

DOCUMENT OF THE INTER-AMERICAN DEVELOPMENT BANK

PANAMA

INTEGRATED HEALTH SERVICE NETWORKS STRENGTHENING PROGRAM

(PN-L1115)

LOAN PROPOSAL

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ABBREVIATIONS

AIN-C	Atención Integral de la Niñez en la Comunidad [Comprehensive Community-level Care Program for Children]
APLAFA	Asociación Panameña para la Planeamiento de la Familia [Panamanian Family Planning Association]
BCU	Basic care unit
BMI	Body mass index
BPCH	Basic prenatal clinical history
CGR	Contraloría General de la República [Office of the Comptroller General]
CONE	Cuidados obstétricos y neonatales esenciales [essential obstetric and neonatal care]
DALY	Disability-adjusted life years
DC	Direct contracting
EFC-APS	Estrategia de Fortalecimiento de Coberturas de Atención Primaria en Salud [Strategy to Strengthen Primary Care Coverage]
ESMR	Environmental and Social Management Report
GDP	Gross domestic product
ICB	International competitive bidding
ICGES	Instituto Conmemorativo Gorgas de Estudios de Salud [Gorgas Commemorative Health Studies Institute]
INEC	Instituto Nacional de Censo y Estadística [National Statistics and Censuses Bureau]
ISTMO	Integración y Soluciones Tecnológicas del Modelo de Gestión Operativa [Integration and Technological Solutions of the Operations Management Model]
MEF	Ministry of Economic Affairs and Finance
MINSA	Ministry of Health
MINSA-CAPSI	Centros de atención primaria en salud innovadores [Innovative primary health care centers]
NCB	National competitive bidding
PACO	Programa de Apoyos Comunitarios a la Salud Materno Infantil [Community Support Program for Mother and Child Health]
PCC	Prenatal control card
QCBS	Quality- and cost-based selection
SIAFPA	Sistema Integrado de Administración Financiera de Panamá [Integrated Financial Information System of Panama]
SEIS	Sistema Electrónico de Información de Salud [Electronic Health Information System]
SIES	Sistema de Información Estadística de Salud [Health Statistics Information System]
SIREGES	Sistema de Registros Estadísticos de Salud [Health Statistics Reporting System]
SM2015	Salud Mesoamérica Initiative
UGSAF	Unidad de Gestión en Salud, Administrativa y Financiera [Administrative and Financial Health Management Unit]
WHO	World Health Organization

PROJECT SUMMARY

PANAMA INTEGRATED HEALTH SERVICE NETWORKS STRENGTHENING PROGRAM (PN-L1115)

Financial Terms and Conditions				
Borrower: Republic of Panama			Flexible Financing Facility ^(a)	
			Amortization period:	20 years
Executing agency: Ministry of Health (MINSa)			Original weighted average life:	12.75 years
			Disbursement period:	5 years
Source	Amount	%	Grace period:	5.5 years
IDB (OC):	US\$140 million	80	Inspection and supervision fee:	^(b)
Local:	US\$34 million	20	Interest rate:	LIBOR-based
			Credit fee:	^(b)
Total:	US\$174 million	100	Approval currency:	U.S. dollars from the Ordinary Capital (OC)
Project at a Glance				
Project objective/description: The objective is to improve the health and nutritional status of the population living in poverty and extreme poverty and to help reduce maternal and infant mortality and noncommunicable diseases through better coverage and quality of health care services.				
Special contractual conditions precedent to the first disbursement of the loan: (i) Delivery by the borrower, to the Bank's satisfaction, of evidence to the effect that (a) the operating manual for the program has been approved and placed into effect; and (b) the operating regulations for provision of the health services have been approved and placed into effect (see paragraph 3.3); and (ii) the external technical auditor for the program has been contracted (see paragraph 3.10).				
Special contractual conditions for execution: (i) the borrower will deliver, to the Bank's satisfaction, within 90 days after the end of each six-month calendar period, the external technical auditor's report determining that the coverage, performance, and satisfaction indicators were met and that no prohibited practices were detected (see paragraph 3.10); and (ii) prior to calling for bids to build or rehabilitate each of the health infrastructure works, evidence will be submitted to the Bank of legal ownership of the land where the work will be built and of fulfillment of the other conditions established in the Environmental and Social Management Report (ESMR) (see paragraph 2.2).				
Exceptions to Bank policies: None				
Project qualifies as: ^(c) SV <input checked="" type="checkbox"/> PE <input checked="" type="checkbox"/> CC <input type="checkbox"/> CI <input type="checkbox"/>				

^(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 and interest rate conversions. The Bank will take operational and risk management considerations into account when reviewing such requests.

^(b) The credit fee and inspection and supervision fee will be established periodically by the Board of Executive Directors as part of its review of the Bank's lending charges, in accordance with the corresponding policies.

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

I. PROJECT DESCRIPTION AND RESULTS MONITORING

A. Background, problem addressed, and rationale

1. Socioeconomic inequalities and the impact on health and nutrition

- 1.1 **Panama is experiencing high economic growth¹ coupled with high levels of per capita income inequality.** Although the Gini income distribution coefficient fell by five points between 2002 and 2012, (from 0.56 to 0.51), inequality continues to be very high. There are wide gaps between urban areas on the one hand and remote rural areas and indigenous territories, or *comarcas*, on the other.² In rural areas, poverty and extreme poverty rates were 49.7% and 26.3% in 2014, compared with 13.8% and 3.3% in urban ones.³
- 1.2 **At the same time, Panama is undergoing an epidemiological and demographic transition.** The prevalence of malnutrition and infectious, maternal, and perinatal diseases is falling while there has been an increase in chronic degenerative diseases, partly owing to the aging of the population⁴ and to unhealthy life styles. Figures for 2013 from the Global Burden of Disease Study indicate that noncommunicable diseases accounted for 75% of all deaths in Panama; infectious, maternal, neonatal, and nutritional diseases for 13%; and accidents and injuries for 12%.⁵ Looking at noncommunicable diseases by group, between 2002 and 2013, the mortality rate from cancer rose from 65.7 to 79.8 for every 100,000 population. The increase in the prevalence of chronic diseases poses a major challenge to the health sector, which calls for better delivery of services and development of proposals that take epidemiological risk factors into account.
- 1.3 **But the epidemiological transition is not happening evenly throughout the country.** The burden of maternal and perinatal diseases, malnutrition, and communicable diseases still plays a large role in mortality in remote rural areas and indigenous *comarcas*. Panama reports high rates of maternal and infant mortality and an increase in the prevalence of chronic malnutrition.
- 1.4 Between 1990 and 2013, the maternal mortality rate rose from 53.4 to 55.6 deaths per 100,000 live births. On the Ngäbe Buglé indigenous *comarca*, maternal mortality is 248 deaths per 100,000 live births, or five times higher than the national rate in 2013.⁶
- 1.5 Efforts to reduce infant mortality have only been partly successful, and the country was unable to achieve the Millennium Development Goal of 6.3 deaths per 1,000 live births. Between 1990 and 2013, the infant mortality rate fell from

¹ GDP grew by 7.8% on average between 2007 and 2013. The figure for Latin America and the Caribbean was 3.1%.

² Five indigenous territories, or *comarcas*, exist, three of which are provinces: Guna Yala, Emberá Wounaan, and Ngäbe Buglé.

³ Ministry of Economic Affairs and Finance (MEF), 2014.

⁴ In 2000, 8.6% of the population was over 60 years of age, whereas in 2013 the figure was 10.4%. National Statistics and Censuses Bureau (INEC).

⁵ Global Burden of Disease Study, 2013. Institute for Health Metrics and Evaluation, University of Washington, 2013.

⁶ MINSA, 2015.

18.9 to 16.0 deaths per 1,000 live births, while the figure for the Guna Yala comarca was 31.5 deaths per 1,000 live births.⁷ These gaps can largely be explained by inequalities in access to basic public health services and to insufficient use of the services and their poor quality.

- 1.6 As for the nutritional status of women and children, Panama is transitioning from a situation marked by malnutrition (chronic child malnutrition and micronutrient deficiencies) to a scenario in which these deficiencies exist alongside problems of overweight and obesity. The transition is most striking in the indigenous comarcas. Women are suffering from an epidemic of overweight and obesity, for a combined prevalence of 64.6% in 2010.⁸ The main problem among children under five is chronic malnutrition, which affects 56% in this age group in the indigenous comarcas, or triple the national rate. At the same time, there are signs that overweight and obesity among children under five is already a national public health problem.
- 1.7 **The way in which health service delivery is currently organized produces an inefficient use of resources and lack of continuity of care.** Health services in the country are provided by the public and private sectors. The first covers nearly 90% of the population, while private care covers about 5%. The public sector institutions consist of the Ministry of Health (MINSA) and the Caja de Seguro Social [Social Security Fund], which serve 60% and 40% of public sector users, respectively. MINSA is the lead agency in the health system, provides services for people who do not have social security, and supplies its users with medications and inputs. At present, MINSA has 12 regional health offices and serves poor and extremely poor groups and people living in remote areas.⁹ The three levels of care are: (i) primary, with resources organized to deal with basic needs and/or the most frequent health problems, which include health posts, subcenters, and centers, in addition to external providers¹⁰ contracted by MINSA that offer mobile services for remote areas; (ii) secondary, which includes polyclinics, polycenters, MINSA-CAPSIs,¹¹ and rural and regional hospitals; and (iii) tertiary, consisting of national hospitals offering highly complex care and treatment capabilities. At the primary care level, MINSA's fixed facilities encounter major difficulties in planning and monitoring services and in the timely procurement of inputs and contracting of medical staff.¹² The external providers need to work in coordination with MINSA facilities since they must serve the same population, depending on their treatment capabilities. This leads to inefficiencies in diagnosis, referrals, and the continuity of care for patients with limited access to health services.

