DOCUMENT OF THE INTER-AMERICAN DEVELOPMENT BANK

ARGENTINA

PROGRAM TO STRENGTHEN THE PRIMARY HEALTH CARE STRATEGY (FEAPS)

(AR-L1020)

LOAN PROPOSAL

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ABBREVIATIONS

AWP	Annual work plan
CEU	Central executing unit
COFESA	Consejo Federal de Salud [Federal Health Council]
FEAPS	Programa de fortalecimiento de la estrategia de atención primaria de la salud [Program to strengthen the primary health care strategy]
INSSJP	Instituto Nacional de Seguridad Social de Jubilados y Pensionados [National Retirees and Pensioners Social Security Administration]
MSAL	Ministry of Health
PHC	Primary health care
PHCC	Primary health care center
PROAPS	Programa de Atención Primaria de la Salud [Primary health care program]
r/e	Recognition of expenditures
RUM	Rational use of medicines
SPS	Secretaría de Programas Sanitarios [Health Programs Secretariat]
UFI-S	Unidad de Financiamiento Internacional de Salud [International Health Financing Unit]
w/r	With reimbursement

PROJECT SUMMARY

ARGENTINA
PROGRAM TO STRENGTHEN THE PRIMARY HEALTH CARE STRATEGY (FEAPS)
(AR-L1020)

Financial Terms and Conditions[1]				
Borrower: Argentine Republic			Amortization period:	25 years
Executing agency: Ministry of Health of Argentina			Grace period:	5.5 years
Source	**Amount (US$ million)**	**%**	Disbursement period:	5.5 years
IDB (Ordinary Capital)	230.0	80	Interest rate:	Variable
Local	57.5	20	Inspection and supervision fee:	0%
Other/Cofinancing	0.0		Credit fee:	0.10%
Total	287.5	100	Currency:	U.S. dollars from the Single Currency Facility

Project at a glance

Project objective:
The program objective is to strengthen the networked operation of public health services in Argentina's provinces, as part of the process of implementing the primary health care (PHC) strategy. The specific objectives are to: (i) develop a prevention and treatment model for chronic diseases, resulting in concrete and objective means of improving the operation of the provincial PHC systems; (ii) strengthen the treatment capabilities of PHC services, consolidating programs for supply management and training healthcare workers, targeted to health promotion and disease prevention; and (iii) strengthen the stewardship role of the federal and provincial ministries of health by introducing a management-by-results monitoring and evaluation system for PHC network operation.

Special contractual conditions:
(i) a Ministry of Health resolution creating the central executing unit (CEU) for the program; (ii) recruitment and formal appointment of the general program coordinator; and (iii) the Bank's nonobjection to the program's Operating Regulations. As a special condition precedent to the start of each provincial project, the PEU will present evidence to the Bank that provincial projects to strengthen systems have been approved and the respective framework agreements and annual management commitments have been signed with the provinces (paragraph 3.22).

Exceptions to Bank policies:
None.

Project consistent with country strategy:	Yes [X]		No [ ]		
Project qualifies as:	SEQ [X]	PTI [X]	Sector [X]	Geographic [ ]	Headcount [ ]

Revolving fund: A revolving fund will be established equivalent to 10% of the loan amount (paragraph 3.19).

Procurement: The program includes the procurement of goods and consulting services, which will be carried out in accordance with the "Policies for the procurement of works and goods financed by the IDB" (document GN-2349-7) and the "Policies for selection and contracting of consultants financed by the IDB" (document GN-2350-7) (paragraphs 3.13 and 3.14).

Verified by CESI on: 21 June 2007

[1] The interest rate, credit fee, and inspection and supervision fee mentioned in this document are established pursuant to document FN-568-3 Rev. and may be changed by the Board of Executive Directors, taking into account the available background information, as well as the respective Finance Department recommendations. In no case will the credit fee exceed 0.75%, or the inspection and supervision fee exceed 1% of the loan amount.*

* With regard to the inspection and supervision fee, in no case will the charge exceed, in a given six-month period, the amount that would result from applying 1% to the loan amount divided by the number of six-month periods included in the original disbursement period.

I. FRAME OF REFERENCE

A. The sector

1. The health situation

1.1 Argentina is far along in its demographic and epidemiological transition. The fertility rate has fallen to 2.3%, life expectancy is 74.6 years, and 14.6% of the population is over the age of 60, which ranks only behind Uruguay and Cuba in the region. The infant mortality rate fell from 26 per 1,000 live births in 1990 to 13.3 in 2005, and the mortality rate among children under 5 declined from 29 per 1,000 live births to 15.5 over the same period, which indicates that Argentina is highly likely to attain the Millennium Development Goals on health. Given the aging of the population and the progress made in preventing infectious diseases, the main challenge for the country is to control chronic diseases.

1.2 Chronic diseases began to prevail over communicable ones as a cause of death in Argentina more than a decade ago. In 2005, diseases of the circulatory system were the leading cause, accounting for 30% of all deaths in the country. Although there are sharp differences among the various provinces and infant mortality rates continue to be relatively high in the poorest ones, in all provinces, deaths from chronic diseases outnumber deaths from infectious diseases.

1.3 Chronic diseases are strongly associated with risk factors related to lifestyle such as smoking, excess weight, physical inactivity, and unhealthy eating habits.[1] In 2006, the Ministry of Health (MSAL) conducted the first national survey on risk factors, providing key information for designing sector policies. According to the survey, 33.4% of Argentines use tobacco, with two trends apparent: an increase in smoking among women and a reduction in the average starting age among young people. The prevalence of overweight is 49.1%, including 14.6% obesity; and 46.2% of the population engages in little physical activity in their free time or at work. Obesity and physical inactivity, lower consumption of fruits and vegetables, and more added salt are inversely related to income and education levels.

1.4 The main risk factors with the greatest burden on the health system include hypertension (high blood pressure) and type 2 diabetes. Hypertension accounts for about 17% of deaths in Argentina and is one of the main reasons for medical consultations. Diabetes is an important predictor of premature death and is associated with a high disease burden and poor quality of life, including blindness and amputations. Like the risk factors mentioned above, the prevalence of hypertension and diabetes is also higher among low-income groups.

