate the health needs of the user population according to the life cycle and type of intervention. Regarding human resources, Paraguay needs to implement comprehensive human development strategies, which include: (i) creating a health career system aimed at improving the availability and distribution of health personnel; and (ii) adapting profiles by reorienting training processes and redesigning recruitment, training, assessment, remuneration, and incentives methods based on the needs of the new services structures anticipated with the sector reform and installation of the RIISS model.

1.18 **Intervention strategy.** The proposed program aims to improve the health of the population by promoting the integration of RIISSs based on PHC, strengthening the resolution capacity of primary and hospital care, and improving support networks and the governance of the network. Priority will be given to mother and child health care, CNCDs (diabetes and hypertension, and cervical and breast cancer), and HIV/AIDS and tuberculosis, in order to reduce morbidity and mortality.

1.19 **Strengthening the care network.** For the PHC health promotion and disease prevention strategy to reach a larger number of people and produce improvements in quality and resolution capability, the program will help expand and repurpose first-level care USFs. To do this, it will increase their capacity by enhancing infrastructure, equipment, and training, as well as organization and management. The focus will be placed on training USF health care teams in EONC, cervical and breast cancer screening, and prevention and control for patients with diabetes and hypertension, as well as those diagnosed with HIV/AIDS and tuberculosis. To configure subnational networks, the program must also properly outfit reference hospitals, where most deliveries take place and where patients with serious acute or chronic decompensated conditions are seen. To this end, maternity wards, emergency rooms, laboratories, and operating rooms in four reference hospitals[57] will be improved and equipped. Furthermore, for these investments to help attain better health outcomes in the priority lines of care, the program will support the education and training of second- and third-level personnel. To ensure that the network operates in a complementary manner, an ongoing quality improvement strategy[58] will be implemented at all levels. The program will target the departments

[57] The MSPBS is currently expanding the nephrology services network to increase care for kidney diseases. Over the last five years, the capacity of these services rose 55%.

[58] This entails documenting and optimizing processes, defining standards and instruments to record and measure compliance, analyzing gaps and their causes, and proposing improvement plans. If any prioritized line of care does not have a standard or protocol, the MSPBS will be supported in designing or implementing one.

of Caazapá, San Pedro, Concepción, and Alto Paraná to build on the RIISS, EONC, and ECD development strategies initiated under loan 2667/OC-PR.[59] These departments present unfavorable poverty and health indicators, in addition to structural weaknesses in infrastructure, human resources, and equipment to cover essential health services. Caazapá and Concepción are the two departments with the country's highest extreme poverty and neonatal mortality rates. All departments selected exhibit equipment, infrastructure, and human resources gaps of greater than 50% to meet EONC demands. Alto Paraná and Caazapá also have large gaps in USF availability.

1.20 **Implementing RIISSs.** Beyond the improvement in services, health personnel must be able to transfer patients between the levels of care (PHC/hospitals) in an organized manner, or on an emergency basis, so they can receive timely care. To accomplish this, the program will strengthen the MSPBS's strategic capacity and management to ensure that services operate effectively under the integrated networks model. The program will help determine the portfolio of services per level of care and prepare and implement a subnational plan that includes guidelines to guarantee the continuity of care in prioritized departments. The MSPBS will also strengthen the network's governance through Local Health Committees and other subnational entities by establishing triage centers in micro-networks within prioritized departments. This will be done using a monitoring and oversight model that measures health outcomes, productivity, and the quality of care. In operational terms, network administrators will focus their work on optimizing care processes, standardizing clinical practices, and periodically measuring their compliance. They will also propose plans to address any deviations found, a key aspect of improving RIISS performance. To measure quality, the program will promote the national quality policy by implementing an ongoing quality improvement strategy for services in prioritized lines of care, as well as interventions to improve user safety and satisfaction.

1.21 **Digital health care transformation and human resources reform.** Network management will require the implementation of a new digital health ecosystem. Beyond enhancing technological infrastructure and governance, the MSPBS must have national regulations for the adoption of health care interoperability standards to share data between facilities and subsystems. The ministry also needs to define and expand the use of electronic clinical files to ensure the privacy and confidentiality of personal information.[60] Concerning the human resources policy, a reform is needed to meet the needs of PHC-based services networks and, thus, address the epidemiological transition that Paraguay is facing. The MSPBS is in the process of hiring health care professionals to complete USF teams and will hire additional staff as new units are inaugurated. In the realm of family medicine, the

[59] The World Bank is designing an operation to support the expansion of RIISSs with interventions that are complementary to this program in other departments of Paraguay. Its aim is to strengthen and expand the PHC model and enhance governance. The Bank will seek to generate synergies with this operation through the MSPBS to avoid duplication and maximize outcomes.

[60] To achieve efficient and quality services, ISO standard 14639-2: Capacity-based eHealth architecture road map, recommends a holistic approach comprising four components: governance, infrastructure, infostructure, and health processes. This is aligned with recommendations from PAHO's IS4H model and the Red Americana de Cooperación para la Salud Electrónica. It is also based on the critical elements in the IDB's maturity model for electronic health records. See optional link 7 for more information.

ministry has launched strategic training programs for specialists in family medicine, through which it aims to produce 1,200 new specialists within eight years. At the same time, Paraguay's Family Medicine Association has agreed on a unified residency program in family medicine to standardize training processes around a highly resolution-oriented skills profile. This will prioritize outpatient care and the prevention of the country's most prevalent diseases.[61] In this same line of developing human talent, the program should include a plan for initial and ongoing training to ensure compliance with clinical care guidelines and improve continuing education opportunities for health care professionals.