⁷ INEC, Vital Statistics.

⁸ Subnational sample, MINSA.

⁹ Areas are classified as remote if it takes one hour or more to reach a health care facility in MINSA's fixed network (staffed by at least one physician and one nurse from Monday to Friday for eight hours per day).

¹⁰ The external providers are autonomous social organizations, legally eligible to be contracted by MINSA to provide health care services.

¹¹ The MINSA-CAPSIs (innovative primary health care centers) are MINSA primary care facilities that are able to treat higher levels of complexity.

¹² Medical inputs can take from 9 to 12 months to procure. It can take up to nine months to hire health care staff. Execution reports 2563/OC-PN.

2. Progress and recent response by the Panamanian government to expand the coverage and enhance the equity of health care services

- 1.8 In response to these inequalities in access to health care services and with the goal of improving coverage and quality, implementation of the Strategy to Strengthen Primary Care Coverage (EFC-APS) has been under way since its launch in 2013. The strategy provides a prioritized portfolio of services for prevention, promotion, and treatment, with an emphasis on an educational communication component to change patterns in child feeding, known as the Comprehensive Community-level Care Program for Children (AIN-C). The prioritized portfolio of services is provided through: (i) contracts between external providers and MINSA to serve remote communities, which constitute the mobile network;¹³ and (ii) management contracts between MINSA and its regional health offices, which use its facilities, constituting the fixed network. The EFC-APS has a [financing model that combines capitation¹⁴ and performance-based payments¹⁵](#) for care providers. The model has gradually created incentives that have translated into better efficiency in service delivery.¹⁶
- 1.9 The IDB has been supporting the EFC-APS through the Health Equity Improvement and Services Strengthening Program (loan 2563/OC-PN) and the SM2015 Initiative (grant GRT/GE-13116). Loan 2563/OC-PN, which focuses on remote communities and indigenous comarcas, is more than 75% disbursed. Program achievements include: (i) expansion of coverage to a total of 352,000 Panamanians, including 78,000 Afrodescendants, or 88% more than in 2012; (ii) improved service quality through the transformation and accreditation of health posts and subcenters and the rehabilitation of 10 centers; (iii) introduction of performance-based payments in the fixed network; (iv) design and launch at MINSA of a strategy for integrating interventions and resources for family planning, obstetric care during the perinatal and postpartum periods, neonatal care, and child health and nutrition.
- 1.10 **In a short time, the EFC-APS has demonstrated the advantages of a performance-based management model.** With the introduction of performance-based payments, some initial efforts have been made to start integrating the services offered by the fixed and mobile networks. Through the basic care units, it has been possible to guarantee services for a reference population, with local management, giving consideration to the distance between where the population lives and the health center.

¹³ Grouped into population groups.

¹⁴ Defined as the amount required to guarantee delivery of the prioritized portfolio of services for each individual, which corresponds to a calculation of the average unit cost of the portfolio per beneficiary per year.

¹⁵ Defined on the basis of: (i) coverage goals: number of communities visited, population protected, population served, and the number of days of care; and (ii) fulfilment of the performance and quality indicators for the services.

¹⁶ Performance-based payments can be effective in increasing the production of services such as immunizations, prenatal care, institutional births, and early cancer detection (Eichler 2009, Rusa 2009, Fairbrother 1999). They can be an instrument for achieving greater equity insofar as incentives are provided to care for the most vulnerable groups. Examples are Plan Nacer in Argentina (Cortez and Romero, 2013) and the SM2015 Initiative. Health and Nutrition Sector Framework Document, IDB, November 2013.

- 1.11 Since implementation, the beneficiary population has seen: (i) an increase from 62% to 67% in the percentage of pregnant women detected who by the end of the third trimester of their pregnancies had received at least three prenatal checkups; (ii) an increase of 10 percentage points in the number of deliveries attended by trained personnel; (iii) twice the number of hypertensive patients who received treatment according to protocol; and (iv) an increase from 21% to 52% in the number of diabetic patients treated according to protocol.
- 1.12 Although the fixed and mobile networks have been able to increase service coverage, the mobile network operated by external providers has achieved better indicators for coverage and performance because it has more flexibility in hiring personnel and procuring inputs and equipment. In 2014, the mobile network achieved 90.75% of the value of its contracts for compliance with coverage and performance indicators. The fixed network achieved 36% of the value of the management agreements for compliance with coverage and performance indicators in the same year. However, the figure was higher than for 2013 (24%), which indicates that the fixed network is gaining a better understanding of the new implementation mechanism and improving its dissemination and use of it.
- 1.13 As part of the supported offered through Bank loan 2563/OC-PN and the SM2015 Initiative for the EFC-APS, complementary interventions are also being developed to reduce maternal and infant mortality, and they cover the entire life cycle: preconception, family planning and contraception, pregnancy, birth, and the postpartum period, and neonatal and child health. MINSA has made progress in designing and approving the following interventions and is in the initial stages of implementing them:
- a. Essential Obstetric and Neonatal Care (CONE) is configured as an operational intervention that has proven to be highly effective, organizing the delivery of the portfolio of services at the three levels of care, with complexity and treatment capabilities increasing from the community to the hospital level.
 - b. The family planning and contraception counselling model and the behavioral change model, both of which take an intercultural approach, have been designed and approved to increase the understanding of and demand for family planning and mother and child health services.
 - c. To increase early and ongoing care during pregnancy, institutional birth, and the postpartum period, the Community Support Program for Mother and Child Health (PACO) was designed. Women will receive financial support so they can travel and use the prenatal, birth, and postpartum services without transportation costs being a limiting factor in their access to them.¹⁷
 - d. The following steps were taken to improve nutritional status: (i) the guidelines for comprehensive health care for children up to the age of nine were updated to include measures for caring for sick children, and the composition of fortified food supplements for children from 6 to 24 months was adjusted, particularly the micronutrient content; (ii) the education communication

¹⁷ The impact of payments to patients to encourage the use of institutional childbirth has been documented in Bangladesh (Nguyen et al., 2012), and demand for preventive and mother and child services has been documented in Mexico (urban areas) and in Honduras (Glassman et al., 2009). Health and Nutrition Sector Framework Document, IDB, 2014.

strategy for changing child feeding behavior under the AIN-C was upgraded to reflect best international practices, with the inclusion of concrete educational actions on specific behavior by health care staff in the institutional platform; and (iii) a comparative study was conducted on the acceptability of and compliance with a regime to administer powdered micronutrients to children between 6 and 24 months, in order to evaluate whether this product should be introduced to replace iron in solution.

- 1.14 These interventions, of proven cost-effectiveness, are significant improvements in mother and infant care and constitute part of the wager that the country is making to reduce maternal and infant mortality. The main challenge is to consolidate and build them into the institutional structure to guarantee their sustainability.

3. Public health challenges. Closing gaps in coverage, improving quality, and integrating services

- 1.15 **Despite the progress made, gaps persist in the coverage of primary preventive care and emergency services for poor remote communities.** In the Guna Yala and Emberá Wounaan indigenous comarcas, just 39% of women went to four or more prenatal checkups by a doctor or nurse and just 10.8% of newborns were checked by qualified staff within 48 hours after birth. As for the triple vaccine (measles, mumps, rubella), the survey reports a coverage rate of 69% among children between 12 and 23 months.¹⁸
- 1.16 **Integration of services at the primary and secondary levels needs to be consolidated.** At the local level, the primary care offered by providers in the fixed and mobile networks is fragmented, so action is needed to consolidate: (i) the linkage and integration of the intervention strategies at the different levels of care; (ii) mechanisms for coordinating the delivery of services by the providers; (iii) training for health care providers at the local level in planning interventions and serving populations with more limited access; (iv) the application of effective tools for monitoring the results obtained by providers in the system.
- 1.17 Progress in integration is important for making gains in the efficiency of the system by explicitly organizing the integration of the services network¹⁹ to limit duplication of tasks, encourage interaction between actors and levels, and guarantee patient follow-up in the diagnostic, prevention, and treatment stages. Some countries have obtained good results in integration by building a network of community agents that is coordinated with the health care network. These efforts should be complemented by better use of existing human resources and the establishment of multidisciplinary teams that take a preventive approach.²⁰
- 1.18 **Problems persist in the availability of equipment, inputs, and personnel at the primary level.** Health care facilities in remote rural areas and comarcas exhibit deficiencies in infrastructure that compromise the continuity and quality of

¹⁸ Baseline, SM2015 Initiative, Panama, 2013.

¹⁹ The approach of integrated networks ensures better and ready access to quality services and facilitates continuity of care across various providers and levels (Kringos et al., 2010; Schoen et al., 2010; WHO, 2008; Starfield et al., 2005; Macinko et al., 2003).