2. The health system

1.5 The Argentine health system is highly fragmented and heterogeneous. It is composed of three subsystems: public, social security, and private. The public

[1] For more information on risk factors and their impact, see World Health Organization, *Reducing Risks, Promoting Healthy Life* (The World Health Report 2002).

subsystem is financed by the government and open to everyone, but is mainly used by the low-income population that has no other coverage. The social security subsystem has many compulsory plans for formal sector workers and public employees and their families. It is financed by employer contributions, salary-based employee contributions, and copayments. The system includes national and provincial union-sponsored plans known as *Obras Sociales* and the National Retirees and Pensioners Social Security Administration (INSSJP). Last, the private subsystem consists of voluntary insurance and prepaid-medicine companies, financed through direct fees paid to those institutions. The three subsystems are poorly coordinated and integrated. There are no general regulations to govern them, which leads to differentiated coverage, different levels of per capita spending, and an oversupply of services coupled with problems of accessibility. This translates into challenges in terms of efficiency and equity that the health system needs to address.

1.6 Given the fragmentation of the system, there is no single roll of beneficiaries that would give an exact idea of the coverage of each subsector. The National Risk Factor Survey estimates that about 35% of the total population depends on the public system. However, variations in that coverage by province are significant, ranging from 15% in Tierra del Fuego and Santa Cruz, to 50% in the northeastern provinces, including Formosa and Chaco.

3. Description of the public health subsystem

1.7 The public subsystem is highly decentralized, composed of the federal Ministry of Health (MSAL), the 24 provincial ministries, their dependent and decentralized agencies, and the municipios. MSAL is responsible for sector planning and coordination but lacks effective instruments to perform its functions. The provincial ministries are responsible for setting health policies in their provinces and for the delivery of services which, in turn, is delegated to the municipios or other institutions. This means that the fragmentation and heterogeneity that mark the Argentine health system as a whole are also observed inside the public subsystem. Although decentralization allows for greater adaptability to local conditions, it has also led to different levels of financing and coverage, accessibility, and quality of public services.

1.8 Despite different modes of organization in the provinces, all the services are structured by level of complexity and territory, which are necessary arrangements for the operation of primary care systems. However, in general, the primary care model is not well defined, which weakens the operation of the services as a network and the effective implementation of the primary care strategy. Health care services continue to focus on spontaneous demand for the treatment of illnesses, with little stress on health promotion and disease prevention or on continuity and patient monitoring. Just 18% of primary health care centers (PHCCs) report that most of their consultations are scheduled. Nor do the PHCCs function effectively as the gateway to the health system. Of every 100 consultations in the public sector, 57 are through hospitals and just 43 through the centers; this situation is even more

drastic for the uninsured population, where 63% use a public hospital first rather than a PHCC.[2] Referral and counter-referral mechanisms are weak and different treatment standards coexist, since there are no health care protocols or clinical guidelines.

1.9 Before the 2001 economic crisis, efforts to reform the sector focused on the social security subsystem, particularly on reform of the national *Obras Sociales*. The advent of the crisis shifted the focus of care to the public subsystem. With the decline in economic activity and the rise in unemployment, there was a reduction in the population covered by social security and voluntary insurance alike, and this drove up demand for public services. Between 1997 and 2001, the uninsured population grew from 36% to 42%. The increase was more pronounced in the lowest quintile, where it rose from 65% to 77%, while it rose from 38% to 51% in the second. This increase in the demand for public services revealed difficulties in public delivery, given fiscal constraints, which was mainly reflected in the lack of basic inputs and essential medicines.

1.10 To respond to the crisis, a health emergency decree was adopted in March 2002, which included implementation of the National Drug Policy. That policy promotes the rational use of drugs and prescription of generics and creates the Remediar program for centralized procurement and free distribution of essential medicines through PHCCs. The Bank-financed Remediar program (loan 1193/OC-AR) helped to reverse the historical trend toward rising drug prices and was able to provide the uninsured and poor population with access to free essential medicines. So far, the Remediar program has benefited more than 12.5 million people. Ninety-four percent of beneficiaries are from poor families and 71% are living below the indigence line; 86% of beneficiaries have no health insurance.[3] Remediar has also been important in strengthening primary health care by developing an efficient logistics system that has been able to make medicines available to the primary level.

1.11 Parallel to the implementation of emergency policies, the process of revitalizing the Consejo Federal de Salud [Federal Health Council] (COFESA), initially established in 1981, was speeded up. COFESA is composed of the federal and provincial ministers of health and the minister of health of the autonomous city of Buenos Aires and has become an important venue for coordinating sector development. In the context of the crisis, a medium-term sector strategy was discussed based on a

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[2] MSAL, *Encuesta de utilización y gasto en servicios de salud* [Survey of use and spending on health services] (2005).

[3] SIEMPRO 2003-Encuesta de evaluación de Remediar [Remediar evaluation survey]. For more information on the program see MSAL 2007. "El Programa Remediar: Gestión y Resultados de un Modelo Innovador en APS" [The Remediar program: Management and results of an innovative program in primary health care] and Maceira, D., I. Apella and E. Barbieri. "Análisis del Programa Remediar: Notas sobre Evaluación y Seguimiento" [Analysis of the Remediar program: Notes on evaluation and monitoring] (Technical note OVE/NT-01/30, 2005).

consensus between the federal and provincial governments and taking into account the situation in each, which was embodied in the Federal Health Plan.

B. Country strategy in the sector

1.12 The Federal Health Plan does not present a proposal for drastic reform but rather is a flexible blueprint for reforms that can be adapted to the different situations in each province and developed over time. One of the most important consensual proposals it contains is the establishment of a primary health care (PHC) strategy as the hub around which the system is organized, giving it absolute priority. The objective is to turn the existing system, in which isolated services respond to spontaneous demand for treatment, into one that is based on programmed care, emphasizing health promotion, disease prevention, and continuity of care. The proposed model is based on strengthening PHCCs as the gateway to the health system, making them responsible for an enrolled population in their area of influence, which will permit them to know their beneficiaries and cover their needs based on risk criteria.

1.13 The Federal Health Plan was a significant step forward in the coordination of health policies between the different jurisdictions. Progress in implementing the plan is based on strong oversight and regulatory performance by the federal and provincial ministries of health and on implementation of management agreements between the federal and provincial levels that will build a new organizational model while respecting the specific conditions in each jurisdiction.

C. Program strategy

1.14 The present program will support implementation of the Federal Health Plan by strengthening service networks structured around the primary health care strategy. The program's intervention strategy is based on the premise that primary care systems are not consolidated in the abstract but rather in response to specific health problems and that concrete health effects must be achieved in order for the actions to be sustainable. Therefore, the program will focus on the management of chronic diseases, giving priority to hypertension and type 2 diabetes. Adequate control of these two diseases will act as a suitable proxy for strengthening the system, given that it covers health promotion and primary and secondary disease prevention, identification and assessment of patient risk, continuity in treatment, and long-term monitoring. The success of these efforts depends on bringing primary care closer to the public in its role as gateway to the system.

