

DOCUMENT OF THE INTER-AMERICAN DEVELOPMENT BANK

PERU

PROGRAM TO CREATE INTEGRATED HEALTH NETWORKS

(PE-L1228)

LOAN PROPOSAL

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LINKS
REQUIRED <ol style="list-style-type: none">1. Multiyear Execution Plan (MEP) and annual work plan (AWP)2. Monitoring and Evaluation Plan3. Environmental and Social Management Report (ESMR)4. Procurement Plan OPTIONAL <ol style="list-style-type: none">1. Economic analysis of the project2. Technical analysis for implementation of the Investment Program for the Transformation of Health Networks3. Climate-smart central clinical support services facility4. Bibliography5. Draft Program Operations Manual6. Environmental screening forms

ABBREVIATIONS

CEM	Emergency Women's Center
CND	Chronic noncommunicable diseases
CSS	Clinical support services
ESA	Environmental and Social Analysis
ESMF	Environmental and Social Management Framework
ESMP	Environmental and Social Management Plan
ESMR	Environmental and Social Management Report
EsSalud	Social Health Insurance of Peru
GBD	Global Burden of Disease
INEI	National Institute of Statistics and Informatics
IPRESS	Health Service Provider Institutions
MINSA	Ministry of Health
PRONIS	National Health Investment Program
PHC	Primary healthcare
SIS	Comprehensive health insurance

PROJECT SUMMARY

PERU PROGRAM TO CREATE INTEGRATED HEALTH NETWORKS (PE-L1228)

Financial Terms and Conditions				
Borrower: Republic of Peru			Flexible Financing Facility ^(a)	
			Amortization period:	11.5 years
Executing agency: Ministry of Health (MINSA) through the National Healthcare Investment Program (PRONIS)			Disbursement period:	5 years
			Grace period:	6.5 years ^(b)
Source	Amount (US\$)	%	Interest rate:	LIBOR-based
IDB (Ordinary Capital):	125,000,000	79	Credit fee:	0.50% ^(c)
Local ^(d)	32,825,000	21	Inspection and supervision fee:	0 ^(c)
Total	157,825,000	100	Weighted average life (WAL):	8.80 years
			Approval currency:	U.S. dollars from the Ordinary Capital (OC)
Project at a Glance				
Project objective/description: The objective of the program is to achieve adequate access for the population to timely, efficient, quality primary health services based on their needs. To this end, it proposes a reorganization of health service provider institutions (IPRESS) into integrated health networks to improve the effectiveness of the current care offering in metropolitan Lima and the priority regions of the country, and to enhance clinical support services in metropolitan Lima.				
Special contractual conditions precedent to the first loan disbursement: The executing agency will provide evidence, to the Bank's satisfaction, of: (i) the appointment of key PRONIS staff to execute the program, including a general coordinator, a procurement specialist, a budget support consultant, an accounting support consultant, and a finance support consultant; and (ii) the approval and entry into force of the program's Operations Manual, under terms previously agreed upon with the Bank (paragraph 3.3). For other socioenvironmental conditions, see the Environmental and Social Management Report (ESMR) (required link 3).				
Special contractual conditions for execution: Prior to disbursement of the funds for Component 2 of the program, the executing agency will have provided evidence of the entry into force of the required agreements between MINSA and the regional governments of the intervention areas (paragraph 3.4). For other socioenvironmental conditions, see the ESMR (required link 3).				
Exceptions to Bank policies: None.				
Strategic Alignment				
Challenges: ^(e)	SI	<input checked="" type="checkbox"/>	PI	<input type="checkbox"/>
Crosscutting themes: ^(f)	GD	<input checked="" type="checkbox"/>	CC	<input checked="" type="checkbox"/>
			IC	<input type="checkbox"/>

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

^(b) Under the flexible repayment options of the Flexible Financing Facility (FFF), changes to the grace period are permitted provided that they do not entail any extension of the original weighted average life of the loan or the 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 the relevant policies.

^(d) To supplement this program, independent parallel financing is expected to be provided by the International Bank for Reconstruction and Development to the Republic of Peru for up to US\$125 million, to finance activities in the framework of the program to Create Integrated Health Networks under the Republic of Peru's National Multiyear Programming and Investment Management System.

^(e) SI (Social Inclusion and Equality); PI (Productivity and Innovation); and EI (Economic Integration).

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

I. PROJECT DESCRIPTION AND RESULTS MONITORING

A. Background, problem addressed, and rationale

1. Background

- 1.1 In recent decades, Peru has made headway in improving the health conditions of its population, especially children. Progress in reducing infant mortality has been particularly successful in the country,¹⁻² falling from 56 per 1,000 live births in 1990 to 13 deaths per 1,000 live births in 2015.³ Disparities in infant mortality based on place of residence, socioeconomic status, and ethnic origin have rapidly declined. Infant mortality of children born to women with complete, incomplete, or no primary education fell by 80% between 1982 and 2008, and the mortality of children born to indigenous women declined by 75% between 1991 and 2008.⁴ In the same period, life expectancy at birth rose from 69.4 to 79.7 years, and 44% of this progress was due to the improvement of infant health and the reduction of infectious diseases.⁵
- 1.2 New epidemiological challenges are affecting the population, primarily in the control and management of chronic noncommunicable diseases (CNDs). The new challenges are associated with the demographic and epidemiological transition in Peru, with the growth, aging, and urbanization of the population.⁶ The CND burden is rapidly increasing, and in 2016 these conditions caused 68.7% of all deaths and 83.4% of years of life lost due to disabilities. Of the top ten causes of death in Peru in 2017, eight were caused by CNDs such as cardiac and cerebrovascular diseases, chronic kidney disease, cancer, diabetes, and chronic obstructive pulmonary disease. People with less education have a greater prevalence of obesity, hypertension, and diabetes.⁷ Furthermore, mortality and morbidity associated with external causes such as accidents and violence are on the rise, particularly gender violence. In Peru, 68.2% of women have experienced some type of violence by their spouse or partner.⁸

2. Challenges in providing services

- 1.3 Peru's health sector is characterized by a high degree of segmentation, with subsystems that operate with different rules, rates, and beneficiaries. The sector is comprised of public and private entities, and the national and regional governments are involved in providing services. At the public level, the main providers of insurance are the Ministry of Health (MINSA) and Social Health Insurance of Peru (EsSalud): (i) MINSA, through the comprehensive health insurance program (SIS), is responsible for providing services to the poor or vulnerable population, and is mostly financed by general taxes; and (ii) EsSalud,

¹ [Global Burden of Disease Study \(GBD\) 2016.](#)

² [Bill and Melinda Gates Foundation, 2017.](#)

³ [http://wdi.worldbank.org/table/2.18.](http://wdi.worldbank.org/table/2.18)

⁴ [Berlinski, Samuel, and Norbert Schady, 2015.](#)

⁵ [GBD 2016.](#)

⁶ [Piñeros et al. 2017.](#)

⁷ [Quispe et al. 2016.](#)

⁸ National Statistics and Informatics Institute (INEI). [Family and sexual violence indicators, 2000-2017.](#)

which reports to the Ministry of Labor and Job Promotion, is the mandatory insurance provider for the formally employed population and is funded by payroll taxes. The SIS currently covers 51% of the Peruvian population, EsSalud covers another 31%, and around 18% of the population is uninsured.⁹ The MINSA health services network, which operates in the Lima metropolitan area, and the regional governments, which operate in all other regions of the country, serve the population insured by the SIS and people with no health insurance, with uninsured individuals paying out of pocket when they receive care. EsSalud has its own network of Health Service Provider Institutions (IPRESS) to treat those covered by its insurance.

- 1.4 Poor service quality in the public health network limits its ability to address the population's health problems. A significant number of people do not use healthcare services when they need them. In 2018, 44.2% of the insured population reported that they did not seek medical care or go to a pharmacy when they had a health problem. Some of the reasons cited for not seeking care were that they had self-prescribed or preferred to use home remedies (31.5%), delays in receiving care or a lack of time (24.0%), and mistrust of doctors or poor treatment by healthcare staff (6.0%).¹⁰ The results of CND treatment reflect the problems with quality; for example, in 2017 in metropolitan Lima, 65.4% of people between the ages of 40 and 59 did not have a checkup to rule out some type of cancer, and 28.5% of people older than 15 who received a diabetes diagnosis and 37.7% of those who received a hypertension diagnosis did not receive treatment in the last 12 months.¹¹ In fact, in 2016 it was estimated that 49% of deaths in Peru that could have been prevented through medical care were due to not having access to services or the poor quality of services received, for a total of 373,000 years of life lost as a result of poor quality medical care.¹²
- 1.5 Ineffective primary healthcare (PHC) overburdens hospitals with avoidable care. International evidence shows that the countries that provide quality PHC as a gateway to the healthcare system achieve better health outcomes, greater patient satisfaction, and better containment of increasing system costs.¹³ However, in Peru the hospital morbidity profile indicates that PHC is not capable of addressing the public's primary health problems, especially given the sharp increase of CNDs. Hospitals are overburdened by an excess of outpatient services, use of emergency rooms, and hospitalizations that could have been prevented had timely, quality treatment been provided at the primary care level. In 2017, 29% of all hospitalizations in the MINSA network in the Lima metropolitan region were avoidable. In other words, they were caused by conditions such as diabetes mellitus, hypertension, and asthma, which are preventable through timely, quality

⁹ [National Superintendence of Health \(SUSALUD\). Register of Universal Health Coverage Participants AUS. August 2018.](#)

¹⁰ INEI, National Household Survey.