²⁰ Countries such as Brazil, Chile, Nicaragua, and Ecuador have made efforts to train and contract professionals organized into multidisciplinary teams, usually associated with family and community medicine programs (Talbot et al., 2009).

services. According to an assessment conducted in 2015 by the IDB and MINSA,²¹ some of the most common problems include the absence of potable water systems, basic sanitation, electricity, and crumbling walls, floors, and ceilings. Since most of this infrastructure is as much as 50 years old, the spaces are inadequate in size, design, and distribution for medical purposes and impede the efficient flow of activities. Most facilities do not comply with the minimum biosecurity requirements, since they do not provide for the proper disposal of solid and hospital waste. Furthermore, 40% of the health care facilities that provide birthing services do not have doctors or nurses available around the clock.

- 1.19 **It is crucial to move ahead with interventions to reduce sociocultural barriers to access and address limited information and lack of knowledge about health issues.** Maternal and neonatal health outcomes are influenced by sociocultural, economic, and geographic barriers to access to services. A study of social networks conducted on the Guna Yala and Emberá Wounaan comarcas found that the families of pregnant women have a decisive influence on decisions to seek medical care during pregnancy and childbirth.²² As well, women and their families have a low perception of risk during pregnancy. Women recognize danger signs but fail to associate them with the decision to seek professional help because they do not know the causes of those signs or the consequences they can have for themselves or their babies. As has been shown by social studies and studies of barriers, transportation costs, particularly travel by water, also restrict access to services.
- 1.20 The feeding and care of pregnant women and children under two are suboptimum in the three indigenous populations and contribute to nutritional deficiencies in the early years of life and overweight in adults.²³
- 1.21 **In short, efforts to optimize the primary health care model must be advanced and consolidated,** with an emphasis on comprehensive care for the population, taking into account the demographic and epidemiological profile, with attention not only to infectious diseases, maternal and perinatal health, and malnutrition but also to noncommunicable diseases.
- 1.22 Ongoing efforts are needed to implement and effectively root CONE, PACO, and the AIN-C in the institutional structure, and the array of services needs to be improved. This would allow the country to lessen inequalities in access to health care services, reduce maternal and infant mortality rates, improve the nutrition of women and children, and reduce overweight and obesity.
- 1.23 Complementarily, it is also necessary to lock in systemic reforms and coordinate the two suppliers of services (fixed and mobile) at the first level of care into basic care units, providing services for a target population, with local management,

²¹ Informe sobre el estado de Instalaciones de salud [Report on the Condition of Health Care Facilities], MINSA-IDB, 2015.

²² Kolodín S. and Rodríguez G. Estudio de Redes Sociales [Social Networks Study], 2014.

²³ *Op. cit.*, note 12. See also, Montes Molina IM and Lara Mendoza LM. Informe final de investigación formativa: prácticas de cuidado, alimentación e higiene y su mejoramiento en la mujer embarazada, en las regiones indígenas de Guna Yala, Ngöbe Buglé, y Emberá Wounaan [Final Formative Research Report: Care, Feeding, and Hygiene Practices and their Improvement among Pregnant Women in the Guna Yala, Ngöbe Buglé, and Emberá Wounaan comarcas], Panama, 2014.

strengthening the local community platform, and supervising health outcomes at the regional and national levels.

4. Relationship with other Bank operations and lessons learned

- 1.24 The proposed program is complemented by the interventions of the SM2015 Initiative. The initiative demonstrated that it is possible to increase the permanent availability of family planning methods, prenatal care, attended births, and inputs for treating children and also improve the round-the-clock availability of doctors and nurses at health facilities. Under the initiative, Panama began to implement community birthing plans, and water quality and sanitation plans.
- 1.25 The proposed program also complements the Rural and Indigenous Water and Sanitation Program in Panama (grant GRT/WS-13329-PN), which provides for the expansion and construction of new systems and the strengthening of community and comarca water commissions to ensure the sustainability of the systems.
- 1.26 Lastly, together with the National Department of Science, Technology, and Innovation (SENACYT), technological innovations in aspects of health will be identified as part of the Social Inclusion and Competitiveness Program (PN-L1117).
- 1.27 **Lessons learned.** The lessons learned can be summarized as follows: (i) taking an inventory and categorizing the aspects that keep service providers from attaining their goals, such as delays in signing agreements, in the flow of resources, and in feedback on results has been useful in gradually improving service delivery; (ii) MINSA has understood the importance of strengthening the role of community actors as health promoters, midwives, and assistants; (iii) an imperfect understanding and positioning of the EFC-APS and its impact among key stakeholders generates mistrust and jeopardizes budget appropriations; and (iv) timely external audits are important for providing MINSA with feedback on the results of the work of its service providers. These lessons have been included in the design of this operation, particularly: (i) the development of management, monitoring, and evaluation systems at the central, regional, and local levels of MINSA to ensure feedback for service providers; (ii) the design and implementation of a community platform to bolster promotion, prevention, and treatment in addition to referral systems, at the local level; (iii) the development of a communication strategy to project and position the EFC-APS; and (iv) review of the terms of reference and methodology for audits, in order to improve the usefulness and timeliness of the reports.

5. Strategic alignment

- 1.28 This program is aligned with the Update to the IDB's Institutional Strategy 2010-2020: Partnering with Latin America and the Caribbean to Improve Lives (document GN-2788-5) and is consistent with its lending program to achieve broader coverage of quality health care services. The program will contribute to the lending priorities identified in the Report on the Ninth General Increase in the Resources of the IDB (document AB-2764) for (i) small and vulnerable countries and (ii) poverty reduction and equity enhancement, since it will target groups living in poverty and extreme poverty. It will also contribute to the regional goals for infant mortality reduction, and the outputs for individuals receiving health services, and for individuals listed in a civil or identification registry. The

objectives contribute to the Strategy on Social Policy for Equity and Productivity (document GN-2588-4) and the lines of action of the IDB's Health and Nutrition Sector Framework Document (document GN-2735-3), specifically through the support for efficient redistributive tools that promote human capital accumulation and the delivery of quality health services for the vulnerable population.

- 1.29 The operation is aligned with the government's Strategic Plan 2015-2019, which is aimed at the development of human capabilities. Insofar as it increases access to mother and child health services, the operation is also aligned with the health pillar of the country strategy with Panama for the period 2010-2014 (document GN-2596). In addition, it is consistent with the strategic pillars of the strategy for the period 2015-2019, which is in preparation, particularly the line to improve the quality of life of low-income groups.

B. Objectives, components, and cost

- 1.30 The objective of the program is to improve the health and nutritional status of the population living in poverty and extreme poverty and to help reduce maternal and infant mortality and noncommunicable diseases through better coverage and quality of health care services.
- 1.31 The specific objectives are to: (i) increase coverage and consolidate integrated services networks to ensure that the actions of care providers at the primary and secondary levels are harmonized; (ii) improve the quality of health care services that are responsive to the life cycle and culturally appropriate; and (iii) strengthen institutional and managerial capacity at MINSA at the central and regional levels to enable it to make the most of planning, management, and monitoring tools to guarantee the continuity of care.
- 1.32 **Component 1: Increase coverage and consolidate integrated services networks (IDB US\$113.1 million; local contribution US\$30.5 million).** The objective of this component is to expand the coverage of services in the prioritized portfolio of services in remote rural areas and indigenous comarcas by consolidating and operating integrated networks, consolidating the capitation and performance-based payment model for care providers, and offering technical support for the process of harmonizing the activities of providers at the first and second levels of care.
- 1.33 **Subcomponent 1.1. Increase coverage.** Financing will be provided for capitation payments, defined as the amount earmarked to provide the prioritized portfolio of services for each individual who is a program beneficiary, which corresponds to a calculation of the average unit cost of providing the portfolio services associated with each beneficiary for one year.
- 1.34 For calculation purposes, capitation payments will include: (i) the services delivered by MINSA's basic care units and the external providers; (ii) the costs of the additional human resources contracted by the regional health offices for MINSA's basic care units or by the external providers, including the management team, the basic health care team, and the community team; and (iii) the costs of inputs, materials, travel, goods, and equipment procured by the regional health offices and the basic care units of MINSA or the external providers, related to delivery of the services in the prioritized portfolio.
- 1.35 The eligible expenses in this subcomponent will be: (i) payment based on communities visited, population protected, population treated, and days of

service (gains in coverage); (ii) payment based on fulfillment of the respective performance and quality indicators for the services; and (iii) payment based on user satisfaction. Payments related to gains in coverage will account for up to 62% of the capitation payments; payments related to performance indicators, up to 30%; and user satisfaction payments, up to 8%. The payments described in (i) and (ii) will be validated by the external technical audits, and the payments referred to in (iii) will be validated by the social and social responsibility audits. MINSA will study, evaluate, and monitor the information related to the capitation payments.