1.15 The proposed program is divided into two large areas of intervention: (i) provincial projects to strengthen systems that will benefit from technical assistance and incentives given based on compliance with management indicators for the selected diseases; and (ii) provision of key inputs for the operation of systems, through the adjustment and consolidation of national programs, such as the Remediar program and the Community Doctors Program.

D. The Bank's strategy with the country

1.16 The Bank's strategy with the country for 2004-2008 (document GN-2328-1) has poverty reduction, rebuilding the human resource base, and promotion of sustainable development as its main lines. Strengthening primary health care targeted to the low-income population that relies on the public subsystem contributes to those objectives and lends continuity to the Bank's previous actions in the sector.

1.17 The Bank has had a strong presence in the sector. The primary health care program (PROAPS) (loan 1193/OC-AR) was approved in March 2000. Its objective was to promote equity and improve public health through a reform in the organization, delivery, and financing of primary health care services in three provinces.

1.18 In the context of the health emergency declared after the 2001 crisis, the PROAPS program and other loans in the social portfolio were reformulated and redirected into the social emergency plan. The original program was maintained in the province of Cordoba, and funds were redistributed to the Remediar program and complementary interventions at the national level. The province of Cordoba component has made progress in establishing family health teams, training physicians in PHC, and designing and implementing a master plan for infrastructure works in PHCCs. PROAPS is nearing its final disbursement in September 2007, and actions have been agreed on to link it with the new program.

1.19 The Bank is also supporting provincial health actions under broader programs. The program to support social investment in the province of Buenos Aires (loan 1700/OC-AR) was approved in December 2005, and the social development program for Cordoba province (loan 1765/OC-AR) was approved in August 2006. Both of these have a health component that primarily finances physical works and equipment. The proposed program complements these actions by strengthening the PHC strategy and introducing incentives for achieving results.

E. Coordination with other international cooperation agencies

1.20 The European Union is supporting implementation of the Federal Health Plan through a project to enhance the PHC strategy. The program provides for institutional strengthening of seven provincial health ministries in the northeastern and northwestern regions and investments in equipment.

1.21 The World Bank is financing the maternal-child health insurance program (Nacer program) to improve access to a package of mother and child services on the provincial level, as well as an essential public health functions and programs project, which aims to strengthen the stewardship role of the federal and provincial ministries of health. These World Bank programs and the program proposed here support implementation of the Federal Health Plan and are intended to introduce consensual changes in the relations between the federal and provincial levels and between them and service providers.

1.22 Both programs are being executed through buy-in agreements by the provinces and management agreements based on the achievement of targets, as established in the Federal Health Plan, and the proposed program will also operate on the same basis.

II. THE PROGRAM

A. Objectives and description

2.1 The objective of the program is to strengthen the networked operation of public health services in Argentina's provinces, as part of the process of implementing the primary health care (PHC) strategy. The specific objectives are to: (i) develop a prevention and treatment model for chronic diseases, resulting in concrete and objective means of improving the operation of the provincial PHC systems; (ii) strengthen the treatment capabilities of PHC services, consolidating programs for supply management and training healthcare workers, targeted to health promotion and disease prevention; and (iii) strengthen the stewardship role of the federal and provincial ministries of health by introducing a management-by-results monitoring and evaluation system for PHC network operation.

B. Program structure

1. Component 1. Provincial projects to strengthen health services networks (US$88.34 million)

2.2 This component will enhance the operation of networked health services through provincial projects that incorporate management of chronic diseases, prioritizing hypertension and type 2 diabetes. This component will finance technical assistance for the formulation and implementation of the projects and an incentive fund to be distributed based on compliance with indicators linked to the management of those diseases.

2.3 **Subcomponent 1.1. Technical assistance for provincial projects**. This subcomponent will focus on developing methodologies and tools for networked management and provide technical assistance in the formulation and implementation of projects to strengthen health services systems in the provinces that join the program. Methodological guidelines have been developed for preparing situation analyses of the systems to be supported[4] and the minimum content of the projects has been defined and agreed on for the provincial projects.[5]

2.4 That content includes: (i) epidemiological characterization of the province for the prioritized chronic diseases; (ii) basic information on the network(s) to be strengthened by the program in terms of geographical coverage, total population, indigenous population, and population without healthcare coverage; (iii) description and analysis of those services networks with respect to the management model,

[4] Guía metodológica para elaborar el diagnóstico de situación de las redes provinciales [Methodological guidelines for preparing the situation analysis of the provincial systems].

[5] Contenido mínimo de los proyectos provinciales [Minimum content of provincial projects].

agents responsible for management of the prioritized diseases, installed capacity, processes, and indicators; and (iv) an action plan that contains the baseline and targets for the agreed outcome indicators, implementation mechanism, enrollment actions, health promotion and disease prevention activities, organization of services to classify and monitor patients, cultural adaptation actions and application of environmental safeguards where appropriate, indicators of the technical quality of services, user satisfaction survey, timetable, and implementation costs.

2.5 It is expected that each province, based on the initial analysis, will define the combination of the most pertinent activities to build up their systems. This means that each project, in addition to incorporating the actions necessary to achieve the indicators that trigger the incentives, can work to develop activities to strengthen their systems in terms of improving their organization, programming, referral and counter-referral, human resources and training, information and monitoring, logistics, infrastructure, and community participation mechanisms.

2.6 For the purposes of assuring adequate formulation and implementation of these projects, in-service training will be offered for everyone involved in managing the facilities and services in each province, as well as for the health teams and medical professionals responsible for applying the treatment plans. To that end, training workshops will be held in systems management, formulation of provincial projects, and clinical management.

2.7 This subcomponent will be executed in a centralized manner by the Ministry of Health (MSAL), in order to ensure that the technical assistance activities promote the homogeneous application of an intervention modality based on efficiency and quality criteria that respects provincial individuality and initiatives. Consulting services, technical teams specializing in systems management and chronic disease management, workshops, and the personnel needed to build the technical capacity of the provincial counterpart teams will be financed.

2.8 **Subcomponent 1.2. Implementation of provincial projects**. The provincial projects will be formalized under framework agreements and annual management agreements between the federal and provincial levels. These agreements will link the incentive payments (transfers) to be financed under this subcomponent to verified results and will regulate the conditions for program intervention. For a province to receive incentives, at least 30% of its population that only has public health subsystem coverage must be covered by the systems prioritized in the project.