¹¹ [Ministry of Economy and Finance. RESULTA tool. Budget program performance indicators.](#)

¹² [Kruk et al. 2018.](#)

¹³ [Hansen et al. 2015.](#)

PHC.¹⁴ In terms of rates per person, there were 198.8 hospitalizations per 10,000 women and 113.9 per 10,000 men.¹⁵

- 1.6 Physical PHC infrastructure was not designed to effectively treat CNDs and is in poor condition. Until 2012, the package of benefits covered by the SIS and the portfolio of services offered by PHC facilities gave priority to pregnant women and children: 56 of the 140 conditions covered in the Essential Health Insurance Plan (PEAS) were obstetric, gynecological, and pediatric conditions.¹⁶ Starting in 2012, legislative and regulatory changes expanded the SIS benefits plan and the portfolio of PHC referral services.¹⁷ However, the physical infrastructure of the IPRESS and the services actually provided by health professionals continue to be primarily for maternal-infant health care. The most effective PHC facilities are in the I-4 category and are still called “Maternal Infant Centers,” and their physical spaces were designed with no thought to the treatment of CNDs. Furthermore, of the 364 IPRESS in the Lima metropolitan region, 198 were considered in an emergency state of repair due to the vulnerability and poor condition of their physical infrastructure and equipment.¹⁸
- 1.7 The training and knowledge of PHC professionals are inadequate for properly treating CNDs.¹⁹ As in the previous scenario of infrastructure concentrated on maternal-infant PHC services, the specialization of healthcare professionals at the primary level is also focused on pregnant women and children. A survey of the PHC network in North Lima conducted in 2018 on the use of MINSA clinical practice guidelines for managing type 2 diabetes at the primary care level found significant limitations in the knowledge and training of healthcare professionals. Only 28% of doctors had received training on the guidelines, 65.6% were not familiar with the guidelines’ recommendations on diagnosing diabetes, and 71.9% did not know the purpose of testing glycated hemoglobin (hbA1c), a key way to measure the success of diabetes treatments.²⁰
- 1.8 Available diagnostic clinical support services are insufficient to meet the standards required to provide effective quality medical care. For PHC to be able to effectively address most health problems, it needs diagnosis and treatment support services such as lab tests, diagnostic imaging, and blood and blood component transfusion services. In the metropolitan region of Lima, the level of these services available in the public network is insufficient to meet demand based on the quality standards defined by the sector. In the Lima metropolitan region, fewer than 30% of women between the ages of 40 and 59 had a mammogram in the last 24 months.²¹ In routine laboratory tests, the shortage of these services is even worse. The study of 32 PHC facilities in North Lima mentioned above found that none of the IPRESS

¹⁴ [Calculated based on SIS and INEI data.](#)

¹⁵ Calculated based on administrative records of the SIS (MINSA) and INEI.

¹⁶ [Gutiérrez et al. 2018.](#)

¹⁷ For example, Decree Law 1163 and the Esperanza Plan, which were both passed in 2012.

¹⁸ See Supreme Decree 019-2018-SA.

¹⁹ [Diez-Canseco et al. 2014.](#)

²⁰ [Bellido-Zapata et al. 2018.](#)

²¹ [INEI. Peru: Noncommunicable and communicable diseases, 2016.](#)

were capable of performing hemoglobin A1c or albuminuria tests, which are necessary for proper diabetes control.²² Together, all of the PHC IPRESS laboratories in the MINSA network in the Lima metropolitan region performed 2.1 million diagnostic tests in 2017, whereas the expected total for testing the reference population pursuant to the Ministry's policies should be 20.6 million tests.²³ In addition, the estimated current demand for blood and blood products is 303,000 units per year, but the current production is 93,000 units per year.

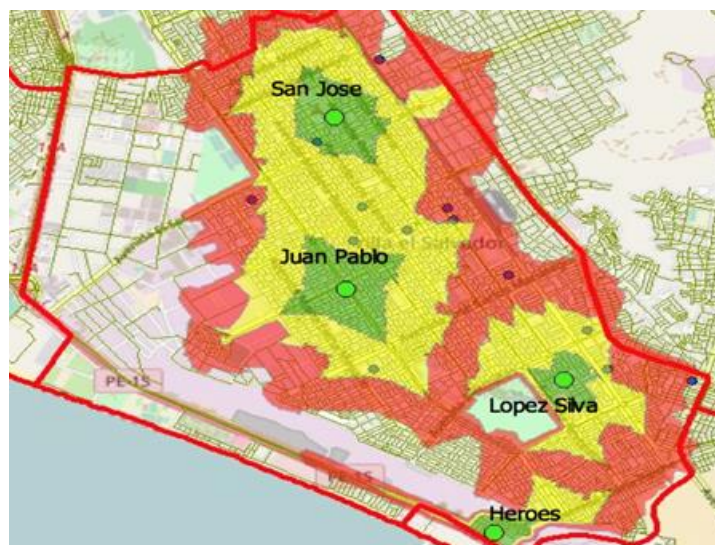
- 1.9 The current organization of the network of PHC IPRESS is fragmented and does not consider an integrated network approach.²⁴ In 2017, through the technical cooperation project to support the Strengthening of Health Services Management (PE-T1349; ATN/OC-15845-PE), the Bank financed a project in a micro healthcare network in the district of Villa El Salvador in the Lima metropolitan region, which has a population of 328,000 people either insured by the SIS or with no health insurance. The project was a rapid response to the Peruvian government's goal of increasing the effectiveness of PHC through a diagnostic assessment and proof of concept study on the reorganization of services. One of the first findings of the project was the absence of a network design and optimization of service delivery, as illustrated in Figure 1. Of the 18 PHC IPRESS in the micro network, four would be sufficient for 95% of the population to be able reach them by walking a maximum of 30 minutes, which illustrates the redundancy of the current structure. The Villa El Salvador project also revealed that the IPRESS operate clinical support services in a fragmented manner, with poor quality standards. There are currently 219 primary care IPRESS in metropolitan Lima that have clinical laboratories but only perform an average of 10,000 diagnostic tests per year, while hospital laboratories perform an average of 720,000 tests per year.

²² [Bellido-Zapata et al. 2018.](#)

²³ [Ministry of Health. Public Investment Project. Improvement of CSS in Metropolitan Lima. September 2018.](#)

²⁴ [Coronado, Enrique Zik. 2017.](#)

Figure 1. Physical access in the district of Villa El Salvador



Fuente: Proyectos Redes Eficientes MINSA/BID. Notas: La figura es un mapa de Villa El Salvador.

● EESS priorizados

● Otros EESS

Pueden acceder a ESS priorizados en < de minutos caminando:

■ 30 minutos

■ 15 minutos

■ 10 minutos

Source: MINSA/IDB Efficient Networks Project. Notes: This figure shows a map of Villa El Salvador.

- 1.10 Shortcomings in IPRESS management processes limit the quality of services and affect the experience of patients. The studies in Villa El Salvador included measurements of the use of time and flow of care in a sample of about 150 patients who sought care in IPRESS. The average length of time the patients were in the IPRESS was 4 hours and 39 minutes; only 14% of the total time was for actual care.²⁵ The average number of points of contact or successive steps required for patients to receive care was seven, with a maximum of 20 different points of contact. When laboratory tests are required, patients often have to schedule additional appointments for samples to be taken and to pick up their test results.
- 1.11 There are opportunities to better integrate healthcare services and services for women who are victims of violence. There are 245 Emergency Women's Centers (CEM) in Peru, which are public establishments that provide legal guidance, judicial protection, psychological counseling, and social assistance for victims of violence against women and family members. Recent initiatives seek to link health services with the services provided by the Emergency Women's Centers, but to

²⁵ [Montes, Cecilia. Midterm evaluation of the Efficient Networks Project in four health facilities in Villa El Salvador. Consulting report, PE-T1349. July 2017.](#)

date there is only one in the entire country that operates in conjunction with a healthcare facility, which opened in February 2018. In addition, MINSA's first technical guidelines on treating women who experience violence by a partner or ex-partner was introduced by MINSA in 2017, but support is needed to implement and integrate it with the healthcare network.²⁶