- 1.36 **Subcomponent 1.2. Improve the capitation and performance-based payment model.** Financing will be provided for technical assistance for the design and implementation of 12 management contracts between the regional health offices and service providers (MINSA and the external providers) in which the latter guarantee access to prioritized services, their use, and quality. Financing will be provided for consulting services by the external technical auditor to validate the coverage and performance indicators.
- 1.37 **Subcomponent 1.3. Consolidate integrated health networks.** Financing will be provided for services to: (i) design the methodology for establishing the health services networks; (ii) train health care personnel to operate the networks; (iii) draft the ministerial regulations necessary to officially establish the networks; (iv) define a plan to implement the health services networks; and (v) implement a strategy to organize and operate community platforms. Economic supports for promoters and pregnant women will be financed under PACO, to help increase use of health services by pregnant women.
- 1.38 **Component 2: Improve the quality of services (IDB US\$17.4 million; local contribution US\$0.17 million).** The objective of this component is to improve the quality of health and nutrition services for the population on indigenous comarcas and in remote rural areas. To attain the objective, the delivery of services will be tailored to the beneficiary life cycle, modern quality assurance measures will be introduced, and steps will be taken to ensure that the interventions are culturally appropriate.
- 1.39 **Subcomponent 2.1. Accredite the first and second levels of care.** Financing will be provided for technical assistance to update and apply national rules that set out the minimum standards for accrediting health care establishments. Works and rehabilitation will be financed, as well as equipment, to upgrade the basic infrastructure of 37 prioritized health centers for mother and child care and four hospitals that are in the referral area for indigenous comarcas.
- 1.40 **Subcomponent 2.2. Define and implement a quality assurance strategy for services.** Financing will be provided for technical assistance to: (i) update and optimize the composition of the prioritized portfolio of services in health and nutrition (AIN-C) through the design or updating and implementation of care protocols; (ii) train personnel to apply the updated protocols; (iii) design a plan and strategy for quality assurance of mother and child health services; and (iv) form quality improvement committees to oversee attainment of the agreed objectives.
- 1.41 **Component 3: Strengthen management, monitoring, and evaluation systems (IDB US\$6.28 million; local contribution US\$0.36 million).** The objective of this component is to build the institutional and managerial capacity of

MINSA and other actors through the provision of planning, management, and monitoring tools that ensure continuity, quality, efficiency, and equity in the delivery of health and nutrition services.

- 1.42 **Subcomponent 3.1. Strengthen capacity at the national level.** At the central level, financing will be provided for services to: (i) optimize and operate the health information system by establishing a unified information platform that integrates the three existing systems—the Health Statistics Reporting System (SIREGES), the Health Statistics Information System (SIES), and the Electronic Health Information System (SEIS); and (ii) design and incorporate adjustments into the program operating manuals and regulations to include a description of the processes and operation of the networks and micronetworks. This subcomponent will also finance basic upgrades at MINSA's central offices.
- 1.43 **Subcomponent 3.2. Strengthen capacity at the regional and local levels.** Financing will be provided for technical assistance to: (i) strengthen the capacity to operate, supervise, and evaluate services using the new integrated networks arrangement and the capitation and performance-based payment model, through the creation of dashboards with information broken down by provider and aggregated at the regional and national levels; and (ii) carry out activities to train providers in the use of pertinent modules in the unified information platform.
- 1.44 **Subcomponent 3.3. Manage information and evaluations.** Financing will be provided for services to design and carry out: (i) evaluations of the impact and quality of PACO and the AIN-C; (ii) evaluation of the performance-based payment model; (iii) the national health survey; and (iv) implementation of a communication strategy to report on program progress and results.
- 1.45 **Administration and monitoring (IDB US\$3.11 million; local contribution US\$2.94 million).** Financing will be provided for the program's financial audits and to contract consultants for the execution unit and key areas of the project.
- 1.46 **Cost and financing.** The project will have a total cost of US\$174 million, with US\$140 million to be financed by the IDB from the Ordinary Capital and US\$34 million by the local counterpart (Table I.1).

Table I.1. Costs

Components	IDB (US\$)	Local (US\$)	Total (US\$)
Component 1	113,149,384	30,527,961	143,677,345
Component 2	17,459,000	172,680	17,631,680
Component 3	6,277,900	361,663	6,639,563
Administration and monitoring	3,113,716	2,937,696	6,051,412
Total	140,000,000	34,000,000	174,000,000

C. Key results indicators

- 1.47 The [results matrix](#) identifies the impact, outcome, and output indicators for this operation. The expected impacts are a reduction in maternal and infant mortality, in the prevalence of chronic malnutrition among children under five, and in premature deaths from diabetes. The expected outcomes include increases in the early detection of pregnant women, prenatal checkups, growth and development checkups, and vaccinations for children under five. The detection of patients with diabetes and hypertension is also expected to rise. The outputs

cover the number of beneficiaries receiving services in the prioritized portfolio, improvements in the quality of services through accreditations at the first and second levels of care, and implementation of a quality assurance strategy for services.

- 1.48 **Economic analysis.** The cost-benefit analysis determines whether the benefits of providing the prioritized portfolio of services justify the costs. The return is measured as disability-adjusted life years (DALYs) avoided, compared with the cost of the prioritized portfolio. Using a discount rate of 5% (estimate by López, 2008), a net present value of US\$87,378,255 is calculated based on the per capita amount. An estimated 60,023.49 DALYs will be avoided each year with the prioritized portfolio, with a value of US\$291.15 for each DALY avoided. Assuming that each DALY is equivalent to one year of full productivity, per capita GDP estimates between 2016 and 2020 were used to obtain a benefit-cost ratio of 9.91. The results are robust to a sensitivity analysis. The investment is highly cost effective regardless of variations in coverage, services, scope of the prioritized portfolio, and the discount rate. See the [economic analysis](#).

II. FINANCING STRUCTURE AND MAIN RISKS

A. Financing instruments

- 2.1 The program will be financed through an investment loan to be disbursed over five years, starting in 2016.

Table 2.1. Disbursement schedule

	2016	2017	2018	2019	2020	TOTAL
IDB	22,750,910	29,897,453	32,525,170	29,496,146	25,330,321	140,000,000
Local	3,049,125	3,450,673	6,697,710	10,123,497	10,678,995	34,000,000
Total	25,800,035	33,348,126	39,222,880	39,619,643	36,009,316	174,000,000

B. Environmental and social risks

- 2.2 In accordance with the Environment and Safeguards Compliance Policy (OP-703), the program was classified as a Category “B” operation. Therefore, an [Environmental and Social Management Report \(ESMR\)](#) was prepared, identifying the program’s potential social and environmental impacts and risks and measures to manage those impacts. Only medium-level potential environmental risks are expected, arising from waste management at the health care facilities to be intervened or reconstructed. As a special execution condition, prior to calling for bids to build or rehabilitate each of the health infrastructure works, evidence will be submitted to the Bank of legal ownership of the land where the work will be built and of fulfillment of the other conditions established in the ESMR.
- 2.3 The operation will have positive social impacts on the country’s poorest groups, particularly on the Guna Yala, Ngäbe-Buglé, and Emberá-Wounaan comarcas and remote rural areas, by improving their health status. The operation will contribute to gender equality, since it promotes actions to improve access by women to family planning and maternal health services, and by men to family planning and services for the prevention and treatment of chronic disease (policy OP-761). Since the interventions include cultural adaptations to infrastructure and care protocols for each indigenous group that take account of

practices and customs in the delivery of health services, the operation will contribute to development with identity consistent with the Indigenous Peoples Policy (OP-765).

C. Fiduciary risks

- 2.4 Possible delays in contracting and payments due to the procedures involved in the prior control by the Office of the Comptroller General were identified as a medium risk, and use of a trustee is proposed to help mitigate it. Scant interest by contractors in building inexpensive works in remote areas has been identified as a high risk, and arrangements will be sought to make the bids attractive, with additional efforts made to publicize information among the actors in the zone (nongovernmental organizations, producers associations) to increase the number of quality bidders.

D. Other project risks

- 2.5 The following risks and mitigation measures were identified: (i) medium risk of fiscal sustainability for continuity of the health services after the program ends, which will be mitigated by including an incremental arrangement for counterpart funding and dissemination of the results showing gains in the performance indicators in the annual resource programming; (ii) high risk of delays in the provision of logistical resources (fuel or vehicles) in the regions, which will be mitigated with adequate planning at the central and regional levels to ensure their ready availability in the quantities needed; (iii) high monitoring and reporting risks that could cause delays and deficiencies in timely, quality recording of the services provided, which will be mitigated by introducing technical innovations for reporting information, accompanied by ongoing training and support; (iv) medium risk of insufficient budget allocations, and therefore coordination between the Ministry of Finance and MINSA will be crucial for ensuring that sufficient funds (loan and counterpart) are allocated; and (v) medium risk of lack of multisector coordination with the water, sanitation, and electricity sectors, which will be mitigated through the preparation of local action plans.

III. IMPLEMENTATION AND MANAGEMENT PLAN

A. Summary of implementation arrangements

- 3.1 **Borrower and executing agency.** The borrower will be the Republic of Panama, and the executing agency will be the Ministry of Health (MINSA), under the following arrangement: (i) a program steering committee, which will be the program's strategic decision-making body; (ii) MINSA's national health offices which will bear technical responsibility for supporting technical aspects of program execution; (iii) the Administrative and Financial Health Management Unit (UGSAF), which will be responsible for coordinating the program and carrying out the fiduciary processes; and (iv) the regional health offices, for regional execution and direct coordination with health care providers at the local level.
- 3.2 Management agreements will be signed between MINSA and the participating regional health offices, and contracts will be signed between MINSA and the selected external providers, which will establish the population to be covered and the performance targets. The basic care units will commit to submit bimonthly reports to the regional offices, identifying the health services provided for each beneficiary and the communities visited, the population protected, the population

treated, and the number of days care was provided (coverage gains), in addition to semiannual reports on the respective performance indicators.