1.22 **Lessons learned and related operations.** The lessons learned and practical improvements from the Bank's portfolio of health operations have informed the design of this operation.[62] These include: (i) adopting a systematic approach for ongoing improvement in the quality of services to reduce maternal and infant mortality (Inter-American Development Bank (IDB), 2016a);[63] and (ii) planning health services on the basis of estimated demand and the projected demographic and epidemiological profile to optimize the services network and formulate infrastructure, human resources, and equipment investment plans.[64] The program builds on headway made by the Early Childhood Development Program (loan 2667/OC-PR) and integrates lessons learned, such as: (i) the importance of enhancing the overall operation of facilities before introducing new lines of care (integrated in Component 1, paragraph 1.27); (ii) elevating the leadership of the program to the minister and creating the RIISS/EONC/ECD Committee to strengthen governance and internal cooperation[65] (integrated in the execution plan, paragraph 3.2); (iii) prioritizing facilities with titles or land use permits to streamline execution, which is a criterion used to prioritize facilities under this program (see Environmental and Social Management Report); and (iv) supporting general environmental licensing for hospitals to streamline specific licensing for hospital infrastructure (activity supported by the Early Childhood Development Program and integrated in the mitigation of environmental risks, paragraph 2.3). The Alto Paraná pilot experiment has also brought about positive changes in maternal and infant indicators, but has shown that, to implement the model at a larger scale, the

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61 Unified Residency Program in Family Medicine. Sociedad Paraguaya de Medicina Familiar, 2018.

62 These lessons are described in the 2016 Health and Nutrition Sector Framework Document (document GN-2735-7) and referred to in the loan documents for the Integrated Health Program II (3608/OC-ES), the Program to Create Integrated Health Networks (4726/OC-PE), the Program to Strengthen the Institutional Healthcare Service Network (PRORISS) (4791/OC-GU), and the Project to Improve the Management and Quality of Maternal-Neonatal Health Services (4619/BL-HO), among others.

63 The Mesoamerican Health Initiative has considerably improved health indicators in eight countries through investment in the offering, use, and quality of mother and child health services, using results-based financing mechanisms. The performance of mother and child care was improved through the optimization of care processes, monitoring and evaluation of indicators, and technical assistance for health care teams.

64 The Bank has supported the formulation of health care network development plans using this methodology in Guatemala, Peru, Argentina, and Honduras.

65 Created by the MSPBS via Resolution S.G. 704/2018.

health care system must undergo structural reforms to adopt the RIISS based on PHC, which is precisely the objective of this loan.[66]

1.23 **Strategic alignment.** The proposed program is consistent with the Update to the Institutional Strategy 2010-2020 (document AB-3008) of the Bank and is strategically aligned with the development challenge of social inclusion and equality, through its contribution to the indicators "reduction of maternal and infant mortality" and the output "persons receiving health packages." The program is also aligned with the following crosscutting areas: (i) gender equality and diversity; and (ii) climate change and environmental sustainability, as it incorporates efficiency measures for USF infrastructure works. Out of the operation's proceeds, 7.98% will be invested in climate change mitigation activities, in accordance with the joint methodology of the multilateral development banks. These funds will contribute to the IDB Group's climate financing target. By seeking to reduce the MMR and increase the number of beneficiaries who receive health services, the program also contributes to the Corporate Results Framework 2016-2019 (document GN-2727-6). It is consistent with the IDB Health and Nutrition Sector Framework (document GN-2735-7), insofar as it helps enhance health infrastructure and technology, the organization and clinical and health management models of services networks, and governance. Lastly, the operation is aligned with the Bank's country strategy with Paraguay 2019-2023 (document GN-2958), especially the strategic area of human capital and living conditions and the expected outcome "improve the health of the population." This operation is included in the Update of the Annex III of the 2019 Operational Program Report (document GN-2948-2).

1.24 **Gender approach.** The program contributes to the abovementioned gender policy to the extent that it strengthens mother and child health care, especially the EONC line, by preparing and updating guidelines and protocols for each level of care, in addition to training second- and third-level health professionals. The cervical and breast cancer lines of care are also being prioritized, thus, positive impacts are expected in the prevention, early detection, and treatment of these types of tumors. For the other CNCDs (diabetes and hypertension) and infectious diseases (HIV/AIDS and tuberculosis), the program will support a protocol update with a rights, gender, and intercultural approach and differentiated care practices for men and women. The program will also finance the new national sexual and reproductive health survey (the last one is from 2008) to obtain more precise data on mother and child health and adolescent pregnancy and to guide a more efficient allocation of resources.

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66 The pilot showed that maternal and infant health outcomes in Paraguay can be improved through the introduction of new management processes, including network-based participatory planning at the subnational level; the reorganization of services; the implementation of a georeferenced information system, complemented by the acquisition of inputs and basic equipment; and a fund linked to performance-based incentives. That said, the country will have to overcome structural barriers to sustain and expand the experiment at the national level. This includes making headway in the adoption of a new PHC-based model, the deconcentration of resource management, and significant investment in human resources, infrastructure, and equipment to improve the resolution capacity of facilities, particularly the new RIISS typologies. "Sistematización del proyecto piloto para la implementación del modelo de redes integradas de servicios de salud (RIISS) con énfasis en cuidados obstétricos y neonatal en Alto Paraná." Centro de Información y Recursos para el Desarrollo (CIRD) 2017.

1.25 **Contribution to reducing climate change.** Lastly, the program is expected to contribute to a reduction in climate change and greater environmental sustainability. When repurposing USFs, building and equipping new units, and updating hospital infrastructure, efficient technologies should be adopted to promote a reduction in energy and water consumption.[67] The new units will be designed bearing in mind the climate conditions of the location where they will be built.

B. Objectives, components, and cost

1.26 **Objective.** The overall objective of the program is to help improve the health conditions of Paraguay's most vulnerable population by strengthening the RIISSs based on PHC. The specific objectives are to: (i) expand and strengthen the care network, and (ii) boost the quality of priority lines of care, including mother and child care; EONC, particularly diabetes, hypertension, and cancer; and HIV/AIDS and tuberculosis. The departments of Alto Paraná, Caazapá, Concepción, and San Pedro will be prioritized, as they have considerable deficits in PHC coverage and significant lags in health indicators.