2.9 The final targets for the component are: (i) **enrollment** of at least 75% of the population over the age of 6, whose only coverage is the public services provided by the provinces that join the program; (ii) **risk classification** of at least 90% of the preselected population with moderate or high general cardiovascular risk classified on the basis of the treatment plan; and (iii) **treatment** of at least 80% of the population classified with moderate general cardiovascular risk or high hypertension and/or type 2 diabetes risk according to the plan. The overall incentive

allocated to each province will be disbursed every four months in per capita terms in function of progress toward the aforementioned targets. Twenty percent of this incentive will be paid for enrollment, 40% for risk classification; and 40% for treatment.[6] Table II-1 describes each of the indicators that will be used as proxies for strengthening the systems.

[6] Justificación del monto per capita por empadronamiento, clasificación y tratamiento [Justification of the per capita amount for enrollment, classification, and treatment.]

Table II-1. Proxies for strengthening PHC systems

Proxy	Description	Why this is a proxy for strengthening PHC systems
Percentage of the population over 6 that only has public health service coverage enrolled.	Health services enroll the population living in their geographic area through an active search (extramural activities) and a passive search (consultations with the PHCCs). In addition, it is verified that individuals have no other health coverage (*Obras Sociales*, private insurance).	• The target spurs the health services to carry out extramural activities to identify the beneficiary population. • As a result of the enrollment process, each PHCC will have a registered population for which it is responsible and can program its actions in function of local problems, which is an essential characteristic of PHC. • Each beneficiary will be assigned to a PHCC, which will be their gateway to the health system.
Percentage of the preselected population with moderate or high general cardiovascular risk, classified according to the treatment plan.	During the enrollment process, a rapid survey is taken of the main risk factors for all persons over 12. Those with more than two risk factors are referred to a PHCC for a consultation, where their general cardiovascular risk will be definitively classified. This consultation includes a medical examination and laboratory tests structured in accordance with the treatment plan.	• The target motivates PHCCs to schedule preventive consultations for people with risk factors. • To comply with the guidelines of the treatment plan, the PHCC must coordinate with existing laboratories from the first visit. • The classification is used to guide the allocation of resources into cost-effective interventions in function of the risk of each patient.
Percentage of the population that has been classified with moderate or high general cardiovascular risk treated under the treatment plan.	Once patients are classified, they will be treated under the treatment plan, which specifies the number of annual visits, the type of physical examination, and the laboratory tests to be performed for each visit, the recommended medications, and criteria for referring patients to specialists and hospitals.	• Under the treatment plan, the generalist physician at the first level of care is responsible for monitoring treatment and coordinating the patient's care. • To comply with the treatment plan, the PHCCs, the diagnostic units (laboratory and imaging) and second and third level services need to operate as a network. • Encourages the development and use of referral and counter-referral systems. • Reduces variations in medical practice, helping to improve quality.

2.10 To ensure the sustainability of the program's intervention rationale, the funds disbursed must be used exclusively for activities and investments that are directly related to strengthening the provincial PHC systems, which will be defined in detail in the respective provincial projects and fall into the following categories: technical

assistance (individual consultants and consulting firms), training, incentives for personnel in the selected systems up to a maximum of 50% of the funds received from the project each calendar year, infrastructure (minor rehabilitation works), building and equipment maintenance, equipment, extramural actions, and promotional activities. The proper use of the funds will be verified by MSAL as part of its annual reviews of the provincial projects. The continuity of financing for them will be contingent on the results of those reviews.

2. Component 2. Provision of strategic inputs for health services (US$119.74 million)

2.11 This component will provide strategic inputs to strengthen the management of health services networks, adapting them to the program strategy through the following subcomponents:

2.12 **Subcomponent 2.1. Provision of inputs and essential medicines—Remediar program**. This subcomponent will support consolidation of the system for managing inputs and essential medicines implemented by MSAL's Remediar program. That program is noted for its high standards of efficiency and transparency in assuring access to drugs at the first level of care in the public healthcare system. New drugs included in the treatment plans adopted will be incorporated to treat diseases prioritized in the provincial projects. The procurement of basic inputs and essential medicines, their logistical distribution, training for healthcare workers in the rational use of medicines, and data entry of prescriptions by sampling as part of program monitoring will be financed.

2.13 **Subcomponent 2.2. Human resource training for PHC.** This subcomponent will provide continuity for the Community Doctors Program, which is intended to reorient training toward primary health care. Professionals working in primary care services will be provided with the operational capacity to intervene in communities, emphasizing health promotion and disease prevention and the application of scientific research tools to local health problems. As a complement, starting in 2008, among the in-service lines of research, a line will be included associated with the management of chronic diseases (particularly hypertension and type 2 diabetes) and an updated module for treatment plans for chronic diseases will be offered to postgraduates from the social and community health program who are working in PHCCs.

2.14 Those professionals will also be involved in implementing the provincial projects to strengthen the services system, particularly promotion, enrollment, risk classification, and patient treatment for prioritized chronic diseases. The subcomponent will finance the costs of university management and tutoring of postgraduates from the social and community health program and the community health research methods program, and permanent in-service professional development courses, the production of educational materials, and research activities.

3. Component 3. Program information, monitoring, evaluation, and auditing (US$13.10 million)

2.15 The objective of this component is to help strengthen the stewardship role of the federal and provincial ministries of health by introducing a system for monitoring and evaluation of management by results into the systems that join the program. The component will finance actions to promote the monitoring of processes, outputs, and program outcomes; investments in equipment and interconnectivity to strengthen the management of systems and services; and procurement of audit services for the program.

2.16 **Information and monitoring**. Considering that under the Nacer plan, MSAL has developed an information system for monitoring its activities on the provincial and services levels whose structure is suited to the needs of the new program, it will be used with the necessary adaptations for recording and monitoring the indicators of component 1, and in accordance with the master health information system. This information and monitoring system will allow the necessary information to flow in due time and form between the different management levels (local, provincial, and federal). Given the relative development of the capacity of the provinces and their health services, the program provides for investments to ensure a minimum level of interconnectivity to allow for adequate management of basic information for the networked treatment of patients. Physical resources (hardware and software), connectivity technology, and training and technical assistance for users and managers will also be financed at the different jurisdictional levels.