- 3.3 **Special contractual conditions precedent to the first disbursement of the loan: Delivery by the borrower, to the Bank's satisfaction, of evidence to the effect that (a) the operating manual for the program has been approved and placed into effect; and (b) the operating regulations for provision of the health services have been approved and placed into effect.** The operating manual defines the technical and fiduciary processes for which MINSA and the IDB will be responsible. The operating regulations for the provision of health services define the technical processes and provision of services by MINSA at the national level and its various providers at the regional and local levels, and the operating mechanisms for the capitation and performance-based payment model.
- 3.4 **Procurement.** The Policies for the procurement of works and goods financed by the Inter-American Development Bank (document GN-2349-9) and the Policies for selection and contracting of consultants financed by the Inter-American Development Bank (document GN-2350-9) will be applied. With regard to the health services financed under the capitation and performance-based model established in Component 1, Subcomponent 1, only the appropriateness of the expenditures will be verified. For services provided by external organizations, the providers will be selected through a competitive process, and contracted directly only on an exceptional basis.
- 3.5 **Retroactive financing and recognition of expenditures.** The Bank may retroactively finance up to US\$28,000,000 (20% of the proposed loan) from the loan proceeds and recognize up to US\$6,800,000 (20% of the contribution) against the local counterpart contribution for eligible expenditures made by the borrower prior to the loan approval date, for works, goods, nonconsulting services, and consulting services in Component 1, provided that procedures substantially similar to those established in the loan contract have been followed. The expenditures must have been incurred on or after 30 September 2015, which is the date on which the project profile was approved, but in no event will expenditures incurred more than 18 months prior to the loan approval date be recognized.
- 3.6 **Direct contracting.** The following will be contracted directly: (i) the Gorgas Commemorative Health Studies Institute (ICGES) (a legal public institution with a social mission and financial and technical independence in its internal governance, asset management, and the exercise of its functions), for an estimated US\$2,500,000 to conduct the national health survey, which is its exclusive responsibility at the national level in accordance with Law 78 of 17 December 2003; and (ii) the Panamanian Family Planning Association (APLAFA) for an estimated US\$350,000 to carry out the activities related to the intervention for behavioral change and family planning counselling services. APLAFA is accredited by the International Family Planning Federation and has unique experience in Panama in designing and implementing programs of this kind. These two reasons make the institution exceptionally valuable, such that this contract is eligible under paragraph 3.10 (d) of the Policies for selection and contracting of consultants financed by the Inter-American Development Bank (document GN-2350-9).

- 3.7 **Disbursement flows.** The IDB will process advances according to the program's liquidity needs for a period of up to 180 days, payable to the bank account of the trustee who will administer the funds.²⁴ In turn, the trustee will pay: (i) the contractors and consultants; (ii) the regional health offices, MINSA, the basic health units, and the external providers, in the case of capitation and performance-based payments; and (iii) the ICGES, for the national health survey. Within one year from the effective date of the contract, MINSA will contract, to the Bank's satisfaction, a trustee or other mechanism satisfactory to the Bank to manage the loan proceeds and the local contribution.
- 3.8 The capitation and performance-based payments to health services providers will be reported and justified on the basis of consolidated reports issued by MINSA. The coverage and performance results will be verified by MINSA and by the external technical auditor. Reimbursements of payments or direct payments to providers can also be made.
- 3.9 **Audits.** There will be three types of audits: (i) annual audits of the program's financial statements and semiannual reviews of the effectiveness of the internal controls; (ii) external technical audits of the program, with reports presented to the Bank within 90 days after the end of each six-month calendar period, following the first disbursement of the loan; and (iii) annual social responsibility and social audits to measure user satisfaction, with reports to be submitted to the Bank within 90 days after the end of each calendar year.
- 3.10 The external technical audits will determine: (i) fulfillment of the coverage and performance indicators by the MINSA's regional health offices and the external providers; (ii) the completeness, reliability, and consistency of the information in the reports submitted by the basic care units to the regional health offices and by the latter to the UGSAF on fulfillment of the coverage and performance indicators subject to capitation payments; (iii) the completeness, reliability, and consistency of the beneficiary population roll; (iv) the extent to which the services provided conform to the prioritized portfolio of services, the manuals, regulations, guidelines, and protocols; and (v) any act, event, indication, or omission that could be considered a prohibited practice in accordance with the general conditions of the loan contract, in which case the Bank will be alerted. For the services provided by MINSA's basic care units, the external technical auditor will verify the costs indicated in Component 1, Subcomponent 1. For the services provided by the external providers, the external technical audits will be limited to verifying expenditures related to fees and employer contributions on behalf of their employees. **As a special condition precedent to the first disbursement, the external technical auditor for the program will be contracted.** As a special execution condition, the borrower will deliver, to the Bank's satisfaction, within 90 days after the end of each six-month calendar period, the external technical auditor's report determining that the coverage, performance, and satisfaction indicators were met and that no prohibited practices were detected.

B. Summary of arrangements for monitoring results

- 3.11 **Monitoring.** MINSA, through its Administrative and Financial Health Management Unit (UGSAF), will deliver the semiannual progress reports mentioned in the general conditions of the loan contract, to include monitoring of

²⁴ If the contract with the trustee is not ready, the funds will be paid into a bank account opened by MINSA.

the program results matrix. The project execution plan will be the tool used for project monitoring.

- 3.12 **Evaluation.** The evaluation will be based on: (i) experimental evaluation of the impact of the Community Support Program for Mother and Child Health (PACO); (ii) experimental evaluation of the impact of the Comprehensive Community-level Care Program for Children (AIN-C); (iii) qualitative evaluation of PACO and the AIN-C; (iv) quasi-experimental evaluation of the impact of capitation and results-based payments on the services network; and (v) experimental evaluation of the impact of supply-side incentives to integrate health services. See the [monitoring and evaluation report](#).

Development Effectiveness Matrix			
Summary			
I. Strategic Alignment			
1. IDB Strategic Development Objectives		Aligned	
Lending Program		-Lending to small and vulnerable countries -Lending for poverty reduction and equity enhancement	
Regional Development Goals		-Maternal mortality ratio -Infant mortality ratio	
Bank Output Contribution (as defined in Results Framework of IDB-9)		-Individuals receiving a basic package of health services	
2. Country Strategy Development Objectives		Aligned	
Country Strategy Results Matrix	GN-2596	Reduce health care coverage gaps in indigenous territories and in rural communities.	
Country Program Results Matrix		The intervention is not included in the 2015 Operational Program.	
Relevance of this project to country development challenges (If not aligned to country strategy or country program)			
II. Development Outcomes - Evaluability		Highly Evaluable	Weight
		10.0	10
3. Evidence-based Assessment & Solution		10.0	33.33%
3.1 Program Diagnosis		3.0	
3.2 Proposed Interventions or Solutions		4.0	
3.3 Results Matrix Quality		3.0	
4. Ex ante Economic Analysis		10.0	33.33%
4.1 The program has an ERR/NPV, a Cost-Effectiveness Analysis or a General Economic Analysis		4.0	
4.2 Identified and Quantified Benefits		1.5	
4.3 Identified and Quantified Costs		1.5	
4.4 Reasonable Assumptions		1.5	
4.5 Sensitivity Analysis		1.5	
5. Monitoring and Evaluation		10.0	33.33%
5.1 Monitoring Mechanisms		2.5	
5.2 Evaluation Plan		7.5	
III. Risks & Mitigation Monitoring Matrix			
Overall risks rate = magnitude of risks*likelihood		Low	
Identified risks have been rated for magnitude and likelihood		Yes	
Mitigation measures have been identified for major risks		Yes	
Mitigation measures have indicators for tracking their implementation		Yes	
Environmental & social risk classification		B	
IV. IDB's Role - Additionality			
The project relies on the use of country systems			
Fiduciary (VPC/FMP Criteria)	Yes	Financial Management: Budget, Treasury, Accounting and Reporting, External control, Internal Audit. Procurement: Information System, Shopping Method, National Public Bidding.	
Non-Fiduciary	Yes	Strategic Planning National System.	
The IDB's involvement promotes additional improvements of the intended beneficiaries and/or public sector entity in the following dimensions:			
Gender Equality	Yes	The project will finance the Community Support Program for Maternal and Child Health (PACO), which will provide women with monetary support to facilitate their attendance to health facilities. This initiative will contribute to increasing the access to health for poor women living in remote areas. The calculations for this PACO monetary support will include a potential companion and transportation costs. The project also comprehends the adequacy of maternal houses so pregnant women can assist there along with their companions.	
Labor			
Environment			
Additional (to project preparation) technical assistance was provided to the public sector entity prior to approval to increase the likelihood of success of the project	Yes	The technical cooperation PN-T1104 provided support for different areas of the Ministry of Health, which has been translated into better and stronger management and planning capacities.	
The ex-post impact evaluation of the project will produce evidence to close knowledge gaps in the sector that were identified in the project document and/or in the evaluation plan	Yes	The impact assessments promoted by the program will contribute to the knowledge base in the region about the effectiveness of incentives to the demand and supply in order to encourage the use of health services and associated health outcomes, as well as the AINC nutritional strategy.	