1.27 **Component 1. Strengthening the RIISS care model based on PHC (IDB: US$37,100,500).** The objective of this component is to comprehensively expand and strengthen the health care network facilities so they can deliver timely and quality services. The following will be financed: (i) rehabilitation of 67 USFs, construction of 33 new USFs, and repurposing of 29 health stations to USFs; (ii) general biomedical and computer equipment for these USFs; (iii) infrastructure retrofit mainly of the Caazapá regional hospital and the Horqueta, San Estanislao, and General Aquino district hospitals, including emergency rooms, maternity wards, laboratories, operating rooms, and effluent treatment plants; (iv) general, biomedical, and computer equipment for the four hospitals; (v) construction and equipping of the MSPBS Clinical Simulation Center; and (vi) human resources training and education.

1.28 **Component 2. Support for improved management, the use of technology, and the promotion of health care innovation (IDB: US$5,739,500).** The objective of this component is to develop and strengthen the organization and governance of the MSPBS to ensure health outcomes, service quality, and network efficiency. The following activities will be supported: (i) implementation plan for health networks and micronetworks; (ii) triage centers and activities for the comprehensive establishment of networks and micronetworks in the four prioritized departments; (iii) design and implementation of protocols for regional management; (iv) studies and technical assistance to update the health care career and strengthen the human resources policy; (v) technical assistance to implement the digital health care transformation strategy, including the adoption of a health information system and modification of regulations for digital health; (vi) technical assistance for the implementation of the ongoing quality improvement strategy through the design and introduction of results-centered protocols and policy evaluation systems, and interventions focused on patient safety and user

[67] The minimum measures to be implemented will be: reflective paint for roofs and exterior walls, reflective roof tiles, polyurethane thermal insulation, double flush toilets, and aerators and water flow restrictors on faucets.

satisfaction. Micronetwork teams and first- and second-level service providers will develop skills to manage and implement the ongoing quality improvement strategy; (vii) the national sexual and reproductive health survey; and (viii) the communication strategy.

1.29 **Component 3. Management, monitoring, and evaluation (IDB: US$2,160,000).** The component will support the MSPBS in effective program execution through planning, management, and ongoing monitoring of outcomes. Financing will be provided to contract a technical management team, as well as to evaluate and audit the program.

C. Key results indicators

1.30 The selected impact indicators reflect the main morbidity and mortality conditions, especially mother and child health and CNCDs. Accordingly, the program will monitor the MMR, neonatal mortality rate, and premature mortality (30 to 70 years) due to diabetes mellitus and cerebrovascular diseases, separately for men and women. The purpose of measuring these indicators is to determine whether there is an improvement in the primary care network's ability to provide timely diagnoses and treatment for NCDs. In terms of outcomes,[68] the program will monitor the rates of prenatal check-ups initiated before week 20 of gestation, the percentage of avoidable hospitalizations, and the coverage of cervicovaginal cytology exams to detect cervical cancer.

1.31 **Economic viability.** The strategies promoted in this operation are based on evidence of the RIISS model's effectiveness. By applying evidence specific to Paraguay, the economic analysis quantifies the incremental benefits derived from the program's investments, which include: (i) savings in hospital spending from a reduction in avoidable admissions; (ii) gains in the population's productivity from improved health, as a result of the lower morbidity and mortality associated with the adopted care model; and (iii) gains in the health of the population from implementing the lines of care under the project. In the base scenario, with a conservative assumption of the effectiveness of the interventions over a six-year time frame (2019-2024), using a discount rate of 3%,[69] the cost-benefit ratio range is 1.23. In the more realistic scenario, the net present value of the program at a discount rate of 3% is US$10,140,267, and the internal rate of return for the same scenario is 43.6%.

II. Financing Structure and Main Risks

A. Financing instruments

2.1 The Bank's financing for this operation will be executed through a multiple works loan chargeable to the Ordinary Capital. The disbursement period will be six years based on the scale of the works and activities to be executed, as well as the environmental, social, and budgetary processes needed in Paraguay. This loan modality was selected because the operation involves physical works similar to,

[68] The selected impact indicators are nationally representative, while the outcome indicators correspond to the value added in the four departments prioritized by the program.

[69] The WHO recommends the use of a 3% rate for health projects. The same rate has been used in other health projects recently approved by the Bank, e.g., loans 4612/BL-BO and 4668/OC-JA.

but independent from, one another. Accordingly, a representative sample was built that covers the four departments targeted by the program and the different works to be executed (repurposing existing health units, building new units, and supplying equipment). See the representative sample of 30% of the works to be executed, with a breakdown of the specific projects in the sample. The period for the material start of works will be three years, as from the date the loan contract takes effect.

2.2 **Eligibility criteria and project prioritization.** For future projects to be included in the program during the execution phase, the following eligibility criteria will be considered: (i) health relevance; (ii) land suitable for building; (iii) legal viability of the land; and (iv) compliance with the Bank's environmental and social safeguards included in special execution condition (iv) of the ESMR (required link 3), excluding financing of Category "A" projects. If during program execution a project has a negative impact on indigenous territories and/or communities or natural habitats or calls for the resettlement/economic displacement of persons, it must be reviewed with the ESG specialist to determine its eligibility for the program.

Table 2.1. Estimated program costs (rounded to US$ millions)

Components	Total (IDB)	%
1. Strengthening the RIISS care model based on PHC	37,100,500	82.4
2. Support for improved management, the use of technology, and the promotion of health care innovation	5,739,500	12.8
Management, monitoring, and evaluation	2,160,000	4.8
Total	**45,000,000**	**100**

* The amounts in the cost table include local taxes, in keeping with Bank policies.

Table 2.2. Disbursement projection (US$ millions)

Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Total
1.3	4.1	16.9	12.2	10.4	0.1	45

B. Environmental and social risks

2.3 In accordance with the IDB Environment and Safeguards Compliance Policy (Operational Policy OP-703), this has been classified as a Category B operation, as the expected construction, improvement, and operation of health infrastructure entails risks and adverse social and environmental impacts identified as localized and temporary. The main ones identified for the construction phase are the possible elimination of vegetation cover, clearcutting, land clearing, increased levels of noise, gas emissions, particulate matter and dust, increased accident rate, visual impacts, disturbances to the landscape, soil structure changes, possible discovery of archaeological remnants, obstruction of traffic in public roads, and the contamination of soil and waterways. The operation phase is expected to generate hospital waste and wastewater and could potentially contaminate the ground or surface water due to leachate seepage or runoff. There is a potential biosafety risk caused by the presence of pathological waste. Odors, the pollution of waterways, and the proliferation of vector-borne diseases are also expected. During the works phase, conflicts with local residents could occur, especially if there is a disorderly influx of construction workers to the projects area. During both

the construction and operation phase, there are social risks resulting from the possible failure to obtain property rights for new construction sights. To mitigate these risks and impacts, the Environmental and Social Management Plan and Environmental and Social Management Framework define specific actions and plans for the sample projects and any future projects under the program.