3. Intervention strategy

- 1.12 **Rationale.** The Government of Peru has requested the Bank's support for MINSA to address challenges in the sector, through an investment program based on the key points outlined below. The intervention strategy will seek to transform health service networks so that they can offer efficient, effective, and high-quality responses to current epidemiological challenges. Instead of trying to expand or reform services based on previously existing models, the program aims to introduce change through "disruptive innovation,"²⁷ i.e. focusing on a radical redesign of the service in order to improve the quality of the care that patients receive, with an emphasis on returning key aspects of clinical practice from the hospitals to PHC, to enhance the primary level of care. This will be achieved by redesigning processes, achieving economies of scale, and using automation and digitization technologies.
- 1.13 **Modernization of the health services delivery model.** Due to changes in demand patterns caused by demographic and epidemiological transition, and a mismatch with the current services organization model, consensus is growing in Peru regarding the fact that the country must organize its primary level of care based on an integrated service network model, with widely accessible and highly effective PHC, including the control and treatment of CNDs. This is consistent with the international literature and experience, which shows that healthcare systems organized in networks that emphasize primary care have better health outcomes, are more efficient, and generate greater public confidence.²⁸ Studies also suggest that enhanced PHC is able to address most healthcare needs,²⁹ thus avoiding the unnecessary use of hospitals³⁰ and emergency rooms, and decreasing the number of therapeutic procedures. There is also evidence that the development, implementation, and ongoing improvement of management and care processes is essential for achieving quality care.³¹ For this reason, the program will support the updating of service delivery and management models and the training of professionals so that clinical practice guidelines and management processes can be effectively implemented.
- 1.14 In keeping with the objectives of transforming the services network and building the response capacity of the primary care level, new knowledge and technologies

²⁶ Ministry of Health. [Technical Guide to Mental Health Care for Women in Situations of Violence Perpetrated by a Partner or Ex-partner. 2017.](#)

²⁷ See how these concepts inspired reforms of the British National Health Services: [Birchall, Daniel. 2010.](#)

²⁸ There is extensive evidence on the importance of primary health care in high- and medium-income countries. See for example [Guanais et al. 2018](#) and [Hansen et al. 2015.](#)

²⁹ See for example: [Bindman et al. 2007.](#)

³⁰ The literature on the role of PHC in preventing hospitalizations is extensive. See for example: [Caminal et al. 2004.](#)

³¹ See the recent report of the Lancet Global Health Commission on quality: [Kruk et al. 2018.](#)

need to be incorporated into the work process of health teams, building their skills and competencies under a new treatment and management model geared to health care. The program proposes a skills development plan for healthcare personnel, which focuses on recognizing talent and building technical skills and abilities for working as a team with shared responsibility, based on collaboration between people and coordination of health care, with an emphasis on collaboration between general practice doctors and specialists. The plan should also provide ways to attract and retain primary care staff, in alignment with the established care and management model, seeking alternatives to increase the motivation of primary care personnel.

- 1.15 **Upgrading the PHC network.** Although some studies question making an automatic association between the condition of infrastructure and the quality of the services provided,³² the poor condition of the PHC network in Peru, which has been declared a health emergency by MINSA, is sufficient to compromise the effectiveness and quality of the services provided, as well as the public's willingness to consider them acceptable. In addition, the type of professionals and work that is required to effectively and efficiently treat CNDs is based on multidisciplinary teams, with shared spaces and use of information and communication technologies, which not only optimize the use of infrastructure and human resources, but encourage collaboration.³³ Therefore, the program will support investments in the upgrading of physical infrastructure and the procurement of equipment for facilities in the PHC network, in order to address maternal-infant health, infectious diseases, and external causes, together with the growing demand for CND-related services that will be prioritized based on a network logic that prevents redundancies in the services offered and optimizes their geographic distribution.
- 1.16 **Optimization of the CSS network.** In order to be financially sustainable, closing wide investment gaps in the provision of CSS requires an approach that seeks efficiency through economies of scale.³⁴ The literature indicates that the centralization of CSS is an effective way to introduce control mechanisms and ensure the quality of services.³⁵ To this end, the program will support the construction and equipping of a central clinical support services facility (laboratory, diagnostic imaging, blood bank, and prehospital care) in Metropolitan Lima, as well as the coordination of the central facility's services with the IPRESS network.
- 1.17 In terms of the clinical pathology laboratory and blood banks, the program will support the centralization and automation of sample processing through robotic systems that can perform the tests and process them with a high level of quality, capitalizing on the strong economies of scale that currently exist in these services.³⁶ The samples will be collected in the IPRESS and sent to the central facility for processing. In the area of diagnostic imaging, the program will support

³² [Leslie et al. 2017](#).

³³ [Bodenheimer et al. 2014](#).

³⁴ [Gonçalves and Pita Barros. 2013](#).

³⁵ See [Kruk et al. 2018](#).

³⁶ The evidence applies to high-income as well as middle-income countries. See: [Fleming et al. 2016](#) and [Chatterjee et al. 2013](#).

the procurement of x-ray digital imaging, tomography, magnetic resonance, and mammography devices to replace current equipment in the IPRESS, and in the central facility the program will support the creation of a diagnostic image reading facility, taking advantage of the high concentration of radiologists in the Lima urban area compared to the rest of the country, as well as the improved quality of diagnostic assessments when the professionals specialize in the frequent reading of tests.³⁷ The central facility will be capable of reading digital images sent from anywhere in the country. Lastly, the program will also support the modernization of the centralized ambulance dispatch service and regulation of prehospital care, to be used in emergencies and urgent care.

- 1.18 **Gender approach.** Although solutions to gender violence problems and the greater exposure of women to CND risk factors require multisector interventions whose importance extends beyond the health sector, the program will contribute to the joint effort to address these challenges. There is significant evidence on the role that healthcare services can play in incentivizing the early detection of suspected cases of violence, providing support for reporting them and coordinating with the courts, and providing emotional support to victims.³⁸ Prehospital care services are often the first point of contact with victims when urgent and emergency calls are received. Therefore, the program will support the development of new clinical practice guidelines and the implementation of existing guidelines³⁹ by training professionals to properly handle these cases.
- 1.19 **Climate change alignment.** The program is aligned with climate change since resources are allocated for the construction of the central clinical support services facility, whose design includes the following measures aimed at reducing the consumption of water, electricity, and the energy embodied in materials: solar orientation, dry construction (water and energy savings); use of cost-effective lighting and motion sensors; light-colored siding; roofs with heat and acoustic protection, and white materials with low solar absorption; use of natural lighting and ventilation; water volume savings, energy savings for heating water, etc. ([optional link 3](#)). The central facility's design also includes the use of technology in its infrastructure, fixtures and furnishings, and equipment, aimed at protecting the facilities from extreme climate phenomena.
- 1.20 **Beneficiary population.** At MINSA's request, the program will have two intervention areas. The first is the metropolitan region of Lima where there are 5.01 million people who are either covered by the SIS or are uninsured. In this metropolitan area, the program will upgrade PHC IPRESS facilities and will centralize the CSS. MINSA is responsible for providing services to the poor, vulnerable, or uninsured populations in the Lima metropolitan region, so by strengthening its own network, the ministry will be in a position to better play its leadership role in providing services in the rest of the country, based on the lessons learned in its own network. The program's second intervention area is in the departments to be prioritized after completion of the Component 2 preinvestment studies. In this case, investments will focus on upgrading PHC

³⁷ See: [ESR Executive Council 2009 and European Society of Radiology. 2010.](#)

³⁸ See: [Leskošek et al. 2017](#) and [Dutton et al. 2015.](#)

³⁹ See for example the [Technical Guide to Mental Health Care for Women in Situations of Violence.](#)

IPRESS. Although the investment planned under the program is not sufficient for a large-scale nationwide intervention, the selection of the prioritized regions will be based on strategic considerations, since the regional governments will express their interest to MINSA in piloting a new primary care model and serving as demonstration sites. Therefore, successful implementation of the program will make it possible for MINSA to scale IPRESS models that can be adapted to all regions of the country.

- 1.21 **Lessons learned and related operations.** The Bank's last investment operation in Peru's healthcare sector, the Second Phase of the Program to Support Health Sector Reform (PARSalud II),⁴⁰ was approved in December 2008, with the last disbursement made in December 2015. One of the important lessons learned from that operation was that approaches that are highly targeted on maternal and child health interventions, as opposed to an integrated service network model, create disincentives for comprehensive care, and may lead to mistrust among users of health services. Therefore, this operation seeks an approach that is more integrated into the mechanisms for achieving efficient, quality services, and is less focused on specific pathologies (Components 1, 2, and 3). In addition, a portfolio of three nonreimbursable technical cooperation projects approved since 2015 for a total amount of US\$1.15 million⁴¹ provided the following lessons that were incorporated into this program: (i) the importance of working on clinical management processes in the IPRESS, as well as measures to improve the quality of services and the experience of patients (Component 1); (ii) the importance of planning services based on estimated demand and the projected epidemiological profile, to prevent redundancies in the services offered (Components 2 and 3); (iii) the central role of primary health care to boost prevention and effectiveness, especially in CND care (Components 1 and 2); and (iv) achieving efficiency by introducing the reorganization of services and economies of scale (Component 3).
- 1.22 **Complementarity with the World Bank's work.** At the Peruvian government's request, the Inter-American Development Bank (IDB) and the World Bank are working on two operations that are coordinated in a single program in the National Multiyear Programming and Investment Management System (Invierte.pe), with a unified strategic approach to the transformation of health networks. For this reason, the program's design includes close coordination with the World Bank, which will finance investments in IPRESS in areas that are complementary to those included in the IDB program. The World Bank will also finance the centralization of the Health Information System and medication and medical supplies logistics in metropolitan Lima, which complement the support services included with this IDB program PE-L1228. Both operations will be executed independently, but will be complementary and coordinated. The World Bank operation is expected to be approved in the first quarter of 2019.
- 1.23 **Strategic alignment.** The program is consistent with the Update to the Institutional Strategy 2010-2020 (document AB-3008) and is strategically aligned with the development challenges of social inclusion and equality by improving access to

⁴⁰ PE-L1005; 2092/OC-PE.