2.17 For program monitoring, the design and implementation of a system to track the purpose and output indicators in the logical framework will be financed. For the provincial project targets, operational and medical audits will be performed to verify the accuracy of the reports presented by the provinces that trigger payment of the incentives (see paragraphs 3.23 and 3.24). Monitoring will also provide data to support the semiannual and annual reports presented to the Bank and will provide inputs for program evaluations.

2.18 **Evaluation**. A series of evaluations of given subcomponents and activities will be financed with a view to evaluating certain actions that have been proposed in relation to the program's objectives, expected impacts and/or outcomes, and applying corrective measures, if necessary. These evaluations will be performed by external consultants to ensure the independence and impartiality of the results. The following evaluations will be financed, among others: (i) evaluation of the course on the rational use of medicines to learn its impact on medical practice; (ii) two FEAPS user satisfaction surveys to learn about the level of information and quality of services received under the program; (iii) evaluation of the efficiency of the inputs and medication management systems in Remediar; and (iv) multidimensional evaluation of the Community Doctors Program that seeks to identify the pertinence and suitability of the contents for local health system needs, the health results obtained by services that have had community doctors since 2005, and employment prospects for graduates in the health system.

C. Cost and financing

2.19 The total cost of this investment program, which will be executed in five years, is an estimated US$287.5 million, with the Bank financing US$230 million and the local counterpart providing the remaining US$57.5 million. The program costs are broken down in the following table.

Table II-2
Program costs (US$ million)

Components	IDB	Local	Total
Component 1. Provincial projects to strengthen systems	**88.34**	**11.0**	**99.34**
1.1 Technical assistance for provincial projects	12.98	0.0	12.98
1.2 Implementation of provincial projects	75.36	11.0	86.36
Component 2. Provision of strategic inputs for health services	**119.74**	**45.20**	**164.94**
2.1 Provision of inputs and essential medicines	107.53	11.05	118.58
2.2 Training of PHC human resources	12.21	34.15	46.36
Component 3. Information, monitoring, evaluation, and auditing	**13.10**	**0.26**	**13.36**
Program administration*	**8.82**	**0.54**	**9.36**
Financial costs	**0.0**	**0.50**	**0.50**
Credit fee	0.0	0.50	0.50
Inspection and supervision fee	0.0	0.0	0.0
Total	**230.0**	**57.50**	**287.50**

*Operating costs, consulting services, communications, and other activities necessary for program execution.

III. PROGRAM EXECUTION

A. Borrower, guarantor, and executing agency

3.1 The borrower will be the Argentine Republic, and the executing agency will be the federal Ministry of Health (MSAL) through its Health Programs Secretariat (SPS).

B. Execution and administration

3.2 In addition to its line directorates, the SPS structure has units that execute externally financed programs such as the Nacer program and the essential public health functions and programs project by the World Bank; the program to strengthen primary care financed by the European Union; and the Remediar and Community Doctors Programs being financed by the IDB under PROAPS (loan 1193/OC-AR), whose structures will be integrated into that of this project.

3.3 For the purposes of the present program the SPS will establish a central executing unit (CEU) that will take charge of overall program execution, as per MSAL's operating practice. The CEU will coordinate its activities with the other programs under way in MSAL's Epidemiology Directorate that reports to the SPS, such as

the national programs for diabetes and cardiovascular disease prevention and control, the national smoking prevention program, etc., and with other directorates such as the Statistics and Health Information Directorate.

3.4 The CEU will have a general coordination unit that will be responsible for overall implementation of the program. That unit will be supported by four line units:

(i) The provincial projects development unit will assist the provinces in preparing and executing their plans to strengthen the health services networks and coordinate the linkage between those projects and the actions for the provision of drugs, human resources training, and MSAL programs responsible for managing prioritized chronic diseases.

(ii) The technical unit of the Remediar program, which is responsible for developing activities for the supply of essential medicines and inputs and for training in the rational use of medicines.

(iii) The technical unit of the Community Doctors Program, which is responsible for implementing actions to train human resources for PHC under the program.

(iv) The monitoring and evaluation unit, which is responsible for implementing the program's monitoring and evaluation system, coordination, preparation, and tracking of the annual work plan, monitoring and auditing of process, output, and outcome indicators for the program and the provincial plans, quality control of the enrollment mechanism and of the provincial monitoring system, and for heading up program evaluation activities.

3.5 Within its internal structure, the general coordination unit will determine the necessary crosscutting functions and support areas to implement and coordinate the program.

3.6 The executing agency's UFI-S will be responsible for management of the program and resources, financial management of the mechanism for transferring incentives to the provinces, and preparation and execution of the procurement plan in coordination with the CEU.

3.7 Execution of Component 1 will be centralized with regard to technical assistance for provincial projects (subcomponent 1.1) and decentralized for their implementation (subcomponent 1.2). In the case of this second subcomponent, each provincial ministry will determine the internal body within its structure that will take charge of executing program activities. That body, which will become the provincial program execution unit will receive technical assistance from and be supervised by the CEU, and will be responsible for: (i) performing the diagnostic assessment of the provincial health care systems; (ii) prioritizing the systems in which it will intervene; (iii) establishing the baseline for the program indicators; (iv) designing, executing, and monitoring the provincial plan to strengthen the

prioritized systems; (v) preparing, negotiating, and administering the management commitments with the systems and their health care providers; (vi) implementing and managing the system for monitoring the program in the prioritized systems; and (vii) preparing and presenting the reports every four months on compliance with targets and indicators.

3.8 Execution of components 2 and 3 will be centralized. For component 2, as mentioned earlier, the structures of the Remediar and Community Doctors Programs established under PROAPS will be used. Universities or specialized institutions will be hired for personnel training and instruction. Logistics companies will be hired for the distribution of basic inputs and essential medicines, and specialized firms, universities, and/or research centers will be engaged for the evaluation activities.

C. Aspects related to execution of subcomponent 1.2: Implementation of provincial projects

3.9 Implementation of the provincial projects will be regulated by the following instruments:

(i) *Framework agreements* between MSAL and the provincial ministries that decide to join the program, which will establish all the technical, administrative, and financial aspects relating to project execution and provincial participation, in terms of the sphere of action in the system, target population, targets, operating and financial mechanism for the incentives and sanctions, auditing requirements, and system for monitoring and results-based evaluation.[7]

(ii) *Annual management agreements* between MSAL and the provincial ministries in the program, which will include targets, the work plan, and the annual budget.