2.4 Four public consultation events were held during program preparation—one for each targeted department. The comments received during those events referred primarily to the quality of health services and the quantity and quality of the human resources available at health centers. There were also suggestions to extend the hours of care and to install a mechanism for ongoing consultation and citizen engagement during project implementation. There was extensive participation by women at each of the events. The lists of attendees were documented and have been added as an annex to the environmental and social analysis. At the events, it was verified that the project had strong support among the population in the areas of intervention.

C. Fiduciary risks

2.5 The program's objectives and outputs could experience delays if: (i) the accounting and internal control areas are not strengthened in compliance with the Bank's financial management policies; and (ii) the necessary tools for financial management are not created, such as an effective accounting system and personnel with experience in execution and administrative processes. These risks would be mitigated through: (i) training workshops on the respective Bank policies and ongoing technical assistance from the Bank; and (ii) the implementation of a financial information system, Operating Regulations, and the program management unit (PMU) strengthening plan.

D. Other key issues and risks

2.6 A high development risk was identified due to the lack of availability of human resources for facilities built under the program. To mitigate this risk, in each budget year, the Government of Paraguay will take measures to secure the human resources that will be assigned to new units.[70] Another high risk identified, in this case, a public management and governance risk, is a potential delay in the National Congress passing the Ley de Préstamo [Loan Act]. As a mitigation measure, joint actions should be taken with the MSPBS to streamline passage. A medium development risk was also identified because of the possibility of changes in the health units to be targeted by the program. To mitigate this risk, the special conditions for execution (see Environmental and Social Management Report) will be supported in the stage prior to program eligibility. Lastly, a medium public management and governance risk was identified in light of the insufficient availability of professional staff in the MSPBS's technical departments to support program implementation. The expected mitigation measure is to strengthen staff in various key departments.

2.7 **Sustainability:** The analysis of sustainability in terms of the increase in health spending due to operating costs (personnel, medicines, and operations) in 33 new USFs shows that an additional US$176,000 per month will be needed starting in

[70] The program Operating Regulations will expand on this point.

the middle of year three, and US$187,000 per month starting in the middle of year four. The Government of Paraguay has pledged to ensure the sustainability of the new and existing works and equipment to be financed under this program, as reflected in the National Health Policy 2015-2030 which envisages the expansion of the USF network. It has also decided to hire additional staff to support the expansion of the public health network, as stated in Law 6258/2019.

III. Implementation and Management Plan

A. Summary of implementation arrangements

3.1 **Executing agency.** The borrower will be the Republic of Paraguay and the executing agency will be the MSPBS, which will implement the project through the creation of a PMU under the Cabinet of the Minister. The PMU will be responsible for the technical, administrative, and operational management of the program, which includes: (i) procuring works, goods, and services; (ii) requesting loan disbursements from the Bank (iii) making arrangements concerning external auditing; (iv) submitting work plans to the Bank—including the financial plan, procurement plan, and annual work plan; (v) submitting reports to the Bank (including audit and progress reports and evaluations) and other program documents; (vi) supporting the monitoring and oversight of works and services contracts; and (vii) acting as a liaison with the Bank.

3.2 The PMU will be composed, at a minimum, of a general coordinator and coordinator for each program component, as well as an infrastructure coordinator, procurement coordinator, administration and finance coordinator, and environmental specialist.[71] To support the PMU, a technical team will be contracted to work full time on the program, and its staff should have the technical profiles described in the program Operating Regulations. This team will support the preparation of technical specifications for the procurement of services and works, planning and scheduling of program activities, review of designs, technical and environmental supervision of works, procurement and financial control, social and environmental considerations, institutional relations, and monitoring and evaluation, among other things. The PMU is also expected to receive support, as necessary, from the line units within the organizational structure of the MSPBS and will coordinate closely with the RIISS/EONC/ECD Committee created to strengthen governance and internal coordination for leadership of the RIISS. During the period between the approval of this program by the Bank's Board of Executive Directors and the signing of the loan contract, the following will take place to the extent possible: (i) designation of the PMU team; and (ii) preparation of the final project designs that are not part of the sample of works to be performed.

3.3 **Special conditions precedent to the first disbursement of the financing: (i) approval by the MSPBS of the program Operating Regulations; and (ii) creation by the MSPBS of the PMU with the basic composition described in paragraph 3.2.** Both conditions are considered essential: the first, so that the executing agency has a detailed description of the specific processes and eligibility criteria for the program's works, as well as fiduciary, monitoring, and evaluation

[71] Support from a monitoring and planning specialist is also expected.

considerations; and the second, to ensure that the MSPBS possesses an effective team to manage the program.

3.4 **Procurement.** Works, goods, and services will be procured and consultants selected in accordance with the Policies for the Procurement of Goods and Works Financed by the Inter-American Development Bank (document GN-2349-9), and Policies for the Selection and Contracting of Consultants Financed by the Inter-American Development Bank (document GN-2350-9). The electronic reverse auction and competitive bidding subsystems of Paraguay's Public Sector Procurement System will be used for the operation in accordance with the Fiduciary Agreements and Requirements (Annex III). The procurement plan provides a breakdown of program procurements.

3.5 **Auditing.** During execution, the PMU will submit audited financial statements for the program on a yearly basis in accordance with the Bank's requirements. The program will require the selection of an independent audit firm deemed eligible by the Bank. The audited annual financial statements will be submitted 120 days after the close of the fiscal year, and the final financial statement, within 120 days following the date set for the last disbursement.