⁴¹ PE-T1327, ATN/OC-14986-PE; PE-T1349, ATN/OC-15845-PE; and PE-T1396, ATN/OC-16882-PE.

quality healthcare services. The program is also aligned with the crosscutting areas of gender equality and diversity by promoting women's health, as well as climate change and environmental sustainability by promoting sustainable practices through the construction of energy-efficient infrastructure. Approximately 36.17% of the operation's resources are invested in climate change mitigation activities, in accordance with the [joint methodology of the multilateral development banks for tracking climate change finance](#).⁴² These resources contribute to the IDB Group target of increasing financing for climate-related projects to 30% of all approvals by the end of 2020. The program will also contribute to the Corporate Results Framework (CRF) 2016-2019 (document GN-2727-6) by increasing the number of beneficiaries receiving health services, in keeping with the Health and Nutrition Sector Framework Document (document GN-2735-7). It is also consistent with the Gender and Diversity Sector Framework Document (document GN-2800-8), in the dimension "promote gender equality and the empowerment of women and children" by increasing access to services for female survivors. It is also aligned with the IDB Group Country Strategy with Peru (2017-2021) (document GN-2889), specifically with the objectives of improving access to and the quality of health care services, by reducing mortality due to chronic diseases and reducing wait times for generic medical checkups. The operation is included in the Update to Annex III of the 2018 Operational Program Report (document GN-2915-2).

B. Objectives, components, and cost

- 1.24 **Objective.** The objective of the program is to achieve adequate access for the population to timely, efficient, quality primary health services based on their needs. To this end, it proposes a reorganization of IPRESS into integrated health networks to improve the effectiveness of the current care offering in metropolitan Lima and the priority regions of the country, and to enhance clinical support services in metropolitan Lima.
- 1.25 **Component 1. Improvement and proper design of the IPRESS organizational model into integrated health networks in metropolitan Lima and the priority regions (IDB: US\$9.87 million, Local: US\$1.78 million).** The objective of this component is to help modernize the health system by means of an adequate organizational model for the IPRESS for primary care, in terms of management, effectiveness, timeliness of intervention, quality, and allocation of resources, with a network approach. The component will finance consulting services and training activities to: (i) redesign the care model with an emphasis on the new disease burden pattern; (ii) develop clinical guidelines and protocols for treating the most prevalent diseases; (iii) redefine the organization, management, and financing models for integrated healthcare networks; (iv) design and implement a skills development program for healthcare staff; (v) design a change and communication management plan; (vi) conduct workshops to raise awareness about the new service delivery model; (vii) develop and support the implementation of guidelines for treating and handling cases of violence against women, including risk screening protocols and protocols for referring victims to social and legal services; and

⁴² See: [2017 Joint Report on Multilateral Development Banks' Climate Finance](#).

(viii) perform other relevant activities defined during the preparation of the preinvestment study.

- 1.26 **Component 2. Improvement and proper supply in primary care IPRESS in metropolitan Lima and priority regions (IDB: US\$52.12 million, Local: US\$9.38 million).** The objective of this component is to improve the supply capacity in health institutions in metropolitan Lima and the priority regions. It aims to achieve an adequate level of infrastructure, equipment, and human capacities for service delivery. To this end, investments will be made in ambulatory IPRESS (primary care) providing service for up to 12 and 24 hours.
- 1.27 **Component 3. Improvement of clinical support services in metropolitan Lima (IDB: US\$63.01 million, Local: US\$11.34 million).** The objective of this component is to achieve clinical support services that are efficient, effective, and have a network approach. To this end, clinical support systems will be modernized in an integrated manner, using a network logic (12- and 24-hour IPRESS).⁴³ The project will feature the following: (i) investment in a central CSS facility that will generate synergies and economy of scale (efficiency); (ii) investment in health technology equipment to enhance clinical effectiveness and generate cost efficiencies; and (iii) enhanced effectiveness for diagnoses and treatment in health interventions through improved clinical pathology, imaging, blood bank, and ambulance system services.
- 1.28 **Component 4. Management of the investment program (Local: US\$10.33 million).** The objective of this component is to support the execution, management, and monitoring of the program. This component will finance the procurement of equipment and contracting of staff and consultants to support the operation of the program execution unit (see paragraph 3.1), external audits, and the contracting of consultants for the program's monitoring and evaluation activities.

C. Key results indicators

- 1.29 **Expected impacts and outcomes.** As a composite indicator to measure the program's impacts, the reduction in the number of hospitalizations for ambulatory care-sensitive conditions is proposed. Avoidable hospitalizations have been widely used in the literature as a way of monitoring the effectiveness and quality of primary care services.⁴⁴ Hospitalizations and their causes are monitored in the health sector, and will be measured based on MINSA's administrative records on hospitalizations.
- 1.30 The expected outcomes of the program are: (i) increased number of tests to diagnose cancer, with checkups for both men and women; (ii) improved quality and accessibility of healthcare services, with timely prehospital care and shorter wait times; (iii) increased effectiveness of healthcare networks in treating chronic

⁴³ The preliminary technical designs of the healthcare facilities and of the equipment that will be part of the integrated networks with an emphasis on primary care, including primary care health facilities and the central clinical support services facility described in Components 2 and 3, are available in the conceptual architecture link ([optional link 2](#)).

⁴⁴ See for example: [Rubinstein et al. 2014.](#); [Rosano et al. 2013.](#); [Caminal et al. 2004.](#); and [Guanais and Macinko. 2009.](#)

patients (with an emphasis on the treatment of diabetic and hypertensive patients); (iv) increased voluntary blood donations; and (v) a higher level of user satisfaction, due to better care received and shorter wait times.

- 1.31 **Economic viability.** The strategies promoted in this operation are based on evidence on the effectiveness of the healthcare network model with an emphasis on primary care. Based on evidence specific to Peru, the Economic analysis ([optional link 1](#)) quantifies the incremental benefits resulting from the project's investments, which include: (i) productivity gains from reducing morbidity and mortality as a result of greater coverage and higher quality of primary care services; (ii) hospital cost savings as a result of reducing admissions for ambulatory care-sensitive conditions; and (iii) earnings from implementing different lines of care. The analysis quantifies disability-adjusted life years (DALY) that may be saved as a result of making investments in a healthcare network context, analyzing the increase in effective coverage and the time it takes for results to materialize. In the base effective coverage scenario, using conservative assumptions regarding the effectiveness of the interventions within a five-year time horizon and a discount rate of 3%, the benefit/cost ratio is 1.51. In addition, the sensitivity analyses in a ten-year horizon show that the benefit/cost ratio is greater than one, even in less favorable scenarios. In a scenario that equalizes costs and benefits with a discount rate of 3%, the internal rate of return is 15.3%.⁴⁵

II. FINANCING STRUCTURE AND MAIN RISKS

A. Financing instruments

- 2.1 The financing instrument is an investment loan under the multiple-works program modality, taking into account physically similar but independent works. The program uses a representative sample (paragraph 2.2), which meets the eligibility criteria (paragraph 2.4). The total cost of the program is US\$157,825,000, financed with a US\$125 million loan from the Bank's Ordinary Capital, and a local counterpart contribution of US\$32,825,000, as shown in Table 1 below.⁴⁶ The disbursement period is five years, and disbursements are estimated based on the scope of outputs in the Multiyear Execution Plan (MEP) ([required link 1](#)). The operation's disbursement schedule appears in Table 2.

⁴⁵ The project adopts the World Health Organization's recommendation for projects in the sector, i.e., using a 3% discount rate. See: [Tan-Torres et al. 2003](#).

⁴⁶ To supplement this program, independent parallel financing is expected to be provided by the International Bank for Reconstruction and Development to the Republic of Peru for up to US\$125 million, to finance activities in the framework of the program to Create Integrated Health Networks under the Republic of Peru's National Multiyear Programming and Investment Management System.

