

DOCUMENT OF THE INTER-AMERICAN DEVELOPMENT BANK

PANAMA

**HEALTH EQUITY IMPROVEMENT AND SERVICES
STRENGTHENING PROGRAM**

(PN-L1068)

LOAN PROPOSAL

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CONTENTS

PROJECT SUMMARY

I.	DESCRIPTION AND RESULTS MONITORING	1
A.	Background, problems to be addressed, and rationale	1
B.	Objectives, components, and cost.....	5
C.	Key results indicators.....	9
II.	FINANCING STRUCTURE AND RISKS	10
A.	Financing instruments	10
B.	Environmental and social safeguard risks	10
C.	Fiduciary risks	11
D.	Other risks	11
III.	IMPLEMENTATION AND ACTION PLAN	11
A.	Summary of implementation arrangements.....	11
B.	Summary of arrangements for monitoring results.....	14

Annexes	
Annex I	Summary Development Effectiveness Matrix (DEM)
Annex II	Results Matrix
Annex III	Fiduciary Agreements and Requirements

Electronic Links
<p>REQUIRED</p> <ol style="list-style-type: none"> 1. AWP (activity plan for the first disbursement and the first 18 months of implementation) http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=36154603 2. Monitoring and evaluation plan http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=36155355 <p>OPTIONAL</p> <ol style="list-style-type: none"> 1. Bibliographic references http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=36167542 2. 2010-2014 Strategic Government Plan http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=36154645 3. Health Coverage Extension Strategy http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=36157602 4. Ex ante economic analysis http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=36155291 5. Risk management workshop http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=36154612 6. Itemized budget and disbursement schedule http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=36157644 7. General Operating Manual for the program http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=36154668 8. Operating regulations for PAISS+N and PSPV provision via institutional mobile units (October 2010) http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=36154694 9. Operating regulations for PAISS+N and PRPV provision via external organizations (October 2010) http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=36154683 10. Disbursement flow of funds for capitation payments http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=36225691 11. Program targeting analysis http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=36157588 12. Safeguard screening form for classification of projects (SSF) http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=36168496

ABBREVIATIONS

AIN-C	Atención Integral de la Niñez en la Comunidad [Comprehensive Community-based Health Care for Children]
BPR	Beneficiary population registry
CODIPRO	Comité Directivo del Programa [Program Steering Committee]
CBPR	Certified beneficiary population registry
DRS	Direcciones Regionales de Salud [Regional Health Departments]
ENV	Encuesta de Niveles de Vida [Standard of Living Survey]
GDP	Gross domestic product
IDB	Inter-American Development Bank
MDG	Millennium Development Goal
MINSA	Ministry of Health
PAISS	Paquete de Atención Integral de Servicios de Salud [Comprehensive Health Services Package]
PAISS+N	Paquete de Atención Integral de Servicios de Salud más AIN-C [Comprehensive Health Services Package plus AIN-C]
PSP	Priority services portfolio
PSPV	Protección en Salud para Poblaciones Vulnerables [Health Protection for Vulnerable Populations]
SIAFPA	Sistema Integrado de Administración Financiera de Panamá [Integrated Financial Administration System of Panama]
UGAF	Unidad de Gestión Administrativa y Financiera [Financial and Administrative Management Unit]

PROJECT SUMMARY
PANAMA
HEALTH EQUITY IMPROVEMENT AND SERVICES STRENGTHENING PROGRAM
(PN-L1068)