B. Summary of arrangements for monitoring results

3.6 The PMU will submit reports on a six-monthly basis on: (i) performance in achieving the objectives and outcomes agreed to in each annual work plan and in the program monitoring report, including risk analysis and monitoring, and mitigation measures; (ii) the status of execution and of the procurement plan; (iii) compliance with contractual clauses; and (iv) status of financial execution. Additionally, the report for the second half of each calendar year will include: (i) the annual work plan for the following year; (ii) the updated procurement plan; and (iii) when appropriate, expected actions to implement the recommendations of the audit. The PMU will also have an advisory service responsible for implementing the monitoring and evaluation plan, and the Results Matrix indicators will be monitored according to the information generated.

3.7 To evaluate the program, a simple difference method will be used, comparing the final outcome indicators in the Results Matrix before and after the operation, in the selected departments and the rest of the country. One of the objectives of this evaluation strategy is to strengthen information systems, so indicators will be reviewed on a six-monthly basis to obtain timely information for program monitoring. Information will also be collected on the implementation of lines of care in USFs to measures the outcomes of training programs and the adoption of care protocols for patient activation, continuity of care, and delivery of services according to clinical guidelines. This will be done by reviewing administrative records (databases) and will help document changes in quality indicators resulting from the implementation of the lines of care.

Development Effectiveness Matrix		
Summary PR-L1167		
I. Corporate and Country Priorities		
1. IDB Development Objectives	Yes	
Development Challenges & Cross-cutting Themes	-Social Inclusion and Equality -Gender Equality and Diversity -Climate Change and Environmental Sustainability	
Country Development Results Indicators	-Maternal mortality ratio (number of maternal deaths per 100,000 live births) -Beneficiaries receiving health services (#)* -Children receiving early childhood development services targeted to the poor (#)*	
2. Country Development Objectives	Yes	
Country Strategy Results Matrix	GN-2958	Improve the health of population
Country Program Results Matrix	GN-2948-2	The intervention is included in the 2019 Operational Program.
Relevance of this project to country development challenges (If not aligned to country strategy or country program)		
II. Development Outcomes - Evaluability		Evaluable
3. Evidence-based Assessment & Solution	10.0	
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	9.0	
4.1 Program has an ERR/NPV, or key outcomes identified for CEA	3.0	
4.2 Identified and Quantified Benefits and Costs	3.0	
4.3 Reasonable Assumptions	1.0	
4.4 Sensitivity Analysis	2.0	
4.5 Consistency with results matrix	0.0	
5. Monitoring and Evaluation	7.0	
5.1 Monitoring Mechanisms	2.5	
5.2 Evaluation Plan	4.5	
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		
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, Accounting and Reporting. Procurement: Information System, Price Comparison.
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:		
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		

Note: (*) Indicates contribution to the corresponding CRF's Country Development Results Indicator.

The Program to Strengthen the Integrated and Integral Health Services Networks (RIISS, by its Spanish acronym) Based on Primary Health Care (PHC) has the objective of contributing to the improvement of the health conditions of the most vulnerable populations of Paraguay through the strengthening of health service networks, based on primary care. The specific objectives of the program are (i) the expansion and strengthening of the healthcare network; (ii) improving the quality of care in priority care lines, including maternal and child health, noncommunicable chronic diseases, particularly diabetes and hypertension and cancer, and HIV / AIDS and tuberculosis. The departments of Alto Paraná, Caazapá, Concepción and San Pedro were prioritized based on deficits in PHC coverage and health lags.

The loan proposal presents a solid diagnosis, as well as evidence of the effectiveness of the interventions to be financed. The results matrix has a clear logic and includes SMART indicators at the level of impacts, outcomes and outputs. The impact indicators include maternal and neonatal mortality, as well as premature mortality due to diabetes mellitus, cerebrovascular diseases and the mortality rate due to ischemic heart disease, all disaggregated by gender. The outcome indicators reflect the reduction in avoidable hospitalizations and the increase in primary health coverage.

The economic analysis of the project includes a cost-benefit analysis assessing the effectiveness of the health coverage in Adjusted Life Years by Disability (DALYs). The cost-benefit analysis demonstrates the viability of the project under various scenarios.

The monitoring activities will be the responsibility of the Project Management Unit, which will present biannual progress reports. The monitoring and evaluation plan proposes: i) a pre-post measurement of the outcome indicators and ii) a quasi-experimental evaluation of the introduction of lines of care (for example in diabetes). The general risk of the program is medium and is mainly associated with the construction, improvement and operation of health infrastructure, as well as a high risk of availability of human resources for the establishments built by the program. Mitigation measures were identified for the main risks.

RESULTS MATRIX

Program objective:	Help improve the health conditions of Paraguay's most vulnerable population by strengthening the RIISSs based on primary health care.

EXPECTED IMPACT

Indicator	Unit of measure	Baseline	Baseline year	Final target 2025[1]	Means of verification	Comments
IMPACT #1						
Final impact indicators						
Maternal mortality ratio (MMR)	/100,000 live births	67.3	2017	52	MSPBS/Vital Statistics Information Subsystem (SSIEV). Basic health indicators/mortality indicators	Calculation: MMR = No. of maternal deaths in a given location and period / No. of live births in a given location and period *100,000
Neonatal mortality rate (NMR)	/1,000 live births	9	2017	7.6	MSPBS/SSIEV. Basic health/mortality indicators	Calculation: NMR = No. of deaths in children under 28 days in a given region / No. of live births recorded in the same location and period *1,000
Premature mortality rate due to diabetes mellitus - women	/100,000 inhabitants	44	2017	42	MSPBS/SSIEV. Basic health/mortality indicators	Calculation: mortality rate due to diabetes mellitus = No. of deaths from diabetes mellitus (E10-E14) in women ages 30 to 70 in a given location and period / population of women ages 30 to 70 in the same location and period *100,000 Pro-género gender monitoring
Premature mortality rate due to diabetes mellitus - men	/100,000 inhabitants	32.9	2017	30.9	MSPBS/SSIEV. Basic health/mortality indicators	Calculation: mortality rate due to diabetes mellitus = No. of deaths from diabetes mellitus (E10-E14) in men ages 30 to 70 in a given location and period / population of men ages 30 to 70 in the same location and period

[1] The expected targets were established on the basis of the recent historical trend and demographic projections and are an annual value.