Table 1. Program Costs (US\$)

Components	IDB	Local	Total
1. Improvement and proper design of the IPRESS organizational model into integrated health networks in metropolitan Lima and the priority regions	9,874,211	1,777,358	11,651,569
2. Improvement and proper supply in primary care IPRESS in metropolitan Lima and priority regions	52,119,409	9,381,494	61,500,903
3. Improvement of clinical support services in metropolitan Lima	63,006,380	11,341,148	74,347,528
4. Management of the investment program	0	10,325,000	10,325,000
▪ Management	0	8,575,000	8,575,000
▪ Monitoring and evaluation	0	1,500,000	1,500,000
▪ Audits	0	250,000	250,000
Total	125,000,000	32,825,000	157,825,000

Table 2. Disbursement Schedule (US\$)

Source of financing	Year 1	Year 2	Year 3	Year 4	Year 5	Total
IDB	168,611	4,833,708	33,375,276	50,115,179	36,507,226	125,000,000
Local	2,903,580	2,635,066	7,772,550	10,785,734	8,728,070	32,825,000
Total	3,072,190	7,468,774	41,147,826	60,900,914	45,235,296	157,825,000
%	1.95%	4.73%	26.07%	38.59%	28.66%	100.00

- 2.2 **Representative sample.** A representative sample of the works with a total cost of equivalent to US\$84.43 million or 53.5% of the program was evaluated during the project preparation phase. The sample includes two types of investments that are part of the integrated healthcare networks that emphasize primary care and need to be coordinated: (i) the primary care health facilities (Component 2); and (ii) the central CSS facility (Component 3). The preliminary technical designs of the works and preliminary technical specifications of the equipment that are part of the representative sample are available at [optional link 2](#).
- 2.3 **Startup of works.** The timeframe for the physical startup of the works will be 36 months from the loan contract's effective date. This timeframe is warranted due to the need to complete the preinvestment studies according to the rules and policies of the Invierte.pe public investment system prior to beginning the works.
- 2.4 **Eligibility criteria and prioritization of projects.** The projects included in Component 2 to be financed by the program consider the following eligibility criteria: (i) they will be 12- or 24-hour IPRESS facilities under an integrated health network planning criterion consistent with Component 1; (ii) these IPRESS will be located in metropolitan Lima and the priority regions; (iii) they will be interventions that comply with the Bank's Environment and Safeguards Compliance Policy and the contents of the Environmental and Social Management Report (EMSR) ([required link 3](#)); and (iv) they will not be classified as Category A operations or involve involuntary resettlement, in accordance with the Bank's Safeguards Policies. The central CSS facility to be financed under Component 3 of the

program will be constructed on a property adjacent to the Sergio E. Bernales Hospital in the district of Comas in the Lima metropolitan area.⁴⁷

B. Environmental and social risks

- 2.5 Given the nature of the proposed infrastructure interventions and in accordance with Operational Policy OP-703, Directive B.03, this program has been classified as a Category B operation, due to fact that any socioenvironmental impacts will be localized, temporary, and short term, and there are already effective and recognized mitigation measures in the health infrastructure sector. The Environmental and Social Analysis (ESA) developed for the three projects in the sample identifies the main potential impacts during the construction phase as the generation of dust, noise, and solid and liquid wastes, risk of spills, traffic disturbances, and safety risks to workers and the community. During the operation phase, risks are related to the generation and disposal of hospital wastewater and solid waste. The Environmental and Social Management Plans (ESMPs) describe mitigation measures for each of the identified impacts. The works included in the sample will be constructed on properties owned by MINSA or currently occupied by IPRESS, so they will not cause any physical and/or economic displacement of the population.
- 2.6 Since this operation involves multiple works, an Environmental and Social Management Framework (ESMF) has been prepared that includes guidelines on the development of socioenvironmental management tools for future projects that are not part of the sample.
- 2.7 Due to the program's geographic location, there is a moderate risk of natural disasters. The mitigation measures for these risks are included in the ESMP and the ESMF. The ESA, the ESMPs for the sample, and the ESMF were published on the websites of the IDB and the executing agency. The public consultations took place at the end of October 2018 and resulted primarily in the recommendation to ensure citizen engagement to support the projects planned under the program, which was incorporated into the ESMPs and the ESMF.

C. Fiduciary risks

- 2.8 During the operation's design, a medium-level fiduciary risk was identified that the program could potentially have higher costs and take more time to implement, due to: (i) lack of experience and knowledge regarding the Bank's fiduciary policies applicable to loan operations; and (ii) the recent creation of the National Health Investment Program (PRONIS) as a new execution unit with a budget that is less than the program's cost. To mitigate this medium risk, the following actions were identified: (i) contracting of key personnel with experience in projects financed by multilateral organizations and the rules of Invierte.pe; (ii) the inclusion of fiduciary process flow charts in the program's Operations Manual specifying the responsible parties and their roles; (iii) fiduciary assistance and support provided to PRONIS by the Bank; and (iv) contracting of consultants to prepare highly complex competitive bidding documentation.

⁴⁷ MINSA already owns the property, which has been earmarked for the central CSS facility project.

D. Other risks and key issues

- 2.9 Three development risks were identified: (i) potential delays in the implementation of Component 1, due to difficulties involved in preparing the consultant terms of reference for network modeling activities (medium); (ii) delays in making progress in the program's stages, due to inconsistencies between the preinvestment studies, final studies, and technical specifications (medium); and (iii) difficulties in assigning primary care medical specialists, due to the absence of policies for attracting and retaining personnel at the primary care level, which could restrict the implementation of the care model (high). Proposed mitigation measures are: (i) contracting an expert in healthcare networks to work with MINSA on the definition of the key terms of reference for Component 1 (care model/management model); (ii) expansion and training of PRONIS's technical team in the design, formulation, and evaluation of investments; and (iii) formulation of a human resources skills development plan that includes incentives for attracting and retaining primary care medical specialists, which will promote coordination and collaboration between generalists and specialists and will contribute to the effectiveness of primary care.
- 2.10 Lastly, two public management and governance risks were identified: (i) failure to implement process reengineering activities in the healthcare facilities, due to the resistance of trade unions and professional associations to the changes needed to create more efficiency in the healthcare system (medium); and (ii) potential difficulties in managing agreements between MINSA and the regional governments, with potential delays in the execution of Component 2. These risks should be mitigated by: (i) developing an awareness-raising strategy backed by a change and communication management plan. This strategy will focus on a dialogue with and involvement of healthcare professionals and the associations that represent them; (ii) formation of a high level technical group in MINSA that will be responsible for monitoring the network transformation agenda and producing strategic information as feedback for decision-making; and (iii) during the first year of execution, technical discussions will be held with MINSA and the regional governments in order to reach the required management agreements.
- 2.11 **Sustainability.** A commitment to the sustainability and maintenance of the works and equipment to be financed by the loan is required in order to declare the viability of the projects included in the program under the rules and policies of the Invierte.pe public investment system. Therefore, MINSA has already made these commitments in the preinvestment stage. The design of the competitive bidding processes for high cost medical equipment financed by the program will include extended warranties.

III. IMPLEMENTATION AND MANAGEMENT PLAN

A. Summary of implementation arrangements

- 3.1 **Borrower and executing agency.** The borrower will be the Republic of Peru, and the executing agency will be MINSA through PRONIS, which is a decentralized unit that reports to the Office of the Deputy Minister of Healthcare Benefits and Insurance, which is responsible for formulating, preparing, and executing the country's public investment projects. PRONIS will be the execution unit for the

- program and will have the following duties: administration (related to budget, financial programming, accounting, cash flow, and procurement), the coordination of technical issues, as well as planning, execution, monitoring, and evaluation.
- 3.2 PRONIS will execute the activities in close coordination with MINSA's line agencies involved in the project, especially the Donations, Transplants, and Blood Bank Bureau and its Blood Bank and Hemotherapy Department (PRONAHEBAS), the Insurance and Benefits Exchange Bureau and its Benefits Exchange, Organization, and Health Services Department, the National Telehealth, Referrals, and Urgent Care Department and its Emergency Mobile Care Service (SAMU), the Health Operations Bureau, and the Healthcare Personnel Bureau. The duties of each entity will be defined in the program Operations Manual.
- 3.3 **Special contractual conditions precedent to the first loan disbursement: The executing agency will provide evidence, to the Bank's satisfaction, of: (i) the appointment of the key PRONIS staff to execute the program, including a general coordinator, a procurement specialist, a budget support consultant, an accounting support consultant, and a finance support consultant; and (ii) the approval and entry into force of the program's Operations Manual, under terms previously agreed upon with the Bank.** PRONIS is currently an investment execution unit in MINSA, but is not authorized to handle any investments with external financing. Therefore, the appointment of key staff in PRONIS and the approval and entry into force of the program's Operations Manual are critical conditions for ensuring an efficient start of execution and proper coordination with the different areas of MINSA and the prioritized regional governments that will participate in the program.
- 3.4 A special contractual condition for execution will be that prior to disbursements for Component 2 of the program, the executing agency will have provided evidence of the entry into force of the required agreements between MINSA and the regional governments of the intervention areas. These agreements are required for the execution unit to be able to carry out the activities indicated in the terms and conditions for the works and procurement of equipment for the IPRESS on behalf of the regional governments.
- 3.5 **Procurement.** PRONIS will manage the procurement plan ([required link 4](#)) through the government electronic procurement system known as the Sistema Electrónico de Adquisiciones y Contrataciones (SEACE) or other system specified by the Bank. All procurement processes under the operation will be carried out in accordance with the Policies for the procurement of goods and works financed by the Inter-American Development Bank (document GN-2349-9) and the Policies for the selection and contracting of consultants financed by the Inter-American Development Bank (document GN-2350-9), or subsequent updates thereof. Any procurement processes related to the subprojects financed by this operation will be executed in accordance with those policies. PRONIS will use the Integrated Financial Management System (SIAF) for financial management and its Project Execution Module to produce financial reports.
- 3.6 **Disbursements.** The fiduciary agreements and requirements establish the financial management and planning framework, as well as the supervision and execution of the procurement processes required to execute the operation. The loan proceeds may be disbursed through the advance of funds, expense

reimbursement, or direct supplier payment modalities. In the advance of funds modality, disbursements will be based on projected expenses for up to 180 days. Disbursements will be subject to justification of at least 80% of the total cumulative balances pending justification, using the Bank's standard forms.