Financial Terms and Conditions ¹				
Borrower: Republic of Panama Executing agency: Ministry of Health (MINSA)			Amortization period:	25 years
			Grace period:	5 years
			Disbursement:	5 years
Source	Amount (US\$ millions)	%	Interest rate:	LIBOR-based
IDB (OC)	50	71	Inspection and supervision fee:	*
Local	20	29	Credit fee:	*
Total	70	100	Currency:	U.S. dollars from the Single Currency Facility of the Ordinary Capital
Project at a Glance				
<p>Project objective: The general objective of the program is to improve health equity by increasing access to, as well as the use and quality of, health services in indigenous comarcas and adjacent rural areas. By strengthening primary care, reinforcing the priority services portfolio (PSP), and adapting health care networks, the program is expected to reduce maternal and child mortality rates and chronic malnutrition, while improving the health of the country's poorest population.</p>				
<p>Special contractual conditions precedent to the first disbursement of the loan proceeds: (i) the borrower will submit, to the Bank's satisfaction, evidence that it: (a) has approved and placed into effect the Operating Manual for the program; (b) has approved and placed into effect the updated versions of the Operating Regulations used in the operation subject to loan contract 1867/OC-PN for the provision of PSP services at Primary Care Centers through institutional mobile units and external organizations; and (c) has approved and placed into effect the Operating Regulations for the provision of services by the regional health departments (DRS) and the external organizations in the fixed health network (see paragraph 3.5); and (ii) has commissioned the financial audit and the external technical audit (see paragraph 3.8). As a condition precedent to disbursements of loan proceeds related to capitation payments, subsequent to the first disbursement, the borrower will present the external technical audit report finding that the coverage, performance, and satisfaction indicators were met and that no prohibited practices were detected (see paragraph 3.9).</p>				
<p>Special considerations: Disbursements of the loan proceeds for the capitation payments will be based on the external technical audit reports and the social audit. Disbursements for the other components will be based on expenses actually incurred (see paragraph 3.7).</p>				
<p>Exceptions to Bank policies: None</p>				
<p>Project qualifies as: SEQ [X] PTI [X] Sector [X] Geographic [X] Headcount [X]</p>				

* 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 applicable provision of the Bank's policy on lending rate methodology for Ordinary Capital loans. In no case will the credit fee exceed 0.75% or the inspection and supervision fee 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. DESCRIPTION AND RESULTS MONITORING

A. Background, problems to be addressed, and rationale

- 1.1 **Health outcomes and challenges.** Between 2004 and 2009, Panama's gross domestic product (GDP) grew at an average annual rate of 8.1%, maintaining its upward momentum even during the 2008 global crisis¹. Yet, while the poverty level edged down from 36.8% to 32.7%² between 2003 and 2008, almost one third of the population continues to live below the poverty line.
- 1.2 In addition, there are significant gaps in health outcomes, primarily regarding maternal and neonatal health and child malnutrition. These gaps are partly due to unequal access to public primary health care, as well as to service utilization and quality. Panama also faces an epidemiological transition characterized by a double burden of disease, with noncommunicable diseases and accidents accounting for an increasingly greater share of the total than infectious diseases³.
- 1.3 With respect to maternal health, between 1990 and 2007 the country's mortality rate rose from 53.4 to 59.4 deaths per hundred thousand live births, far behind the 2015 target of 13.4 deaths per hundred thousand live births set under the fifth Millennium Development Goal (MDG)⁴. In the indigenous autonomous regions known as comarcas and their adjacent rural areas, the rates are higher still: 376.4, 584.8, and 292.7 maternal deaths were recorded per hundred thousand live births in the comarcas of Ngöbe Buglé and Kuna Yala and in the province of Darién, respectively, in 2006. This can be explained by the conditions prevailing in poor and indigenous communities, including difficult access, lack of skilled birth care, and cultural and social barriers to service utilization. Only 27.5% of the indigenous population uses modern contraceptive methods, while 64% receives prenatal care from a physician, and a mere 44% is attended by a physician during delivery.⁵
- 1.4 Over time, Panama has made efforts to reduce infant mortality, with partial success. Between 1990 and 2007, the infant mortality rate fell from 18.9 to 14.7 deaths per thousand live births, still far from the 2015 target of 6.3 deaths per thousand live births associated with the fourth MDG.⁶ Moreover, inequality persists, as evidenced by 2009 data showing that the infant mortality rate in indigenous comarcas was 20.3 deaths per thousand live births while the national average for the same year

¹ World Development Indicators 2011.

² Standard of Living Survey 2008 (ENV 2008).

³ By 2002, years of life lost due to communicable, maternal, perinatal, and nutritional diseases accounted for 38% of the total burden of disease, while noncommunicable (primarily chronic) diseases constituted 44% of the total burden of disease. See: <http://apps.who.int/whosis/data>.

⁴ MDG, III Panama Report, 2009.

⁵ Thirty-six percent of mothers have their first prenatal checkup before the fourth month of pregnancy, and just 50% of pregnant indigenous women give birth at a health facility (ENV 2008).

⁶ MDG, III Panama Report, 2009.