The program aims at improving the population's health by strengthening the different health network care levels and improving the management efficiency of this network. The project document and its annexes present the challenges facing the health sector in Panama that justify the implementation of the proposed activities. The document includes evidence of the effectiveness of the proposed solutions, as well as an account of the effects of previously and currently implemented programs. The target population is clearly established.

The results matrix includes SMART indicators suitable for measuring results and products. The project has a cost-benefit analysis underpinning the economic viability of the proposed activities. Activities, products and monitoring mechanisms have been identified and costed.

The impact assessments and the qualitative evaluation that will be carried out are clearly described in the evaluation plan. Three of these impact evaluations will be experimental and one will be quasi-experimental. The research questions, methodologies, analysis plans, and budget, are clearly detailed for each particular evaluation in the evaluation annex.

RESULTS MATRIX

Objective: The objective is to improve the health and nutritional status of the population living in poverty and extreme poverty and to help reduce maternal and infant mortality and noncommunicable diseases through better coverage and quality of health care services.

	Impact indicator ¹	Baseline ²	Final target (2020)	Source Method of calculation
1	Maternal mortality rate	55.6 (National 2013)	45.8	Source: Vital Statistics –Office of the Comptroller General (CGR) Maternal mortality per 100,000 live births
		274.3 (Ngäbe Buglé 2012)	251	
2	Mortality rate <5 years	19 (National 2013)	8.0	Source: Vital Statistics – CGR Infant mortality per 1,000 live births
		31.5 (Ngäbe Buglé 2012)	16.40	
3	Prevalence of chronic malnutrition in children <5 in the Guna Yala and Emberá Wounaan comarcas	55.9% (2015)	48.0%	Source: SM2015 surveys Method of calculation: Score z for height to weight. Score $z \leq -2$ SD determines chronic malnutrition
4	Prevalence of overweight and obesity in pregnant women (body mass index, BMI) on the Ngäbe Buglé and Emberá Wounaan comarcas	52.7% Ngäbe Buglé (2014)	46%	Source: Nutritional monitoring reports by the basic care units (BCUs) Method of calculation: Numerator: Weight in kg. Denominator: Height in meters. BMI ≥ 25 determines overweight; BMI ≥ 30 determines obesity (WHO).
		56.4% Emberá Wounaan (2014)	49%	Source: Nutritional monitoring reports by the BCUs
5	National premature mortality rate (<70 years) from diabetes	28.6 (2013)	21.6	Source: Vital Statistics – CGR Method of calculation: Numerator: Number of deaths (ages 30 to 69) from diabetes (International Statistical Classification of Diseases Codes 10E10-E14) per 100,000 population. Denominator: Resident population (ages 30 to 69).

¹ Impact indicators 1, 2, and 3 are consistent with the Bank's country strategy with Panama. Impact indicators 2, 3, and 5 will be broken down by gender and be used as value-added information to be processed in the coming months.

² The baseline values will be updated at the workshop to launch the project.

	Outcome indicator ^{3 4}	Baseline ⁵	Final target (2020)	Source Method of calculation
1	Percentage of pregnant women detected before the 13th week of pregnancy	82%	90%	Source: Basic prenatal clinical history (BPCH) sheets, prenatal control cards (PCCs) Method of calculation: Numerator: Number of pregnant women in the beneficiary population roll ⁶ detected prior to the 13 th week of pregnancy in the previous six months. Denominator: Total number of pregnant women in the beneficiary roll.
2	Percentage of pregnant women who at the end of the third trimester of pregnancy have completed at least four prenatal checkups at a BCU (at least one each trimester)	71%	90%	Source: BPCH sheets, PCCs Method of calculation: Numerator: Number of pregnant women in the beneficiary roll who have reached 37 weeks or given birth with four or more PCCs at a BCU (at least one per trimester). Denominator: Total number of pregnant women in the beneficiary roll who have reached 37 weeks or given birth in the previous six months.
3	Percentage of pregnant women who received a second tetanus toxoid or tetanus and diphtheria dose or booster	85%	95%	Source: BPCH sheets, PCCs Method of calculation: Numerator: Number of pregnant women in the beneficiary roll who received a second tetanus toxoid or tetanus and diphtheria dose or booster. Denominator: total number of pregnant women in the beneficiary roll.
4	Percentage of pregnant women on the Ngäbe Buglé comarca who report having eaten fruit at least once a day over the last seven days	N/A ⁷	+10pp	Source: Comprehensive Community-level Care Program for Children (AIN-C) evaluation Method of calculation: Numerator: Number of pregnant women who report having eaten fruit at least once a day over the last seven days. Denominator: Number of pregnant women in Ngäbe Buglé.
5	Percentage of births attended by qualified staff at a BCU	83%	90%	Source: BPCH sheets, PCCs Method of calculation: Numerator: Number of births attended by qualified staff at a BCU. Denominator: Total number of pregnant women detected in the beneficiary roll who completed their third trimester in the previous six months.

³ Outcome indicators 1 to 9 will be broken down by ethnicity and indicators 8, 9, 12, 13, and 15 to 17 by gender.

⁴ All outcomes refer to the population in communities that have been targeted for the prioritized portfolio of services and have residents who have been registered by care providers, except 4, 6, 7, 10, and 11.

⁵ All the baseline data correspond to reports by the Service Delivery Directorate (2015), except 6, 7, 10, and 11 (SM2015 baseline survey, 2013).

⁶ Beneficiary population roll: Total number of people living in targeted communities who have been registered by care providers.

⁷ N/A = Not available.

	Outcome indicator	Baseline	Final target (2020)	Source Method of calculation
6	Percentage of mothers of infants <6 months on the Guna Yala, Ngäbe Buglé, and Emberá Wounaan comarcas who exclusively breastfeed their babies	45.3%	55.3%	Source: SM2015 surveys and AIN-C evaluation Method of calculation: Numerator: Number of mothers of infants <6 months who report having exclusively breastfed their baby on the previous day. Denominator: Number of mothers of infants <6 months.
7	Percentage of mothers on the Guna Yala, Ngäbe Buglé, and Emberá Wounaan comarcas who report having started supplementary feeding when their babies reached six months of age	88%	93%	Source: SM2015 surveys and AIN-C evaluation Method of calculation: Numerator: Number of mothers of infants from 6-11.9 months who report having started supplementary feeding when their babies reached six months of age, in the previous six months. Denominator: Number of mothers of children 6-11.9 months old.
8	Percentage of children who have received six or more growth and development checkups upon turning one	N/A	+10pp	Source: Clinical files, checkup cards Method of calculation: Numerator: Number of children turning one in the previous six months who have received six or more checkups. Denominator: All children in the beneficiary roll who turned one in the previous six months.
9	Percentage of children <1 year with full immunization for their age	91%	95%	Source: Clinical files, vaccination cards Method of calculation: Numerator: Number of children turning one in the previous six months with full immunization for their age (as defined in the WHO Expanded Programme on Immunization). Denominator: Total number of children in the beneficiary roll who turned one in the previous six months.
10	Percentage of mothers on the Guna Yala, Ngäbe Buglé, and Emberá Wounaan comarcas who gave their children <59 months oral rehydration salts and zinc during the most recent episode of diarrhea in the last two weeks	0.6%	20.6%	Source: SM2015 surveys and AIN-C evaluation Method of calculation: Numerator: Number of mothers who gave their children from 0-59 months oral rehydration salts and zinc during the most recent episode of diarrhea in the last two weeks. Denominator: Number of children from 0-59 months who had at least one episode of diarrhea in the last two weeks.
11	Percentage of children between 12-59 months on the Guna Yala, Ngäbe Buglé, and Emberá Wounaan comarcas who received two antiparasitic treatments in the last year.	8.7%	38.7%	Source: SM2015 surveys and AIN-C evaluation Method of calculation: Numerator: Number of children between 12-59 months in the beneficiary roll who received two antiparasitic treatments in the last year. Denominator: Number of children between 12-59 months in the beneficiary roll.
12	Percentage of children between 1-4 years who received at least two growth and development checkups in the previous six months	N/A	+10pp	Source: Clinical files, checkup cards Method of calculation: Numerator: Number of children in the beneficiary roll turning 2, 3, 4, and 5 years during the previous six months who have at least two checkup cards dated at different times in the previous year for each age group. Denominator: Total number of children in the beneficiary roll who turned 2, 3, 4, or 5 years in the previous six months.

	Outcome indicator	Baseline	Final target (2020)	Source Method of calculation
13	Percentage of children turning 2, 3, 4, and 5 years who are fully immunized	85%	90%	Source: Clinical files, vaccination cards Method of calculation: Numerator: Number of children in the beneficiary roll turning 2, 3, 4, and 5 years who are fully immunized (as defined in the WHO Expanded Programme on Immunization). Denominator: Total number of children in the beneficiary roll who turned 2, 3, 4, or 5 years in the previous six months.
14	Percentage of women aged 20 to 70 years who receive annual PAP tests	59%	70%	Source: Clinical files, cytology control cards Method of calculation: Numerator: Number of women aged 20 to 70 years in the beneficiary roll who received a PAP test in the twelve months prior to the end of the six-month period. Denominator: All women aged 20 to 70 years in the beneficiary roll.
15	Percentage of adults with respiratory symptoms who have taken a sputum test	7%	25%	Source: Registration and follow-up records, clinical files, and laboratory records Method of calculation: Numerator: Number of adults with respiratory symptoms detected in the previous six months who have taken a sputum test. Denominator: Number of adults with respiratory symptoms expected in the beneficiary roll in the previous six months.
16	Percentage of diabetic patients detected who were treated in accordance with MINSA standards	39%	65%	Source: Clinical file, registration cards, and follow-up records Method of calculation: Numerator: Number of diabetic patients detected who were treated in accordance with MINSA standards in the previous six months. Denominator: Number of diabetic patients in the beneficiary roll.
17	Percentage of patients with hypertension who were treated in accordance with MINSA standards	18%	65%	Source: Clinical file, registration cards, and follow-up records Method of calculation: Numerator: Number of patients with hypertension detected who were treated in accordance with MINSA standards in the previous six months. Denominator: Number of patients with hypertension in the beneficiary roll.