- 3.7 **Audit.** PRONIS will submit audited financial statements annually and at the end of the operation, under the terms and timeframes specified in the Bank's policies. Accordingly, PRONIS agrees to select and contract an independent audit firm acceptable to the Bank for the duration of the operation.

B. Summary of arrangements for monitoring results

- 3.8 **Monitoring arrangements.** To monitor the program's progress, the executing agency and the Bank have agreed to closely monitor the program's execution using the Results Matrix (Annex II), the Multiyear Execution Plan ([required link 1A](#)), and the annual work plans (AWP) ([required link 1B](#)), as well as the semiannual Progress Monitoring Reports (PMR). To facilitate monitoring, the Social Protection and Health Division (SPH), in collaboration with the Bank's Country Office in Peru, will conduct periodic field visits and meetings with the work team to discuss the needs identified in those reports. The Monitoring and Evaluation Plan ([required link 2](#)) provides details on the monitoring activities.

- 3.9 **Arrangements for evaluating results.** The synthetic controls method will be used to evaluate the program's impact on reducing hospitalizations for ambulatory care-sensitive conditions in metropolitan Lima. The methodology consists of creating a valid control for the treatment unit, in this case metropolitan Lima, based on a weighted average of other units, in this case the other departments of Peru. This control is called the synthetic control, and the other departments are called donors. The methodology is used to construct a synthetic control with a behavior similar to that of the treatment unit during the period prior to the intervention. In this way, the observed difference after the intervention between the synthetic control and the treatment unit can be attributed to the program. It should be mentioned that the data used to produce the estimate consider all existing observations; in other words, this is not sample data that represent a population ([required link 2](#)). The designing of tools, data collection, and the baseline report will be done in year 1, and data collection and the monitoring report will occur in year 5 of the program. A midterm evaluation of progress will be conducted at month 30 of program execution, and the final evaluation will be submitted to the Bank 90 days after the last disbursement.

C. Post-approval design activities

- 3.10 To move forward with the program's implementation, the Bank and MINSA teams agreed that once the loan is approved, they will work on developing the preinvestment projects for improving the healthcare facilities with less complexity (Component 2), which should be ready in 2019. In addition, to supplement the Monitoring and Evaluation Plan ([required link 2](#)), a survey will be conducted with the counterpart to obtain additional information about the program's outcomes. The survey design and its indicators will be defined in the first year of program execution, in conjunction with the counterpart. It was specified that this survey will be based on the Survey on Access, Experience, and Coordination with Primary Care in Latin America and the Caribbean for the adult population and will be

adapted to the situation in Peru and the characteristics of the program.⁴⁸ The base survey captures and measures patient experiences with primary care services, and can be used as a tool to evaluate the quality of care or monitor the improvement of services. Considering that the program's objective is to contribute to the transformation of the healthcare services network by organizing integrated health networks with an emphasis on improving the quality of primary care services, the creation of an adapted version of the aforementioned survey has been proposed.

⁴⁸ [Guanais et al. 2018.](#)

Development Effectiveness Matrix		
Summary		
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)	
2. Country Development Objectives	Yes	
Country Strategy Results Matrix	GN-2889	Improve access to and quality of health care services
Country Program Results Matrix	GN-2915-2	The intervention is included in the 2018 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		10.0
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		1.0
5. Monitoring and Evaluation		8.0
5.1 Monitoring Mechanisms		2.5
5.2 Evaluation Plan		5.5
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		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. Procurement: Information System, Price Comparison, Contracting Individual Consultant, National Public Bidding.
Non-Fiduciary	Yes	Strategic Planning National System, Environmental Assessment 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	Yes	PE-T1396. Support to the Transformation of Health Networks (US\$300,000).

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

The objective of the program is to contribute to the improvement of the quality of primary care services through the transformation of the health services network and the organization of services in integrated health networks. To achieve this objective, the program considers four components which aim to (i) renew/update the health services model, (ii) improve on the supply of health services in specific prioritized areas, (iii) enhance the support services and (iv) management of the investment program. The project presents a cost-benefit analysis that supports the economic viability of the proposed activities, with a benefit / cost ratio of 1.51. The vertical logic is consistent with the indicators presented in the results matrix. The results matrix includes indicators for the main outputs, outcomes and impacts. Indicators in the results matrix meet SMART criteria and include baseline values and targets for the indicators, as well as the sources and means of verification that will be used to measure them. The final impact indicators are the percentage of primary care case sensitive hospitalizations, disaggregated by gender and the mortality rate from low-quality health services. The executing agency and the Bank are in charge of the monitoring and evaluation of the program. The indicators of the results matrix will be reported using administrative data sources from MINSA including the SIS, PRONAHEBAS and SAMU, the RESULTA platform of the MEF, as well as surveys including the ENDES and SUSALUD. The project includes an impact evaluation that will use a synthetic control methodology.

RESULTS MATRIX

Project objective:	The objective of the program is to achieve adequate access for the population to timely, efficient, quality primary health services based on their needs. To this end, it proposes a reorganization of health service provider institutions (IPRESS) into integrated health networks to improve the effectiveness of the current care offering in metropolitan Lima and the priority regions of the country, and to enhance clinical support services in metropolitan Lima.
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EXPECTED IMPACT

Indicators	Unit of measure	Baseline	Baseline year	Target	Means of verification	Comments
Percentage of hospitalizations for ambulatory care-sensitive conditions – women	/100 hospitalizations	24.9%	2017	23.6%	Administrative records - SIS (MINSA)	Number of hospitalizations for ambulatory care-sensitive conditions in the female population in a given place and period / Number of hospitalizations in the female population in a given place and period x 100 Gender monitoring
Percentage of hospitalizations for ambulatory care-sensitive conditions – men	/100 hospitalizations	40.6%	2017	36.5%	Administrative records - SIS (MINSA)	Number of hospitalizations for ambulatory care-sensitive conditions in the male population in a given place and period / Number of hospitalizations in the male population in a given place and period x 100
Percentage of hospitalizations for ambulatory care-sensitive conditions –total	/ hospitalizations	29.0%	2017	24.6%	Administrative records - SIS (MINSA)	Number of hospitalizations for ambulatory care-sensitive conditions in the population in a given place and period / Number of hospitalizations in the population in a given place and period x 100
Mortality rate due to poor quality health services	Deaths due to poor quality health services/ population	20.8	2017	17.5	National Center for Disease Epidemiology, Prevention, and Control (MINSA)	Number of deaths associated with poor quality health services in a given place and period / Population in that same place and period x 100,000. ¹

¹ The baseline was estimated based on the results of: [Kruk, Margaret E., Anna D Gage, Naima T Joseph, Goodarz Danaei, Sebastián García-Saisó, and Joshua A Salomon. 2018. "Mortality due to Low-Quality Health Systems in the Universal Health Coverage Era: A Systematic Analysis of Amenable Deaths in 137 Countries." The Lancet 6736 \(18\).](#)

EXPECTED OUTCOMES

indicators	Unit of measure	Baseline	Baseline year	Target	Means of verification	Comments
Percentage of women aged 30 to 59 who had a Pap smear in the last three years and knew the results	% women	88.1%	2017	92%	RESULTA tool (MEF) - ENDES	Number of women aged 30 to 59 who had a Pap smear in the last three years and knew the results in metropolitan Lima / Number of women aged 30 to 59 in metropolitan Lima x 100 Gender monitoring, Pro-Gender
Percentage of people aged 40 to 59 who had a checkup to rule out any type of cancer in the last 24 months	% of people	34.6%	2017	38%	RESULTA tool (MEF) - ENDES	Number of people aged 40 to 59 who had a checkup to rule out any type of cancer in the last 24 months in metropolitan Lima / Number of people aged 40 to 59 in metropolitan Lima x 100
Percentage of people who voluntarily donated blood	% of people	5.36%	2016	8%	PRONAHEBAS (MINSA)	Number of people who voluntarily donated blood in the Department of Lima / Number of people who donated blood in the Department of Lima x 100
Percentage of ambulance dispatches requested but not available	% of ambulance dispatches	46%	2017	41%	Administrative records - SAMU (MINSA)	Number of ambulance dispatches requested but not available in metropolitan Lima / Number of ambulance dispatches requested in metropolitan Lima x 100
Percentage of people 15 or older diagnosed with diabetes mellitus who received treatment in the last 12 months	% of people	71.54%	2014	74.5%	RESULTA tool (MEF) - ENDES	Number of people 15 or older diagnosed with diabetes mellitus who received treatment in the last 12 months in metropolitan Lima/ Number of people 15 or older diagnosed with diabetes mellitus who received treatment in the last 12 months in metropolitan Lima x 100
Percentage of people 15 or older diagnosed with hypertension who received treatment in the last 12 months	% of people	62.3%	2017	70%	RESULTA tool (MEF) - ENDES	Number of people 15 or older diagnosed with hypertension who received treatment in the last 12 months in metropolitan Lima / Number of people 15 or older diagnosed with hypertension in metropolitan Lima x 100
Beneficiaries who received healthcare services	Number of people	2,850,430	2017	3,049,109	RESULTA tool (MEF) - ENDES e INEI	Combination of indicators on Pap tests, checkups to rule out cancer in the last 24 months, people 15 and older diagnosed with diabetes mellitus or hypertension who received treatment in metropolitan Lima

indicators	Unit of measure	Baseline	Baseline year	Target	Means of verification	Comments
Percentage of users of outpatient services who were “satisfied” or “very satisfied” with the care received	% of users	78.8%	2016	84%	National survey on healthcare user satisfaction - SUSALUD	Number of users of outpatient services who were “satisfied” or “very satisfied” in metropolitan Lima / Number of users of outpatient services in metropolitan Lima x 100
Percentage of users of outpatient services who rated their wait time to receive care in a healthcare facility as 6 or more on a scale of 1 to 10	% of users	77.2%	2016	83.5%	National survey on healthcare user satisfaction - SUSALUD	Number of users of outpatient services who rated their wait time to receive care in a healthcare facility as 6 or more on a scale of 1 to 10 in metropolitan Lima / Number of users of outpatient services in metropolitan Lima x 100