- was 12.2 deaths per thousand live births.⁷ Some of these deaths are preventable and occur in the initial days following birth. Of the deaths of children under one year of age in 2008, 34% were from causes arising in the perinatal period, 11% from pneumonia, 6% from diarrhea or protein-calorie malnutrition, and 4% from external causes, which could mean inadequate care of the infant by the family.⁸
- 1.5 Inequality in children's health is present at birth and persists throughout childhood. Chronic malnutrition⁹ is most prevalent in indigenous populations, where it affects 62% of children under five years of age, three times the national rate (19.1%).¹⁰ Moreover, there are disparities in terms of full vaccination coverage, which in some areas is just 30%.
- 1.6 Regarding the health system, there are persistent gaps in the availability of preventive primary care and emergency health care services in both indigenous and non-indigenous communities. The province of Panamá has close to 60% of the country's skilled health workers. In the poorer areas, an inadequate primary care infrastructure, a scarcity of supplies, a lack of incentives to improve the quality of health care, and a disconnection between primary and secondary care are obstacles to continuity of care and disease management. These missing pieces are essential for adequate prenatal and delivery care, timely obstetric and neonatal emergency care, regular growth and development checkups, and chronic disease prevention.¹¹
- 1.7 **Government response.** Efforts by the national government, acting through the Ministry of Health (MINSa) and supported by the Inter-American Development Bank (IDB) and the World Bank,¹² have focused on interventions aimed at addressing health issues in indigenous communities and rural areas with serious health care access problems. In 1995, the country launched the [Health Coverage Extension Strategy](#) with a combined capitation and performance-based financing model, creating incentives for providers to deliver primary health care services more efficiently. Under the Health Coverage Extension Strategy, a Health Protection for Vulnerable Populations (PSVP) package targets rural populations, and a Comprehensive Health Services Package (PAISS), strengthened by Comprehensive Community-based Health Care for Children (AIN-C), known as PAISS+N, targets the indigenous comarcas. These health services are provided via

⁷ Instituto Nacional de Estadística y Censo [National Statistics and Census Institute] 2009.

⁸ MDG, III Panama Report, 2009.

⁹ Chronic malnutrition is defined as a deficit in expected height for age, based on the growth curves published by the World Health Organization (2006).

¹⁰ ENV 2008.

¹¹ Remington, et al., 2010.

¹² IDB: Social Protection Program - Phase I (1867/OC-PN). World Bank: Health Equity and Performance Improvement Program (L7587-PA).

[mobile clinics](#) by [external organizations](#)¹³ and health professionals contracted by MINSA's regional health departments (DRS). By late July 2010, the Health Coverage Extension Strategy with PAISS+N covered a total of 170,326 individuals listed in the beneficiary population registry (BPR) in comarca regions. However, only 78,349 of these beneficiaries actually received any type of service. Of the group that received services, according to administrative data, 43,140 children under five years of age received AIN-C interventions including to promote growth and development, and 74% of enrolled pregnant women received three or more adequate prenatal and postnatal checkups.

- 1.8 **Intervention rationale and value-added of this operation.** Under the existing service delivery strategy, the fixed and mobile networks are essentially separate and there is no performance-based payment system in the fixed network. The lack of coordination between the two levels of service (fixed and mobile) introduces significant inefficiencies between the phases of diagnosis and primary care in the field by mobile units, and patient follow-up at fixed-site facilities. In addition, public health literature and experiences in other countries¹⁴ point to promising results when capitation payments are incorporated into the fixed facility network and combined with incentives for improving the quality and utilization of maternal and child health services. Accordingly, building on the existing health care system, this program will introduce performance-based payments at local primary care networks, unifying fixed-site and mobile services under the concept of a Primary Care Center providing services to a target population,¹⁵ with region-based management of various health care models.
- 1.9 So that Primary Care Center services can improve health indicators, the priority services portfolio (PSP) will include supplementary interventions aimed at strengthening and supporting Primary Care Center performance as integrated primary health care networks. The concept of primary care networks, integrated with post-primary care, has been positively reviewed in other countries.¹⁶
- 1.10 The primary care services to be reinforced span the entire family life cycle, emphasizing the pre-conception stage, with family planning services; care during pregnancy, with prenatal checkup¹⁷ and neonatal care reinforcement; and nutrition programs to reduce chronic malnutrition,¹⁸ with particular emphasis on early

¹³ External organizations are civil society organizations lawfully established in a Bank borrowing member country.