	Output indicator ⁸	Baseline	Year 1	Year 2	Year 3	Year 4	Year 5	Target (2020)	Source Comments
Component 1									
1.1	Number of people who benefitted from prioritized portfolio of services ⁹	360,000	400,000	440,000	590,000	530,000	575,000	575,000	Source: SIREGES Comment: Total beneficiary roll.
1.2	Number of people who received at least one service in the prioritized portfolio	210,000	235,000	260,000	285,000	310,000	380,000	380,000	Source: SIREGES Comment: The beneficiary's clinical files show at least one prioritized portfolio activity.
1.3	Document containing methodological guidelines for establishing integrated health services networks prepared	0	1					1	Source: MINSA Resolution Comment: The methodology includes georeferencing of BCUs, gaps in service delivery, and condition of access to services.
1.4	Number of health regions with health networks established	0		3	3	3	3	12	Source: MINSA Resolution
1.5	Plan prepared and approved for implementing health services networks	0	1					1	Source: Plan approved by the Health Services Provision Directorate
1.6	Number of institutional and community personnel trained in the methodology for establishing health services networks	0	2,650	2,650				2,650	Source: Training reports Comment: Institutional health personnel includes staff assigned to a BCU. Training will include the methodology for establishing networks.
1.7	Document prepared proposing a methodology for organizing and operating the community platforms	0	1					1	Source: Consulting report Comment: Membership of the community platforms, profiles, and functions will be reviewed.
1.8	Number of agents in central communities that form part of the community platform (receive incentives)	0		450	900	1,300	1,900	1,900	Source: SIREGES Comment: Central communities are assistance points with no more than 600 people in total.

⁸ Indicators 1.1, 1.2, 1.6, 1.8, 1.10, 2.8, and 3.7 should not be added at end of period.

⁹ This indicator corresponds to the number of people benefitting from health care services (included in the institutional results framework and is also a sector indicator).

	Output indicator ⁸	Baseline	Year 1	Year 2	Year 3	Year 4	Year 5	Target (2020)	Source Comments
1.9	Number of pregnant women receiving community support	0	500	500	500	500	800	2,800	Source: SIREGES Comment: Community support involves financial transfers to cover the transportation costs of pregnant women to encourage them to attend health services facilities.
1.10	Number of volunteer health promoters who receive community support	0		450	900	1,300	1,900	1,900	Source: SIREGES Comment: See 1.9.
1.11	External technical auditor contracted	0	1	1	1	1	1	5	Source: Auditor's reports
Component 2									
2.1	Standard for accrediting the entire services network updated	0	1					1	Source: MINSA Decree Comment: The standard should cover functions by level of treatment capability, human resources, supplies of inputs and medications, and service infrastructure and equipment, among other aspects.
2.2	Number of health centers with upgraded infrastructure	0			15	12	10	37	Source: Certificates of acceptance of works and equipment Comment: The works must comply with the accreditation standards.
2.3	Number of health centers and regional referral hospitals equipped	0			16	11	10	37	Source and comment: See 2.2.
2.4	Number of referral hospitals for indigenous comarcas upgraded	0			4			4	Source and comment: See 2.2.
2.5	Number of care protocols updated	0			48			48	Source: MINSA Resolution Comment: Updated based on the best scientific evidence, and culturally appropriate.
2.6	Number of staff trained to apply care protocols that have been updated and are culturally appropriate	0				740		740	Source: SIREGES Comment: "Trained" means training in updated protocols and indigenous languages.
2.7	Quality assurance strategy document prepared	0		1				1	Source: Consulting report Comment: The strategy identifies tools for the effective application of standards and protocols.

	Output indicator ⁸	Baseline	Year 1	Year 2	Year 3	Year 4	Year 5	Target (2020)	Source Comments
2.8	Number of BCUs that consolidate the AIN-C monthly, with 80% of children < 24 months registered	18	23	28	30	33	37	37	Source: SIREGES
Component 3									
3.1	Diagnostic analysis of MINSA's central infrastructure prepared	0	1					1	Source: MINSA document approved
3.2	Number of MINSA's central areas upgraded	0		2	1	1	1	5	Source: Certificates of acceptance of the works Comment: Upgraded to comply with the accreditation standards.
3.3	Operating regulations designed for the micro-network program	0	1					1	Source: MINSA Resolution approving the operating regulations
3.4	Information system designed	0	1					1	Source: SIREGES report and manual Comment: The design includes the creation of a unified information platform for SIREGES, SIES, and SEIS.
3.5	Number health centers and hospitals equipped with hardware and software for operating the information system	0		15	15	6	5	41	Source: SIREGES reports and manual Comment: The centers will be equipped with hardware and software. "Operating" means that: (i) the system enables regional data to be consolidated at the national level; and (ii) the BCUs are able to input data and generate reports on coverage and performance at the regional/local level.
3.6	Number of data-entry and accounting-record technicians trained to manage the information system and to use innovative technologies	0		135				135	Source: SIREGES Comment: "Trained" means that they can: (i) input data from the prioritized portfolio and clinical files; (ii) administer the beneficiary roll and monitor the services provided.
3.7	Communication strategy document prepared that is culturally appropriate and includes a gender perspective	0	1					1	Source: Consulting report Comment: To include messages and communications for dissemination.

	Output indicator ⁸	Baseline	Year 1	Year 2	Year 3	Year 4	Year 5	Target (2020)	Source Comments
3.8	Impact and qualitative evaluations completed			1	2	2		5	Source: Evaluation reports Comment: Includes the impact evaluation and the qualitative evaluation of PACO, the AIN-C, and capitation and results-based payments in the fixed network, and supply-side incentives for the integration of health care services.
3.9	National health survey completed						1	1	Source: Documents on results and databases
Administration and monitoring									
3.10	Financial audits contracted	0	1	1	1	1	1	5	Source: Auditor's reports

FIDUCIARY AGREEMENTS AND REQUIREMENTS

Country: Panama

Project no. and name: PN-L1115 – Integrated Health Service Networks Strengthening Program

Executing agency: Ministry of Health (MINSA)

Prepared by: Ezequiel Cambiasso and Juan Carlos Dugand (FMP/CPN)

I. FIDUCIARY CONTEXT OF THE EXECUTING AGENCY

- 1.1 The executing agency will be the Ministry of Health (MINSA), through the Administrative and Financial Health Management Unit (UGSAF), which will be responsible for procurement, accounting records, payments, and disbursements. It has the experience needed to execute this project. A trustee will be used to ensure the timely flow of resources.
- 1.2 In the case of Component 1, Subcomponent 1.1, the regional health offices or external providers will receive capitation payments from the central level (MINSA) so they can provide the prioritized portfolio of services. Since the service areas are scattered and small recurring purchases will be made locally, in programs of this kind it is more efficient to finance a fixed payment against an output and certain management targets rather than financing the inputs that give rise to the capitation payments. This helps to: (i) reduce transaction costs; (ii) verify fulfillment of the development objectives; and (iii) incentivize MINSA to improve the quality of services.
- 1.3 To receive the payments, management agreements will be signed between MINSA and the regional health directorates and contracts will be signed between MINSA and the external providers, in which the scope of the targets will be established. Attainment of the targets for coverage and health outcomes will be supervised and reviewed by MINSA. External technical audits, a social audit, and a financial audit will also be performed.

II. FIDUCIARY RISK EVALUATION AND MITIGATION MEASURES

- 2.1 Two procurement risks have been identified: (i) potential delays in contracting owing to the ex ante controls established by the Office of the Comptroller General (CGR) in the event that the contract with the trustee is not ready (medium risk); and (ii) scant private sector interest in executing the works owing to the remote location and low cost of the health center upgrades (high risk). This risk will be mitigated by analyzing how the works are to be executed on a case-by-case basis.
- 2.2 There is a low risk of insufficient budget allocations. To mitigate this risk, once the operation is approved, MINSA will make arrangements with the Ministry of Economic Affairs and Finance (MEF) for the project allocations to be included in the 2016 budget. MINSA will also need planning tools in order to request the funds required in subsequent years.

- 2.3 In Component 1, there is a high risk with the capitation payments that not all the information and the verification mechanisms (external technical audits) needed to measure the coverage and performance indicators will be available, which may delay project disbursements.
- 2.4 There is a medium risk that the trustee may not be contracted on time, and to mitigate this risk, the contract will initially be paid with funds from loan 2563/OC-PN. If the trustee has not been contracted and the protection services are slated to begin, the percentage to be justified before a new advance can be requested will be lowered from 80% to 50%,¹ to compensate for the delays that will occur in administrative processing without the trustee.