OUTPUTS

Outputs	Unit of measure	Baseline	Baseline year	Year 1 2019	Year 2 2020	Year 3 2021	Year 4 2022	Year 5 2023	Target	Means of verification	Comments
Component 1. Improvement and proper design of the IPRESS organizational model into integrated health networks in metropolitan Lima and the priority regions											
Healthcare model with emphasis on the new disease burden pattern, redesigned	Model	0	2018	0	1	0	0	0	1	Final consulting report and semiannual progress report	The final report should be validated by MINSA and agreed upon with the IDB
Clinical care guidelines and protocols on chronic noncommunicable diseases designed: diabetes, breast cancer, mental illness, hypertension	Protocols	0	2018	0	1	1	2	0	4	Final care guidelines and protocol documents and semiannual progress report	The clinical guidelines and protocols should be validated by MINSA
Healthcare professionals (doctors, nurses) trained on how to use the clinical guidelines and protocols	Professionals	0	2018	0	0	200	200	400	800	Semiannual progress report	

Outputs	Unit of measure	Baseline	Baseline year	Year 1 2019	Year 2 2020	Year 3 2021	Year 4 2022	Year 5 2023	Target	Means of verification	Comments
Organization, management, and financing models for integrated healthcare networks	Model	0	2018	0	1	0	0	0	1	Final consulting report and semiannual progress report	The final report should be validated by MINSA and agreed upon with the IDB
Human resource skills development plan for working in a network, developed and validated by MINSA	Plan	0	2018	0	0	1	0	0	1	Skills development plan validated by MINSA	The plan will include skills profiles and ways to attract specialized primary care staff
Guide to treating and managing cases of violence in women with a gender approach, reviewed and improved	Guide	0	2018	1	0	0	0	0	1	Final guide document and semiannual progress report	The guide will focus on the primary care level
Strategy to raise awareness about the new healthcare model for the different actors in the system	Strategy	0	2018	0	1	0	0	0	1	Semiannual progress report	The awareness raising strategy will be continuously implemented each year of the project
Workshops to raise awareness about health care and the centralized Clinical Support Services (CSS)	Workshop	0	2018	0	10	15	15	10	50	Semiannual progress report	In year 5, two workshops will be conducted for each CSS
Component 2. Improvement and proper supply in primary care IPRESS in metropolitan Lima and priority regions											
12-hour healthcare facilities designed	Healthcare facility	0	2018	0	7	0	0	0	7	Architectural plan for the facility and semiannual progress report	The architectural plans will be approved by PRONIS (MINSA)
12-hour healthcare facilities remodeled	Healthcare facility	0	2018	0	0	3	4	0	7	Works supervision report and semiannual progress report	

Outputs	Unit of measure	Baseline	Baseline year	Year 1 2019	Year 2 2020	Year 3 2021	Year 4 2022	Year 5 2023	Target	Means of verification	Comments
12-hour healthcare facilities equipped	Healthcare facility	0	2018	0	0	3	4	0	7	Semiannual progress report	
12-hour healthcare facilities in operation	Healthcare facility	0	2018	0	0	0	3	4	7	Semiannual progress report	
24-hour healthcare facilities designed	Healthcare facility	0	2018	0	10	0	0	0	10	Architectural plan for the facility and semiannual progress report	The architectural plans will be approved by PRONIS (MINSA)
24-hour healthcare facilities remodeled	Healthcare facility	0	2018	0	0	2	5	3	10	Works supervision report and semiannual progress report	
24-hour healthcare facilities equipped	Healthcare facility	0	2018	0	0	2	5	3	10	Semiannual progress report	
24-hour healthcare facilities in operation	Healthcare facility	0	2018	0	0	0	2	8	10	Semiannual progress report	
Component 3. Improvement of clinical support services in metropolitan Lima											
Central CSS facility designed	Central facility	0	2018	0	1	0	0	0	1	Central facility's architectural plan and semiannual progress report	The architectural plan will be approved by PRONIS (MINSA)
Central CSS facility built	Central facility	0	2018	0	0	0	0	1	1	Works supervision report and semiannual progress report	
Operations manual with rules for operating the central CSS facility drafted	Operations manual	0	2018	0	0	1	0	0	1	Manual drafted and semiannual progress report	The final report will be validated by MINSA
Central CSS facility's laboratory equipment installed	Device	0	2018	0	0	0	0	1	1	Semiannual progress report	
Central CSS facility's digital reading equipment installed	Device	0	2018	0	0	0	0	1	1	Semiannual progress report	

Outputs	Unit of measure	Baseline	Baseline year	Year 1 2019	Year 2 2020	Year 3 2021	Year 4 2022	Year 5 2023	Target	Means of verification	Comments
Central CSS facility's blood bank equipment installed	Device	0	2018	0	0	0	0	1	1	Semiannual progress report	
Central CSS facility's prehospital care equipment installed	Device	0	2018	0	0	0	0	1	1	Semiannual progress report	
Central CSS facility's complementary equipment installed (cold chain, gases, etc.)	Device	0	2018	0	0	0	0	1	1	Semiannual progress report	
Design of the central facility's services with functional protocols for coordinating with the network completed	Protocol	0	2018	0	0	0	1	0	1	Semiannual progress report	
CSS professionals trained	Professionals	0	2018	0	0	0	0	532	532	Semiannual progress report	
Startup of the central CSS facility	Central facility	0	2018	0	0	0	0	1	1	Semiannual progress report	
Institutional Healthcare Providers (IPRESS) created	IPRESS	0	2018	0	0	0	1	0	1	Accreditation from the Regional Health Directorate (DISA) for metropolitan Lima and semiannual progress report	
IPRESS in operation	IPRESS	0	2018	0	0	0	0	1	1	Semiannual progress report	

Outputs	Unit of measure	Baseline	Baseline year	Year 1 2019	Year 2 2020	Year 3 2021	Year 4 2022	Year 5 2023	Target	Means of verification	Comments
Campaigns to raise the public's awareness about CSS	Awareness-raising campaigns	0	2018	0	0	0	3	0	3	Semiannual progress report	The awareness-raising campaigns include the following subjects: voluntary blood donation, managing the change toward centralization, and information about calls to the central emergency response service (SAMU)
Hospital medical equipment replaced (7 tomography devices, 1 MRI device, 3 mammography devices, 65 x-ray devices)	Medical device	0	2018	0	0	59	5	12	76	Procurement records and semiannual progress report	

FIDUCIARY AGREEMENTS AND REQUIREMENTS

Country:	Peru
Project number:	PE-L1228
Project name:	Program to Create Integrated Health Networks
Executing agency:	Ministry of Health (MINSA), through the National Health Investment Program (PRONIS)
Fiduciary team:	Allizon Milicich Nieto-Polo, Andrés Suarez, and Gabriele del Monte (FMP/CPE)

I. EXECUTIVE SUMMARY

- 1.1 The fiduciary situation and institutional capacity of PRONIS were assessed, and meetings were held with key staff of PRONIS, MINSA, and the project team. In the fiduciary area, an identified medium-level of risk was the staff's lack of experience and knowledge about the Bank's fiduciary policies in loan operations, and the level of PRONIS's budget as of the date of the assessment.

II. THE COUNTRY'S FIDUCIARY CONTEXT

- 2.1 The country's financial management systems are adequate and reliable. In terms of the country procurement system, the electronic reverse auction and electronic catalogues for framework agreements subsystems under the public procurement system approved in document GN-2538-11 are currently being used.

III. FIDUCIARY CONTEXT OF THE EXECUTION UNIT AND THE ADMINISTRATIVE EXECUTING AGENCY FOR THE PROJECT BENEFICIARIES

- 3.1 The executing agency will be MINSA through PRONIS, which will coordinate with the executing agency's other organizational units.
- 3.2 Under the operation's institutional framework, PRONIS is the execution unit responsible for the program. The following specific support specialists (part of the key staff) will be contracted to handle the different fiduciary areas: budget consultant, accounting consultant, cash flow consultant, and procurement specialist, who will be recruited to work full-time on the project. Two other procurement support staff will also be contracted.
- 3.3 PRONIS will use the Electronic State Procurement System (SEACE) to record the Procurement Plan for the dissemination of procurement processes.
- 3.4 PRONIS will use the Integrated Financial Management System (SIAP) as the operational financial management system, and the system's Project Execution Module to produce financial reports.