¹⁴ See the cases of Argentina (with Plan Nacer) and other countries (Basinga, et al., 2011; Rusa, et al., 2009).

¹⁵ Beneficiaries are estimated at 205,000 people in indigenous comarcas and adjacent rural areas.

¹⁶ See the Family Health Program in Brazil (Guanais, F.C., et al., 2009; Macinko, J., et al., 2006).

¹⁷ The international evidence suggests that acceptance of institutional birth increases when mothers receive adequate prenatal checkup information (Nikiema, B., et al., 2009).

¹⁸ Chronic childhood malnutrition has been associated with adverse future outcomes, such as cognitive deficits, greater propensity to obesity, and risk of chronic disease. (Maurer, J., 2010; Kimani-Murage, E. W., et al., 2010).

intervention during the 6- to 24-month stage, using updated nutritional techniques.¹⁹ In view of the burden of noncommunicable diseases in Panama, the program also includes primary care action for chronic disease prevention and control.

- 1.11 To boost the resolution capacity of maternal-child health services and further integrate local networks, the program includes a component aimed at enhancing the specialized services that require secondary care. This involves strengthening: (i) interventions with proven effectiveness, with an emphasis on increasing institutional birth rates;²⁰ and (ii) the capacity of maternity institutions to handle obstetric emergencies and complications, which are part of essential obstetric and neonatal care.²¹
- 1.12 A reinforced primary care services portfolio and a lineup of incentives are expected to generate additional demand for health services at the secondary level of care. This new management model will be implemented by conducting an analysis of health care networks as a function of demand flow, access, and quality criteria, and by redefining health districts and local networks. Improvements to be introduced will be aimed at enhancing coordination between the primary and secondary levels of care, implementing management models, reinforcing diagnostic services and medical procedures, identifying long-distance medical protocols, and enhancing referral and counter-referral mechanisms.
- 1.13 In addition, the program will place particular emphasis on culturally sensitive adaptation of health services. On the supply side, the program will ensure that infrastructure and human resources are strengthened in accordance with the practices and customs of the various indigenous groups. To reduce the “social distance” between health providers and patients, health professionals will be sensitized to and trained in the health and nutrition values, practices, and beliefs of the indigenous peoples.²²
- 1.14 **Relation to the country’s sector strategy and the Bank’s country strategy.** The [Strategic Government Plan 2010-2014](#) contains a social inclusion component with the following goals: (i) reducing malnutrition, particularly among pregnant women; (ii) expanding basic health care coverage and quality, with a focus on primary care; and (iii) strengthening the hospital network. The proposed operation reflects the Bank’s institutional strategy, included in the [Report on the Ninth General Capital](#)

¹⁹ For example, the literature suggests that lipid-based micronutrient supplements can have a large impact on low height for age (Adu-Afarwuah, S., et al., 2007).

²⁰ Recommendations in favor of institutional birth as a way of preventing maternal mortality are the norm in the international public health literature (Campbell, O. M., et al., 2006).

²¹ Essential obstetric and neonatal functions are the recommended components and human resources needed to reduce maternal and neonatal mortality (Pagel, C., et al., 2009; Díaz, J. J., and Jaramillo, M., 2009).

²² Support is being provided for a study of sociocultural barriers in indigenous comarcas. The evidence confirms the importance of service adaptation in order to increase institutional birth rates among traditional groups (Gabrysch, S., et al., 2009; De Broa, S., 2005).

[Increase](#),²³ and is in line with the [Strategy on Social Policy for Equity and Productivity](#). Through the [2010-2014 Country Strategy](#), the Bank will support the Government of Panama in its efforts to close health gaps in rural areas and indigenous comarcas. This operation is consistent with these strategies,²⁴ as well as with the 2015 Mesoamerican Health Initiative.²⁵