Indicator	Unit of measure	Baseline	Baseline year	Final target 2025[1]	Means of verification	Comments
						*100,000 Pro-género gender monitoring
Premature mortality rate due to cerebrovascular diseases - women	/100,000 inhabitants	24.1	2017	22	MSPBS/SSIEV.	Calculation: mortality rate due to cerebrovascular diseases = No. of deaths due to cerebrovascular disease (I60-I69) among the female population in a given location and period / female population in the same location and period *100,000 Pro-género gender monitoring
Premature mortality rate due to cerebrovascular diseases - men	/100,000 inhabitants	33.9	2017	31.9	MSPBS/SSIEV.	Calculation: mortality rate due to cerebrovascular diseases = No. of deaths due to cerebrovascular disease (I60-I69) among the male population in a given location and period / male population in the same location and period *100,000 Pro-género gender monitoring
Mortality rate due to ischemic cardiopathology - women	/100,000 inhabitants	29	2017	27	MSPBS/SSIEV.	Calculation mortality rate due to ischemic cardiopathology = No. of deaths due to ischemic cardiopathology (I20 –I25) among the female population in a given location and period / female population in the same location and period *100,000 Pro-género gender monitoring
Mortality rate due to ischemic cardiopathology - men	/100,000 inhabitants	56.9	2017	54.9	MSPBS/SSIEV.	Calculation: mortality rate due to ischemic cardiopathology = No. of deaths due to ischemic cardiopathology (I20 –I25) among the male population in a given location and period / male population in the same location and period *100,000 Pro-género gender monitoring

EXPECTED OUTCOMES[2]

Indicators	Unit of measure	Average baseline of four health regions	Baseline year	Final target[3]	Means of verification	Comments[2]
Final impact indicators						
Hospitalization rate due to diabetes mellitus and associated complications	/10,000 inhabitants	19.6	2017	18	Hospital discharge system	Calculation: No. of hospitalizations due to diabetes mellitus in facilities in the four regions in the period / population in the same location and period (year) *10,000
Percentage of avoidable hospitalizations for women	%	11.2	2017	10.8	Hospital discharge system	Calculation: No. of avoidable hospitalizations for women / Total number of hospitalizations for women *1,000
Percentage of avoidable hospitalizations for men	%	16.1	2017	15.7	Hospital discharge system	Calculation: No. of avoidable hospitalizations for men / Total number of hospitalizations for men *1,000
Prenatal check-ups initiated before week 20 of pregnancy	%	5	2017	40	SAA/SIG information system	Calculation: No. of prenatal check-ups for new cases before week 20 / Total prenatal check-ups for new cases *100
Intermediate outcome indicators						
Beneficiaries receiving health services	# of people	647,403	2019	864,403	MSPBS Department of PHC monthly report on PHC/USF census	The targeted regions currently cover 647,403 persons surveyed; that is 39% of the 1,667,819 persons, according to the DGEEC. With installation of the 62 new USFs, 217,000 more people will be covered, increasing coverage by 13%, to 52%. This is a corporate indicator set forth in document GN-2727-6.
Women ages 25 to 64 who undergo a cervicovaginal cytology exam	%	23	2016	35	"Sistema Experto" for cervical cancer	Calculation: No. of cytology exams performed in the last 12 months /

[2] Expected outcomes at the level of health networks to be targeted (average of Concepción, San Pedro, Caazapá, and Alto Paraná).

[3] The expected targets were established on the basis of recent administrative data and MSPBS planning and are an annual value.

Indicators	Unit of measure	Average baseline of four health regions	Baseline year	Final target[3]	Means of verification	Comments[2]
					control and monthly reports.	Total number of women in the target population of (166,726)

OUTPUTS

Outputs	Unit of measure	Baseline	Baseline year	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Final target	Means of verification	Comments
Component 1: Strengthening the RIISS care model based on PHC												
O1. USFs targeted	USFs	0	2019	0	0	65	64	0	0	129	Works execution plan/final delivery of works	Includes rehabilitated, repurposed, or newly constructed USFs.
O2. Retrofitted hospitals	Hospitals	0	2019	0	0	0	0	0	4	4	Works execution plan/final delivery of works	
O3. USFs equipped	USFs	0	2019	0	0	65	64	0	0	129	Record of receipt of goods	
O4. Hospitals equipped	Hospitals	0	2019	0	0	0	0	0	4	4	Record of receipt of goods	
O5. MSPBS Clinical Simulation Center built and equipped	Centers	0	2019	0	0	0	1	0	0	1	Final delivery of works and record of receipt of goods	
O6. Human resources trained in maternal, fetal, and neonatal mortality surveillance	Professionals	0	2019	0	766	765	0	0	0	1,531	Certificates awarded	
Component 2. Support for improved management, the use of technology, and the promotion of health care innovation												
O7. Implementation plan for networks and micronetworks prepared	Plan designed	0	2019	0	1	0	0	0	0	1	Six-month progress report	
O8. Networks and micronetworks implemented in the four regions	Networks and micronetworks	0	2019	0	0	0	1	2	1	4	Six-month progress report	
O9. New regional management tools implemented	Management tools	0	2019	0	0	1	0	0	0	1	Resolution of approval	

Outputs	Unit of measure	Baseline	Baseline year	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Final target	Means of verification	Comments
O10. Health career studies implemented	Studies	0	2019	0	2	1	0	0	0	3	Final consultancy report	
O11. Health information system implemented	System implemented	0	2019	0	0	0	0	129	6	135	Health units with operating systems	129 USFs, six hospitals
O12. National rules and protocols for digital health approved	Rules approved	2	2019	0	1	1	0	0	0	4	Resolution of approval	Rules and protocols on Interoperability standards, electronic clinical history content, and privacy and confidentiality of personal health data
O13. National Policy on Quality Health Care implemented	Plan	0	2019	0	0	1	0	0	0	1	Plan approval	
O14. Communication campaign executed	Campaign	0	2019	0	1	0	0	0	0	1	Approval of campaign proposal	
O14. Sexual and reproductive health survey implemented	Survey	1	2008	0	0	1	0	0	0	2	Survey results published	Latest survey conducted in 2008