IV. FIDUCIARY RISK EVALUATION AND MITIGATION ACTIONS

- 4.1 During the operation's design, a medium-level fiduciary risk was identified that the program could potentially have higher costs and take more time to implement, due to: (i) lack of experience and knowledge regarding the Bank's fiduciary policies applicable to loan operations; and (ii) the recent creation of PRONIS as a new execution unit with a budget that is less than the program's cost. To mitigate this medium risk, the following actions were identified: (i) contracting of key personnel with experience in projects financed by multilateral organizations and the rules of the National Multiyear Programming and Investment Management System (Invierte.pe); (ii) the inclusion of fiduciary process flow charts in the program's Operations Manual specifying the responsible parties and their roles; (iii) fiduciary assistance and support provided to PRONIS by the Bank; and (iv) contracting of consultants to prepare highly complex competitive bidding documentation.

V. CONSIDERATIONS FOR THE SPECIAL PROVISIONS OF THE LOAN CONTRACT

- 5.1 It is particularly important to consider the conditions precedent set out in the program's Operations Manual and the contracting of the recommended key staff specified in the loan proposal's Executive Summary.
- 5.2 PRONIS will submit the program's annual and final audited financial statements, under specific terms of reference acceptable to the Bank, within 120 days after the close of each fiscal year of the Office of the Comptroller General (CGR) during the original disbursement period or any extensions thereof. The final audit report will be submitted within 120 days after the end of the original disbursement period or any extensions thereof.
- 5.3 To determine the equivalence of an eligible expense incurred in the borrowing member country's local currency converted to the disbursement or approval currency for accounting and expense justification purposes, the exchange rate in effect on the date the approval or disbursement currency is converted to the borrowing country's local currency will be used (Article 4.10(b)(i) of the General Conditions of the loan contract). To determine the equivalence of expenses incurred in local currency and charged to the local contribution or the reimbursement of expenses charged to the loan, the exchange rate will be the rate in effect on the date when the borrower, executing agency, or any other individual or legal entity authorized to incur expenses makes the respective payments to the contractor, supplier, or beneficiary.

VI. AGREEMENTS AND REQUIREMENTS FOR PROCUREMENT EXECUTION

- 6.1 **Procurement execution.** Procurement processes will be carried out in accordance with the Policies for the procurement of goods and works financed by the Inter-American Development Bank (document GN-2349-9) and the Policies for the selection and contracting of consultants financed by the Inter-American Development Bank (document GN-2350-9). The threshold established for the use of international competitive bidding will be made available to the borrower through the executing agency on the website www.iadb.org/procurement. For amounts below that threshold, the selection method will be determined based on the

complexity and characteristics of the procurement process, which will be reflected in the procurement plan approved by the Bank.

- 6.2 **Procurement of works, goods, and nonconsulting services.** Contracts for works, goods, and nonconsulting services¹ arising under the project will be executed using the standard bidding documents issued by the Bank. Bidding processes subject to national competitive bidding will be executed using national competitive bidding documents agreed upon with the Bank (or satisfactory to the Bank if not yet agreed upon). The project team leader will be responsible for reviewing the technical specifications of procurement items.
- 6.3 **Selection and contracting of consultants.** Contracts for consulting services arising under the project will be executed using the standard request for proposals issued by or agreed upon with the Bank (or satisfactory to the Bank if not yet agreed upon), regardless of the contract amount. The project team leader will be responsible for reviewing the terms of reference.
- 6.4 **Ex ante review of procurement.** The Bank will review the selection and procurement processes in accordance with the provisions of the procurement plan. The Bank may change the modality for reviewing these processes at any time during the execution of the projects, by giving advance notice to the borrower or executing agency. Any changes approved by the Bank will be reflected in the procurement plan.
- 6.5 **Use of the country procurement system.** Given the Board's approval of advanced use of Peru's national government procurement system, this system may be used upon implementation of the implementation and monitoring actions included in the approved "Report for Acceptance of Partial Use of the Country Procurement System in Peru," and upon prior modification of the procurement plan. The electronic reverse auction and electronic catalogues for framework agreements subsystems may be used upon implementation of the recommendations prior to their use.
- 6.6 **Initial procurement plan.** See the detailed [Procurement Plan](#) for the first 18 months. The executing agency will publish the procurement plan in the Procurement Plan Execution System (SEPA) and will update it at least once every six months or as requested by the Bank to reflect the program's actual execution requirements and the progress achieved.
- 6.7 **Procurement supervision.** The Bank's ex post reviews will cover a sample of the contracts based on technical-professional criteria and will be performed by external consultants or auditors. Once the use of the country procurement system has been implemented, the arrangements may be updated on the basis of fiduciary risks.²
- 6.8 **Records and files.** Files will be located in the executing agency's offices under conditions that ensure the integrity and security of the documentation.

¹ Under the Bank's procurement policies, nonconsulting services are treated as goods.

² Once the reverse auction and framework agreement systems have been implemented in the operations, as part of the strategy for country system use, all procurement processes undertaken will be systematically monitored and supervised by tracking and verifying the stability of Peru's country system.

VII. FINANCIAL MANAGEMENT AGREEMENTS AND REQUIREMENTS

- 7.1 **Programming and budget.** Expenses related to the project activities will be viable under the regulatory framework specified by the Ministry of the Economy and Finance (MEF). The Invierte.pe public investment system will be used to facilitate the approval of investment projects and streamline their execution at the three levels of government. The preparation of the annual programming and budget will be based on the directives of the MEF's National Budget Bureau. The Multiyear Execution Plan will be prepared and used to formulate the annual budget. The budget allocated to the projects will be approved by the MEF and Peru's National Congress and reported annually to the Bank. The budget will be executed using the SIAF.
- 7.2 **Accounting and information system.** The MEP-SIAF will be used for accounting and reporting activities, including disbursement requests, exchange rate control, and others based on the Bank's requirements, which will provide transparency and specific budget execution controls. The cash-basis accounting principle will be followed, based on international accounting standards and the directives of the National Public Accounting Bureau.
- 7.3 **Disbursements and cash flow.** The country's treasury system will be used following the directives of the National Debt and Treasury Bureau. Expenditures will be subject to the budget and financial execution process, with data recorded in the MEP-SIAF as the expense is formally processed under the regulatory framework applicable to each of its stages: commitment, obligation, warrant, and disbursement. PRONIS will open and maintain a specific bank account in U.S. dollars and another in Peruvian soles (monetization) to manage the IDB loan proceeds. The MEF has expressed interest in promoting the use of the Treasury Single Account (CUT) for loan operations, and this option may be implemented in the short term.
- 7.4 Disbursements will be based on the program's actual liquidity needs. PRONIS will submit disbursement requests to the Bank, along with a financial plan covering disbursements for the next 180 days. Disbursements will be subject to justification of at least 80% of the total cumulative balances pending justification, using the Bank's standard forms. The loan proceeds may be disbursed through the advance of funds, reimbursement of expenses, and direct supplier payment modalities.
- 7.5 The records and supporting documentation for activities and transactions will be subject to ex post review by external auditors. All documents and records will be kept for a minimum of three years after the date of the last disbursement. Any expenses not deemed eligible by the Bank will be reimbursed from the local contribution.
- 7.6 **Internal control and internal audits.** The control environment, oversight, communication and information activities, and monitoring of PRONIS's activities will be governed by the country's rules and regulations, which are based on the Law Governing the National Oversight System and the CGR. Internal control duties will be performed by the institutional control unit of MINSA's CGR.
- 7.7 **External control and reporting.** Given the role of the CGR and its regulations, the external audit of projects will be outsourced to independent audit firms acceptable to the Bank. These independent audit firms will be periodically evaluated by the

- Bank. The CGR authorizes the process for selecting and contracting the firms according to Bank policies during the entire program execution period, including any extensions to the final disbursement date. The selected independent audit firm will be required to have tier I or II eligibility.
- 7.8 The financial statements include: the cash flow statement, statement of cumulative investments, the notes to these financial statements, and the statement issued by the program's management (PRONIS). The audit report will include an assessment of the internal control system. External audits will be covered by the loan proceeds or the local contribution, at an estimated cost of US\$250,000 over the program's five-year execution period. The program's Operations Manual will specify that the Bank's procedures will be followed to select the audit firm, even if the cost of the audit is financed using counterpart funds.
- 7.9 **Financial supervision plan.** This plan may be adjusted based on the execution of the operations and external audit reports.

Table 1. Supervision Plan

Activities	Nature/Scope	Frequency
Financial	Portfolio review with executing agency and the MEF	2 per year
	Financial audit and delivery of financial statements	Annual and final
	Review of disbursement requests and attached reports	3-4 per year
	Inspection visit / project progress review / analysis of PRONIS's control environment	Annual

DOCUMENT OF THE INTER-AMERICAN DEVELOPMENT BANK

PROPOSED RESOLUTION DE-___/18

Peru. Loan ____/OC-PE to the Republic of Peru
Program to Create Integrated Health Networks

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 Peru, as borrower, for the purpose of granting it a financing to cooperate in the execution of the Program to Create Integrated Health Networks. Such financing will be for the amount of up to US\$125,000,000 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 ____ 2018)