3.10 An incentive fund for US$75 million will be established to be distributed in about three years among the provinces that join the program. In principle, these funds will be allocated to the country's 24 provinces (primary distribution) in function of the population that only has public health service coverage.[8] Each year a joint review will be performed by federal and provincial authorities of progress in implementing the provincial projects. In the event that a province presents limited progress, its management agreement will be terminated.[9] Unused resources will be placed in a fund for secondary distribution which will be allocated proportionally to

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[7] Modelo de Convenio Marco [Model framework agreement].

[8] Distribución por provincia del incentivo global [Distribution of the global incentive by province].

[9] The program's Operating Regulations will contain a detailed definition of the criteria for classifying progress in the provincial plans and the procedure for terminating cases classified as presenting "limited progress."

jurisdictions that comply with the established targets and are interested in expanding them.

3.11 The incentives will be disbursed through MSAL transfers to the provinces based on the reported level of compliance with the targets defined in paragraph 2.9 measured in terms of the number of people. The unit value of these incentives for each indicator will be established in the program's Operating Regulations. The Bank will accept the information on compliance as substantiation for those disbursements. This supporting information will be verified periodically through the operational audits (enrollment) and the medical audits (risk classification and treatment).

3.12 **Advance payment**. To enable the provinces that join the program to make a start on activities to get their provincial projects underway, MSAL will grant them an initial disbursement of up to 15% of the ceiling assigned. Presentation and approval of the provincial project and signature of the framework agreement and the respective annual management agreement are conditions precedent to that disbursement. The advance payment will be deducted from the first disbursements of the incentive payments made every four months, and therefore regular transfers against achievement of results will be made after 100% of the advance is deducted. The program's framework agreement and Operating Regulations will establish the mechanism to be used by MSAL to recover advances not justified by the provinces. MSAL will assume responsibility before the Bank for such unjustified advances.

D. Procurement

3.13 The program includes the procurement of goods and consulting services in accordance with the "Policies for the procurement of works and goods financed by the IDB" (document GN-2349-7) and the "Policies for selection and contracting of consultants financed by the IDB" (document GN-2350-7). The procurement plan for the first 18 months is presented in Annex II.

3.14 International competitive bidding will be compulsory for goods estimated to cost US$500,000 or more. National competitive bidding will be used for goods costing US$100,000 to US$500,000. Shopping will be used for goods under US$100,000. For consulting services estimated to cost US$500,000 or more, a shortlist of six firms that are highly representative geographically and national and international publicity will be required. For amounts between US$200,000 and US$500,000, a shortlist of six firms that may all be local, and national and international publicity will be required; and for amounts under US$200,000 a shortlist of six firms that may all be local, and national publicity will be required.

3.15 Given that the eligibility criterion for receiving the incentives under subcomponent 1.2 is fulfillment of the targets defined in paragraph 2.9, the provinces will not be required to use the Bank's procurement policies in applying the resources. This does not represent an exception to the Bank's procurement policies since those incentives will be disbursed against previously verified outcomes.

3.16 **Bank supervision of procurement processes**. The Bank will supervise procurements ex post, as stipulated in Appendix 1, point 4, of document GN-2349-7 and GN-2350-7 and in accordance with the procedure stipulated in the program's Operating Regulations. The ex post review system will come into effect once a model standard program document for each type of procedure has been agreed on by the executing agency and the Bank. In light of the relevance, priority, and risks of each activity, the procurement plan will be used by the Bank as the basis for identifying annually, in conjunction with the executing agency, the procurement processes that will be subject to ex ante review. During the program, the Bank will perform ex ante reviews in the event that execution periods are extended or if there are other contractual amendments or assignments of contracts in the cases of international competitive bids.

3.17 **Procurement plan**. Before issuing the first bid call for any work, good, or consulting service, the borrower will present to the Bank for approval and review, a procurement plan covering an 18-month period, which includes estimates of the costs of the contracts, sources of financing, grouping of processes, the procurement methods for each process, and applicable procedures. As established in paragraph 3.13 of the policies mentioned earlier, the borrower will present an update of the plan for the subsequent 18 months each year to the Bank for review and approval. All procurements will be carried out in accordance with the most recent version of the procurement plan approved by the Bank.

E. Execution period and disbursement schedule

3.18 The program's financial resources will be committed in 54 months, and the disbursement period will be 66 months after the loan contract comes into effect. The tentative disbursement schedule is presented in Table III-1.

Table III-1
Estimated disbursement schedule (US$ million)

Source	Year 1	Year 2	Year 3	Year 4	Year 5	Total US$	%
IDB	16.6	54.6	64.6	59.4	34.8	230.0	80
Local	4.15	13.65	16.15	14.85	8.7	57.5	20
Total	20.75	68.25	80.75	74.25	43.5	287.5	100
% Year	7.22	23.74	28.09	25.83	15.13	100	100

F. Revolving fund

3.19 A revolving fund will be established for program execution, to be deposited into the specific bank account that the borrower has opened for the program. Considering the projected flow of funds to finance the program's activities and procurements, particularly the purchase of medicines, a revolving fund will be established equivalent to 10% of the loan. The CEU will present semiannual reports to the

Bank on the status of the revolving fund within 60 days after the end of each six-month calendar period.

G. Management of funds, accounting records, and control of disbursements

3.20 The CEU will be responsible for the signature and administration of all contracts for goods and services and for making and recording payments under those contracts and keeping the financial accounts for transactions and disbursements during the program.

3.21 The CEU, in coordination with the UFI-S, will also be responsible for: (i) maintaining separate, specific bank accounts for the loan proceeds and the local counterpart contribution; (ii) expeditiously presenting disbursement requests and vouchers for eligible expenditures; (iii) maintaining adequate information systems for program accounting and financial management, integrated with the official accounts, and a system for contract administration and project control and the corresponding internal control structure for managing IDB and local counterpart resources in accordance with Bank requirements; (iv) preparing and presenting the financial reports on the project, the semiannual reports on the revolving fund, and any other financial reports required by the Bank, including the audited financial statements of the program; and (v) maintaining an adequate system for filing the documentation in support of eligible expenditures for verification by the Bank and the external auditors.

H. Special conditions

3.22 In addition to the general conditions precedent to the first disbursement, which are established in the General Conditions of the loan contract, the borrower will present evidence to the Bank that it has complied with the following special conditions precedent to the first disbursement: (i) Ministry of Health resolution creating the CEU for the program; (ii) recruitment and formal appointment of the general program coordinator; and (iii) the Bank's nonobjection to the program's Operating Regulations. As a special condition precedent to the start of each provincial project, the PEU will present evidence to the Bank that the provincial project to strengthen health systems has been approved and the respective framework agreements and annual management agreements have been signed with the province.