FIDUCIARY AGREEMENTS AND REQUIREMENTS

Country:	Paraguay
Name:	Program to Strengthen Comprehensive Integrated Health Services Networks Based on Primary Care
Project number:	PR-L1167
Executing agency:	Ministry of Public Health and Social Welfare (MSPBS)
Prepared by:	Fernando Glasman, Jorge Seigneur, and Jorge Luis González (Fiduciary Specialists)

I. EXECUTIVE SUMMARY

1.1 The institutional assessment for the program's fiduciary management was performed on the basis of: (i) the country's fiduciary context; (ii) the results of the fiduciary risk assessment and project risk management workshop; and (iii) the findings report of May 2019 on the application of the Institutional Capacity Assessment System (ICAS) to the executing agency (MSPBS). The Fiduciary Agreements applicable to the execution of the program have been prepared on the basis of that assessment.

II. THE COUNTRY'S FIDUCIARY CONTEXT

2.1 In general, the country's financial management systems have a medium level of development. Nonetheless, they need to be supplemented for execution of Bank-financed projects. Specific financial reports are produced using auxiliary accounting systems. The tools for financial control, such as the Integrated Financial Administration System (SIAF), the Accounting System (SICO), and other subsystems, allow executing agencies to manage transfers of payment to suppliers through the Central Bank of Paraguay under acceptable conditions. External control is currently being performed through independent audit firms.

2.2 With regard to the National Public Procurement System, efficiency and transparency have improved significantly in recent years, as a result of the creation of a governing body, the National Public Procurement Office (DNCP). This entity has enabled the implementation of a transactional platform for purchases via electronic procedures like electronic reverse auctions, as well as a system for suppliers and the Statistical Information System. Bank-financed operations have been employing the Public Procurement Information System and the country electronic reverse auction and competitive bidding subsystems for the amounts and categories established in the agreement for their use signed on 17 June 2014.

III. THE EXECUTING AGENCY'S FIDUCIARY CONTEXT

3.1 The executing agency will be the Ministry of Public Health and Social Welfare (MSPBS), which, through its project management unit (PMU) under the Cabinet of the Minister, will be responsible for overall coordination of program execution, programming, and monitoring. The PMU will ensure compliance with the conditions and targets established in the loan contract and act as the main point of contact between the IDB and the borrower throughout execution.

3.2 During program preparation, an institutional capacity assessment was performed on the MSPBS, which covered: programming and organizational capacity; execution capacity, including personnel, goods and services, and financial management systems; and control capacity. According to this assessment, the MSPBS has a PMU that is executing program PR-L1051. Nevertheless, it is considered timely to request Sub-UAF (Financial Sub-unit) and Sub-UOC (Operational Procurement Sub-unit) autonomy from the Ministry of Finance.[1] The consolidated findings on the MSPBS's capacities indicate a medium risk level.

IV. FIDUCIARY RISK EVALUATION AND MITIGATION ACTIONS

4.1 Based on the abovementioned assessments of the MSPBS, the focus should be on the following opportunities for improvement:

- A financial and accounting information system should be implemented to record transactions and report information required by the IDB;
- Profiles should be designed and developed for PMU positions and program Operating Regulations;
- Accounting and internal control should be strengthened to ensure compliance with the Bank's financial management policies.

4.2 **Procurement management.** According to the ICAS evaluation report from May 2019, the PMU presents a satisfactory level of development and a low risk level.

4.3 **Financial management.** Basic functions should be established in the PMU to mitigate the risk of any overlap. A financial information and accounting system should also be acquired to: (i) generate reliable financial information for the preparation of financial statements and other reports; and (ii) provide details for the identification of procured goods and services.

V. CONSIDERATIONS FOR THE SPECIAL PROVISIONS OF CONTRACTS

5.1 The agreements and requirements to be included in the Special Conditions are as follows:

(i) The program's annual financial statements will be submitted 120 days after the close of the fiscal year. The audit firm must have been deemed eligible by the Bank to prepare audit reports.

[1] Obtain autonomous status to perform procurement and financial processes.

VI. Fiduciary Agreements and Requirements for Procurement Execution

6.1 The procurement policies to be applied are those set forth in documents GN-2349-9 and GN-2350-9. In addition, the Bank's Board of Executive Directors has approved the use of the electronic reverse auction and competitive bidding subsystems (document GN-2538-11) of Paraguay's Public Procurement System (Law 2051/03). Use of other country systems approved subsequent to approval of this program will be applicable automatically, and this will be indicated in the procurement plan.

A. Procurement execution

6.2 **Procurement of works, goods, and nonconsulting services.** Contracts for works, goods, and nonconsulting services[2] subject to international competitive bidding (ICB) will be procured using the Bank's standard bidding documents. Bidding processes subject to national competitive bidding (NCB) will be conducted using the national bidding documents agreed upon with the Bank. The program's sector specialist will be responsible for reviewing the technical specifications for procurement. Initially, no selection processes involving single-source selection are planned.

6.3 **Selection and contracting of consultants.** Consulting services contracts under the program will be procured using the standard request for proposals issued by or agreed upon with the Bank. The program's sector specialist will be responsible for reviewing the terms of reference for the procurement of consulting services.

(i) **Selection of individual consultants.** Pursuant to the Bank's procurement policies set forth in document GN-2350-9.

(ii) **Training.** Procurement workshops will be held.

(iii) **Use of country systems.** Pursuant to document GN-2358-11 of October 2013, the use of the electronic reverse auction and competitive bidding subsystems of Paraguay's Public Sector Procurement System (SCSP) in IDB-financed operations will apply to:

a. All contracts for goods and nonconsulting services eligible for use of the electronic reverse auction under the SCSP, for amounts below the threshold set by the Bank for use of the shopping method for off-the-shelf goods (for reference, US$250,000).

b. All works contracts for amounts below the threshold set by the Bank for use of the shopping method for complex works (for reference, US$250,000), and contracts for goods and nonconsulting services up to the threshold set by the Bank for use of the shopping method for complex goods and services (for reference, US$50,000).

c. Contracts for amounts equal to or above the aforementioned thresholds will be governed by Bank policies (document GN-2349-9).