III. CONSIDERATIONS FOR THE SPECIAL CONDITIONS OF THE CONTRACTS

- 3.1 The policies set forth in documents GN-2349-9 and GN-2350-9 will be applied. With regard to the services financed through capitation payments, only the appropriateness of the expenditures will be verified. In cases in which health care services are rendered by an external provider, that provider will be selected through a competitive process, and contracted directly only on an exceptional basis.
- 3.2 The Bank's Board of Executive Directors approved the use of the framework agreement subsystems (document GN-2538-11) up to the threshold established for national competitive bidding (NCB) and the mechanism for smaller purchases up to US\$50,000, which may change if the Bank approves higher levels.
- 3.3 The guidelines established in document OP-273-6 will apply, and in accordance with this policy: (i) financial statements for the project that have been audited by an independent firm of auditors acceptable to the Bank will be delivered annually within 120 days after the end of each fiscal year or after the date of the final disbursement; (ii) advances of funds will be requested for financial plans of up to 180 days; and (iii) new advances may be requested when 80% of the previous disbursements have been justified. If the trustee has not been contracted, a new advance may be requested when 50% of the previous advance has been justified, until such time as the trustee becomes available, owing to the administrative paperwork required for ex ante control by the CGR.
- 3.4 Panama has exchange rate parity between the balboa and the U.S. dollar, making the exchange rate irrelevant.

IV. AGREEMENTS AND REQUIREMENTS FOR PROCUREMENT EXECUTION

A. Procurement execution

- 4.1 The policies set forth in documents GN-2349-9 and GN-2350-9 will apply. In the case of health care services financed through capitation payments, only the appropriateness of the expenditure will be verified. In cases in which health care services are rendered by an external provider, that provider will be selected through a competitive process, and directly contracted only on an exceptional basis. The execution plan for PN-L1115 calls for the use of a trustee. This trustee

¹ As provided in document OP-273-6.

will be contracted through a shopping process of institutions that are legally authorized and registered in the country to provide trustee services.

- a. **Procurement of works, goods, and nonconsulting services:** International competitive bidding (ICB) will be carried out using the Bank's standard bidding documents. Procurements subject to national competitive bidding (NCB) and shopping will be carried out using the models determined by the Bank for this operation. The Bank's Board of Executive Directors approved the use of the framework agreements subsystems (document GN-2538-11) up to the threshold established for NCB and for smaller purchases of up to US\$50,000.
- b. **Selection and contracting of consultants:** Consulting service contracts generated under the project will be executed using the standard request for proposals issued by the Bank.
- c. **Selection of individual consultants:** Selection will be based on their qualifications to perform the work, comparing the qualifications of a minimum of three candidates.
- d. **National preference:** Not applicable.
- e. **Advance procurement and retroactive financing:** The Bank may retroactively finance up to US\$28,000,000 (20% of the proposed loan) from the loan proceeds and recognize up to US\$6,800,000 (20% of the contribution) against the local counterpart contribution for eligible expenditures made by the borrower prior to the loan approval date, for works, goods, nonconsulting services, and consulting services in Component 1, provided that procedures substantially similar to those established in the loan contract have been followed. The expenditures must have been incurred on or after 30 September 2015, which is the date on which the project profile was approved, but in no event will expenditures incurred more than 18 months prior to the loan approval date be recognized.
- f. **Direct selection:** See paragraph 3.6 of the proposal.
- g. **Recurring expenses:** These will be financed from the local contribution.
- h. **Procurement plan:** The procurement plan execution system or its most recent version will be used.

B. Table of thresholds (US\$)

Works			Goods			Consulting services	
ICB	NCB/ Shopping	Shopping for complex works	ICB	NCB/ Shopping	Shopping for complex goods	International	National
US\$3,000,000 and over	Over US\$250,000 and under US\$3,000,000	Under US\$250,000	\$250,00 and over	Over US\$50,000 and under US\$250,000	Under US\$50,000	Over US\$200,000	US\$200,000 and under

C. Main procurement processes

Activity	Type of process	Estimated amount US\$
Works		
Infrastructure upgrades	NCB	20,000,000
Goods		
Procurement of equipment	ICB	7,000,000
Consulting services		
Information system	QCBS	400,000
National health survey	DC	2,500,000
External technical auditor	QCBS	700,000
Family planning counselling services	DC	350,000
Nonconsulting services		
Trustee	Shopping	2,000,000

DC: Direct contracting; ICB: International competitive bidding; NCB: National competitive bidding; QCBS: Quality- and cost-based selection.

D. Procurement supervision

- 4.2 ICB and direct contracting of goods, works, and nonconsulting services will be subject to prior review. Consulting services costing more than US\$200,000 and direct contracting will be subject to prior review. For the remaining contracts, the type of review will be determined on a case-by-case basis in the procurement plan, which will be updated by MINSA at least once a year.

E. Special provisions

- 4.3 None.

F. Records and files

- 4.4 The executing agency and the trustee who administers the capitation payments will keep up-to-date records and duly classified files for review by the Bank. The procurement documentation should be filed as follows:
- Kept in a single file or folder that can be easily differentiated from processes financed with the local contribution or sources outside the program.
 - The documents will be kept in due order, paginated, and numbered so they can be clearly and immediately located and identified, and made available at any time for review by the Bank and the auditors.

V. FINANCIAL MANAGEMENT

A. Programming and budget

- 5.1 The MEF is responsible for preparing and controlling the budget. Prior to 31 July each year, it will present a proposed budget to the National Assembly, which is responsible for its approval and any increases. The budget is annual in nature and includes all public sector investments, income, and expenditures. Funding for this loan was not included in the annual budget for 2016, and therefore MINSA will have to make arrangements to have it added.

B. Accounting and information systems

- 5.2 In January 2015, the government began to gradually implement a new financial information system known as ISTMO,² developed under the SAP platform, which will replace the Integrated Financial Information System of Panama (SIAFPA). The system requires a break-in period to resolve any initial glitches and has therefore not yet been evaluated for use in IDB-financed projects,³ so a parallel system is required. The UGSAF is not using ISTMO yet, and rollout is scheduled to begin in January 2016.
- 5.3 The UGSAF uses the PENTAGON financial information system, which includes modules for planning, contracting, budgeting, and accounting, and will be used for the project's financial management.
- 5.4 Accounting will be governed by the standards issued by the CGR, which do not conform to the International Public Sector Accounting Standards.

C. Disbursements and cash flow

- 5.5 In the second half of 2013, Panama enacted a law that establishes use of a General Treasury Account, and its implementation began at the end of 2014 for the accounts of the MEF and some other ministries. Since the General Treasury Account is recent and closely linked to implementation of ISTMO, it will be necessary to wait until they have been operating for some time before they can be evaluated for use in IDB-financed projects.
- 5.6 Paragraph 3.7 of the proposal describes disbursement flows.
- 5.7 Accounting for the capitation component will be based on demonstration of the payments made to health service providers. The coverage and performance results will be verified by MINSA, the external technical auditor, and the social auditor.
- 5.8 Reimbursements of payments or direct payments to providers can also be made.
- 5.9 The initial financial plan indicates that IDB disbursements of US\$22.7 million will be required during 2016.

D. Internal control and internal audit

- 5.10 The manner in which the CGR conducts prior control of government agencies means that the internal control and internal audit systems of those institutions are poorly developed, since they rely on the work of the CGR instead of having effective processes and controls. As a result, the systems are not considered suitable for carrying out the control function required for projects.

E. External control and reports

- 5.11 The CGR has focused on prior control of actions involving the disposition of government property, and its audit function is poorly developed. Furthermore, since it participates in administrative procedures through prior control, it does not

² Integración y Soluciones Tecnológicas del Modelo de Gestión Operativa [Integration and Technological Solutions of the Operations Management Model].

³ The budget, treasury, accounting, and reporting systems were evaluated in 2011, and SIAFPA was only accepted for financial management of Bank-financed projects if used through the SIAFPA-PRO project module. With the change to ISTMO, the module ceased to operate and will be evaluated once the system has been operational for a full fiscal year.

have the independence required to perform audits, which means that it does not have the capacity to perform external control of the program.

- 5.12 The project's annual reports will be audited by an independent firm of auditors acceptable to the Bank and delivered within 120 days after the close of each fiscal year or after the final disbursement. For assurance purposes, the auditors will be asked for semiannual opinions on the effectiveness of the internal controls.

F. Financial supervision plan

- 5.13 Financial supervision will center on periodic meetings with the executing agency, the auditors' reports mentioned in the preceding paragraph, and the external technical audits. The supporting documentation for disbursements will be subject to post review by the auditors or during the financial inspection visits.

DOCUMENT OF THE INTER-AMERICAN DEVELOPMENT BANK

PROPOSED RESOLUTION DE-___/15

Panama. Loan ____/OC-PN to the Republic of Panama
Integrated Health Service Networks
Strengthening Program

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 Panama, as Borrower, for the purpose of granting it a financing to cooperate in the execution of an integrated health service networks strengthening program. Such financing will be for the amount of up to US\$140,000,000 from the resources of the Bank's Ordinary Capital, and will be subject to the Financial Terms and Conditions and the Special Contractual Conditions of the Project Summary of the Loan Proposal.

(Adopted on ____ 2015)