I. Audits

3.23 **Operational and financial auditing**. During the program the borrower, through the CEU, will present the audited financial statements of the program annually. The audits will be performed by a firm of independent external auditors acceptable to the Bank or by the national audit office, as agreed between the government and the Bank. These audits must conform to Bank requirements (documents AF-100, AF-300, and AF-500). If pertinent, the Bank's standard procedures for the selection of external auditing services (document AF-200) will be followed, and the process will be based on the guidelines established in the terms of reference for external auditing of projects financed by the IDB (document AF-400) already approved by

the Bank. The annual financial statements will be presented within 120 days after the end of the fiscal year and the final statement within 120 days after the last disbursement.

3.24 In addition, the auditors will issue semiannual financial and operational audits that will include:

a. Midterm financial reports at 30 June. These reports will include an opinion on the comprehensive review of procurement processes and the documentation supporting the disbursement requests presented to the Bank in the immediately preceding six-month period. The requirements for this work are established in document AF-500.

b. Semiannual operational audit reports at 30 June and 31 December. These reports will include an evaluation of compliance with the program's operating parameters, the effectiveness indexes, and confirmation of the efficiency, status, and security of the information systems. Also, as part of the verification of the performance of component 1, the reports will include a review of the consistency and pertinence of the procedure for cross-checking the databases on enrollment to verify the legal identification of the persons enrolled and their membership in the program's target population; validation of the registration mechanism, and monitoring of the program indicators; and sampling to confirm the records and level of compliance with the enrollment indicator in the networks and services taking part in the program. The terms of reference for these audits will be agreed on in advance by MSAL and the Bank.

3.25 **Medical audits**. These audits will verify compliance with the indicators for risk classification and the treatment plan for patients suffering from the diseases that have been prioritized in each system, taking a random sample of the clinical records of patients as the basis. The audit reports will be issued as of 30 June and 31 December during the first year of the program and as of 31 December in subsequent years. The terms of reference will be agreed on in advance by MSAL and the Bank.

3.26 The semiannual financial, operational, and medical reports should be presented within 60 days after the end of the corresponding six-month period. The costs of these audits will be included in the program and financed from the loan proceeds.

J. Monitoring and evaluation

3.27 The CEU will present semiannual reports containing information on the following: (i) performance in compliance with the objectives and outcomes agreed in each AWP for each component, including a risk analysis and risk monitoring and measures to mitigate them; (ii) progress report on the status of the procurement plan; (iii) compliance with the contractual clauses of the loan contract; and (iv) financial execution of the program's budget by investment category and source of financing which, as a minimum, will include investments up to the start of the

period, investments during the period, and cumulative investments at the end of the period, and the balance to be executed, including the revolving fund. The reports in the second half of each calendar year will also include: (i) the AWP for the following year; (ii) the updated procurement plan for the following 18 months, and actions to implement the recommendations by the external auditors, if any.

3.28 A technical mission will be sent in the first year of the program to study experience in its implementation and, if necessary, to agree on adjustments, particularly in relation to component 1, such as the indicators and the selected diseases, the incentive mechanism, the information and monitoring system, federal-provincial relations, and others.

3.29 As part of program monitoring, a midterm evaluation will be performed together with a final evaluation of the outcomes. The latter will focus on the specific indicators in the logical framework and the expected benefits, and will extract lessons learned. The midterm evaluation will be commissioned 24 months into the project or when 40% of the proceeds have been disbursed, whichever comes first. The final evaluation will be commissioned within six months prior to the date of the last disbursement or when 90% of the loan proceeds have been disbursed, whichever comes first. The executing agency will hire an independent specialized firm to perform these evaluations, in accordance with terms of reference agreed on with the Bank.

IV. FEASIBILITY AND RISKS

A. Institutional feasibility

4.1 Considering that this operation will provide continuity for the Remediar and Community Doctors Programs that were partially financed by loan 1193/OC-AR (PROAPS), which will serve as the basis for establishing the CEU for this program (FEAPS), an assessment of the technical, administrative, financial, and procurement institutional capacity of the bodies in charge of executing the PROAPS program was performed. It rated the capacity of the PROAPS executing unit as medium development (MD) on average, which implies medium risk (MR). The assessment highlighted the capacities and experience developed by MSAL in procurement of drug supplies, which justifies the adoption of ex post reviews for this operation. The assessment includes five recommendations to build up the capacity of the executing unit and concludes that once they are implemented, capacity will be sufficient to administer the new program satisfactorily. MSAL has undertaken to implement the recommendations before the new program begins. These recommendations are straightforward and partly refer to authorizations for access to information systems.

4.2 Relations between MSAL and the provincial ministries for execution of component 1 will be governed by framework agreements and annual management agreements (paragraph 3.8). This arrangement, which is envisaged in the Federal Health Plan, is being used with very good results in the Nacer program, which also

has a system for the transfer of resources similar to the one to be used under FEAPS to allocate the incentives.

B. Financial feasibility

4.3 The Bank's share of the financing is modest compared to the provincial and national health budgets. In the case of component 1, the incentives to be transferred to the provinces to strengthen their health services networks amount to less than 2% of provincial spending on health care. This amount is not significant when compared to total provincial spending but is expected to promote larger allocations of existing provincial resources into PHC. In the case of component 2, which will be executed centrally by MSAL, the loan amounts to less than 3% of the ministry's annual budget in 2007. This means that these expenditures could eventually be absorbed by the national government.

C. PTI/SEQ

4.4 Since it is a health sector operation, the program qualifies as a social equity enhancing project (SEQ) as described in the indicative targets for Bank activities established in the Eighth General Increase of Resources (document AB-1704). It also qualifies automatically as a poverty-targeted investment (PTI), since the funds will support implementation of the primary health care strategy.

D. Environmental safeguards

4.5 The program obtained a "C" classification and has not required any policy directive in accordance with the form on compliance with environmental and social safeguards.

4.6 The incentives to be transferred to the provinces can be used for expenditures predetermined by the federal level, including investments in small infrastructure rehabilitation works that do not pose environmental risks. The method used to analyze and formulate the provincial projects will apply national standards for hospital waste management by health care providers in the networks of services that participate in the program.