[2] Policies for the Procurement of Goods and Works Financed by the IDB (document GN-2349-9), paragraph 1.1: Nonconsulting services are treated as goods.

6.4 Section 1 of the Bank's policies (document GN-2349-9) will remain applicable to all contracts, regardless of the amount or procurement method. Any system or subsystem subsequently approved will be applicable to the operation. The procurement plan for the operation and its updates will indicate which contracts are to be executed using the approved country systems.[3]

6.5 **Domestic preference.** None planned under this operation.

Table 6.1. Thresholds for International Bidding and International Shortlist (US$)

Method	ICB for works	ICB for goods and nonconsulting services	International shortlist for consulting services
Threshold	3,000,000	250,000	200,000

Table 6.2. Amounts per procurement type

Total: Works	23,566,905
Total: Goods	10,333,707
Total: Nonconsulting services	265,940
Total: Consulting firms	5,256,048
Total: Individual consultants	3,775,300
Total: Training programs	602,100
Total: procurement plan	**43,800,000**

6.6 **Procurement supervision.** All procurement processes governed by the Bank's procurement policies (documents GN-2349-9 and GN-2350-9) will be subject to ex ante review by the Bank, bearing in mind the position of the Ministry of Finance on the matter. All procurement processes under the SCSP electronic reverse auction and competitive bidding subsystems (document GN-2538-11) will be supervised using the country system.[4]

6.7 **Special provisions.** No special provisions are anticipated apart from those indicated in paragraph 5.1 of this annex.

6.8 **Records and files.** The program's reports will be prepared and filed using the systems, formats, and procedures specified by, or agreed upon with, the Bank.

VII. FIDUCIARY AGREEMENTS AND REQUIREMENTS FOR FINANCIAL EXECUTION

B. Financial management

7.1 **Programming and budget**

(i) Coordination of program execution will be centralized in the MSPBS PMU, which will work with the Office of Administration and Finance (DGAF). The PMU will receive support from all other MSPBS departments and offices, as necessary.

[3] If the Bank validates another system or subsystem, it will be applicable to the operation in accordance with the terms of the loan contract.

[4] Depending on the scope of use of the system, supervision may be supplemented with program audits, in which case mention must be made in this annex.

DOCUMENT OF THE INTER-AMERICAN DEVELOPMENT BANK

PROPOSED RESOLUTION DE-___/19

Paraguay. Loan ____/OC-PR to the Republic of Paraguay. Program to Strengthen Comprehensive, Integrated Health Services Networks Based on Primary Care

The Board of Executive Directors

RESOLVES:

That the President of the Bank, or such representative as he shall designate, is authorized, in the name and on behalf of the Bank, to enter into such contract or contracts as may be necessary with the Republic of Paraguay, as Borrower, for the purpose of granting it a financing aimed at cooperating in the execution of the Program to Strengthen Comprehensive, Integrated Health Services Networks Based on Primary Care. Such financing will be in the amount of up to US$45,000,000, 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 __ _____ 2019)

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Pipeline: PR-L1167

(ii) Budget programming, administration, and execution, under the zero-based budgeting system, will be the responsibility of the MSPBS.

7.2 **Accounting and information systems.** The country primarily employs modified cash basis accounting; however, accountability reporting for IDB-financed projects operates on a cash basis.

7.3 **Information systems.** The PMU will have access to the SIAF through the DGAF. Country systems do not issue the reports required by the Bank, as they are prepared using different systems, so the PMU will be responsible for that additional task.

7.4 **Disbursement and cash flow.** Program disbursement will normally be made through advances of funds, corroborated by the monthly submission of a detailed financial plan covering a six-month period, and another long-term plan, making it possible to determine the program's actual needs, as reflected in the multiyear execution plan, the annual work plan, and the procurement plan. The second and subsequent disbursements will require justification of at least 80% of the advance granted.

7.5 **Exchange rate.** The exchange rate agreed upon with the executing agency for accountability reporting will be the monetization rate, unless the Ministry of Finance, in its capacity as the borrower, decides otherwise during the loan negotiation.

7.6 **Internal control and internal audit.** The ICAS finds that, while the MSPBS is in the process of developing the Standard Internal Control Model for Public Entities (MECIP), there are certain aspects of internal control that require improvement. These are covered by the institutional strengthening plan.

7.7 It should be noted that the plan for the internal audit of the MSPBS does not include Bank-financed projects.

7.8 **External control and reports.** The executing agency will file annual reports on program audits, which are to be performed by a Bank-accepted independent audit entity, pursuant to the previously approved terms of reference. Financial statements for the program will include cash flow statements, a statement of cumulative investments, and the notes to said financial statements. Audit reports will also include an evaluation of the internal control system.

7.9 **Financial supervision plan.** Financial supervision may be adjusted depending on the status of program execution and the findings of audit reports, and will be performed in three ways:

Table 7.1. Financial supervision plan

Nature/scope	Frequency
Financial audit and submission of financial statements	Annually
Review of disbursement requests and attached reports	2 to 3 times per year
Inspection visit / analysis of internal controls and control environment in the executing agency.	Annually

7.10 **Execution mechanism.** The MSPBS PMU, in coordination with the DGAF, will be responsible for: (i) coordinating all program-related activities; (ii) preparing financial progress reports; (iii) submitting no objection and loan disbursement requests, and maintaining accounting records, which will be the source of information for such

requests and any financial report; (iv) implementing and maintaining a financial system solely for the program to ensure the appropriate use of resources, as well as maintaining the transaction documentation file; and (v) preparing and updating the required reports prior to their submission to the IDB. The PMU will be responsible for timely compliance with the clauses and agreements of the loan contract, and with program-related activities.

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The Board of Executive Directors

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