4.7 The provincial projects will also include specific actions for cultural adaptation and promotion of participation by indigenous populations as program beneficiaries, depending on the situation in each province. The postgraduate program in social and community health has modules for training healthcare workers in aspects related to social inclusion, equity and culture, prevention of environmental damage, and environmental protection.

E. Benefits

4.8 The program will have a concrete health impact by implementing a strategy to control chronic diseases, particularly hypertension and type 2 diabetes, geared to the poor population that relies on the public health system. Identification and enrollment of persons not diagnosed as yet, activities for health promotion and primary and secondary disease prevention, and monitoring of persons classified

with moderate and high risk under the evidence-based treatment plan will help to reduce morbidity and premature mortality from cardiovascular events. The impact on the quality of life and productivity of the beneficiaries, mainly diabetics, could be substantial in its reduction of disabilities caused by amputations and blindness.

4.9 Actions to control chronic diseases will have an impact on the organization, treatment capacity, effectiveness, and quality of health services, strengthening their operation as a network. Consistent with the commitment to primary health care in the Federal Health Plan, the program's interventions focus on the first level of care, identified as the gateway to the system and responsible for the enrolled population. The active search for families in the enrollment process will expand health coverage, bring services closer to the beneficiary population, and decongest hospitals. The adoption of uniform treatment plans will result in an improvement in clinical quality, use of highly cost-effective interventions, emphasis on programmed health promotion and disease prevention activities, and the development of referral and counter-referral systems.

F. Risks

4.10 **Provincial participation**. Attaining the objective of component 1 hinges largely on whether the provinces decide to join and participate in it. Also, since the incentives allocated to the provinces will be based on the population that only has public health coverage, about 40% of the resources should go to the province of Buenos Aires and therefore its participation is even more relevant for the program's viability. To mitigate the risk that most of the provinces, particularly Buenos Aires province, might fail to participate, MSAL, through the Federal Health Council (COFESA), has informed the provincial ministers about the conceptual aspects of the operation. As a result, it has received written letters of intent to participate in FEAPS from 20 provinces, including Buenos Aires.

4.11 **Logistics operators**. One of the characteristics of MSAL's inputs and essential medicines management system is that distribution is outsourced. This has improved efficiency and coverage in the delivery of drug kits to PHCCs. However, few logistics operators have the capacity to provide services nationwide, which has led to considerable increases in the cost of services in the most recent tenders under PROAPS. To ensure that this situation does not affect system operation, during the program, MSAL and the Bank will examine different options for extending the period or scope of the services in order to obtain a larger number of competitive bids.

PROGRAM TO STRENGTHEN THE PRIMARY HEALTH CARE STRATEGY (FEAPS)
AR-L1020

LOGICAL FRAMEWORK

NARRATIVE SUMMARY	INDICATORS	MEANS OF VERIFICATION	ASSUMPTIONS
GOAL			
To help improve the health of Argentines and reduce mortality and morbidity from chronic diseases.	*Three years after the program ends:* ▪ Hospitalization rates for cardiovascular and metabolic events are reduced.	National hospital statistics	
PURPOSE			
To strengthen health service networks based on the PHC strategy.	*By the end of the program for each participating provincial network:* ▪ At least 75% of the population that only has public health coverage is enrolled. ▪ At least 90% of the population that was preselected with moderate or high overall cardiovascular risk is classified under the treatment plan. ▪ At least 80% of patients classified with moderate or high overall cardiovascular risk are being treated under the plan.	Operational audits (cross checking of the database on enrollment and sampling) Periodic studies to validate program outcomes (medical audits based on a sampling of clinical records at PHCCs)	MSAL and the provincial ministries continue to invest in campaigns to promote a healthy lifestyle.

NARRATIVE SUMMARY	INDICATORS	MEANS OF VERIFICATION	ASSUMPTIONS
COMPONENTS/OUTPUTS			
Provincial projects to strengthen health service networks			
1.1. Technical assistance for provincial projects	*By the end of the program:* ▪ 80 workshops held on training in network management. ▪ 18 provincial projects approved and reflected in management agreements between the federal and provincial governments. ▪ 80 workshops held on training and development in health management and treatment plans. ▪ Guidelines for clinical practices for treating hypertension and type 2 diabetes approved and distributed.	Progress reports	The provinces sign and maintain management agreements for implementing the provincial projects. The province of Buenos Aires approves and implements its provincial project.
1.2 Implementation of provincial projects	*By the end of the program:* ▪ 18 provincial projects implemented as planned and reviewed each year on the federal level.	Progress reports	PHCC physicians use the treatment plans.
2. Provision of strategic inputs for health services			
2.1 Provision of inputs and essential medicines – Remediar program	*By the end of the program:* ▪ 151,800,000 treatments with essential medicines distributed. ▪ 700,000 treatments for hypertension and type 2 diabetes distributed. ▪ 6,000 physicians trained in the rational use of medicines.	Progress reports	Competitive bids are made for contracting the logistics operator.

NARRATIVE SUMMARY	INDICATORS	MEANS OF VERIFICATION	ASSUMPTIONS
2.2 Personnel training for PHC	*By the end of the program:* ▪ 5,855 healthcare professionals completed the post-graduate program in social and community health. ▪ 6,500 healthcare professionals completed the post-graduate program in research methods. ▪ 10,500 professionals receiving ongoing in-service training. ▪ 90% of participants in the Community Doctors Program are employed by PHCCs. ▪ 75% of PHCCs belonging to the networks financed have at least 1 participant in the Community Doctors Program among their staff.	Progress reports	The federal government provides funds for continuity of the Community Doctors Program.
3. Information, monitoring, and evaluation			
	By the end of year one of the program: ▪ Manual of monitoring procedures prepared. ▪ Course on rational use of medicines evaluated. ▪ Efficiency of Remediar processes evaluated. ▪ Community Doctors Program evaluated. *By the end of the program:* ▪ FEAPS user satisfaction surveys completed	Progress reports	

NARRATIVE SUMMARY	INDICATORS	MEANS OF VERIFICATION	ASSUMPTIONS
	▪ Midterm evaluation completed ▪ Final evaluation completed		

DOCUMENT OF THE INTER-AMERICAN DEVELOPMENT BANK

PROPOSED RESOLUTION

Argentina. Loan /OC-AR to the Argentine Republic
Program to Strengthen the Primary Health Care Strategy

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 Argentine Republic, as Borrower, for the purpose of granting it a financing aimed at cooperating in the execution of a program to strengthen the primary health care strategy. Such financing will be in the amount of up to US$230,000,000, from the resources of the Single Currency Facility 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.