B. Objectives, components, and cost

- 1.15 **Objective.** The general objective of the program is to improve health equity by increasing access to, as well as the use and quality of, health services in indigenous comarcas and adjacent rural areas. By strengthening primary care, reinforcing the [priority services portfolio \(PSP\)](#),²⁶ and adapting health care networks, the program²⁷ is expected to reduce maternal and child mortality rates and chronic malnutrition, while improving the health of the country's poorest population.
- 1.16 **Component 1. Strengthening primary health care (IDB US\$43.3 million; Local US\$14 million).** This component's objective is to ensure and strengthen disease prevention, health promotion, and primary care services at the community level at both fixed-site and mobile Primary Care Centers. The PSP will be financed through capitation and performance-based payments to health providers.
- 1.17 **Subcomponent 1.1.** Implementation of capitation and performance-based payments in the fixed and mobile primary care network (IDB US\$40.8 million; Local US\$12.5 million). This subcomponent will finance capitation payments, defined as the amount allocated to ensure delivery of the PSP to each individual included as a program beneficiary, to be calculated as the average unit monetary cost of the PSP associated with each such beneficiary for one year.²⁸ Capitation payment calculation will include: (i) delivery of services by MINSA's regional health departments (DRS) (whether via mobile units or at fixed-site facilities) and

²³ This strategy gives priority to financing efforts to reduce poverty and enhance equity. It supports the scope of the regional development goals for: reducing maternal and infant mortality rates and the incidence of waterborne diseases; developing preventive health protocols; and responding to the epidemiological transition.

²⁴ The social policy strategy indicates the need to strengthen the country's health systems and promote comprehensive primary health care. The country strategy includes the following indicators: maternal and infant mortality reduction and chronic malnutrition reduction.

²⁵ The objective is to reduce maternal mortality and chronic malnutrition by increasing the use and quality of maternal and child health services for the poorest 20%.

²⁶ The PSP is a set of services (health promotion, disease prevention, and health care) to be provided to beneficiaries under this program.

²⁷ The beneficiary areas of the program include the comarcas of Ngöbe Buglé, Bocas del Toro, Kuna Yala, Darién, Panamá, Coclé, Herrera, Los Santos, Panamá Oeste, Veraguas, Chiriquí, and Colón.

²⁸ For the Ngöbe Buglé and Bocas del Toro regions, the amount is US\$44.58; for Kuna Yala, Darién, and Panamá, it is US\$53.21; for Coclé, Chiriquí, Herrera, Los Santos, Panamá Oeste, and Veraguas, it is US\$40.88. MINSA may on an annual basis apply to the Bank for a modification of the PSP, providing due justification.

by external organizations; (ii) the cost of additional human resources contracted by the MINSA DRS or by external organizations, including a management team, a primary health care team, and a community team; (iii) the cost of supplies, materials, transportation, goods, and equipment procured by the MINSA DRS or the external organizations in connection with delivery of the PSP. In addition, capitation payment calculations will include the cost of payments based on performance and user satisfaction to the MINSA DRS and external organizations. In the case of the MINSA DRS, these departments will be required to reinvest the proceeds of performance-based payments to strengthen the health care network.

- 1.18 Eligible expenses under this subcomponent will consist of capitation payments, which will include: (i) payments as a function of communities visited, population protected, population served, and days of care (coverage achievements); (ii) payments based on attainment of the respective performance and service quality indicators; and (iii) payments as a function of user satisfaction. Payments relating to coverage achievements will represent up to the equivalent of 65% of the capitation payments, while payments relating to performance indicators will represent up to the equivalent of 30% and payments relating to user satisfaction will represent up to the equivalent of 5%. The payments described in subparagraphs (i) and (ii) above will be validated by the external technical audit and the payments described in subparagraph (iii) will be validated by the social audit. MINSA's Health Services Division will analyze and monitor the information associated with capitation payments.
- 1.19 **Subcomponent 1.2.** Development of a primary care management model (IDB US\$476,000; Local US\$118,000). Using the funds allocated for this subcomponent, the executing agency will procure technical assistance services and training for the design and establishment of health care networks based on the protected and beneficiary population flow, access, and redefined resolution areas of health districts. Network redesign will be based on the assigned population, the service portfolio, the human resources, and an analysis of maintenance cost inclusion.
- 1.20 **Subcomponent 1.3.** Strengthening of the primary care service portfolio (IDB US\$2 million; Local US\$1.4 million). This subcomponent will finance specific interventions aimed at improving: (i) the quality of preventive and primary care services already included in the PSP, focusing on women and children; and (ii) chronic disease prevention and management. The executing agency will use the resources allocated to this subcomponent to procure the following:
- a. Sexual and reproductive health services: (i) technical assistance services and training aimed at introducing separate family planning services for adolescents; (ii) contraceptive devices in order to ensure their availability; and (iii) equipment for Pap smears and other tests. The local counterpart resources will be used to finance demand-side incentives to increase the use and enhance the quality of prenatal checkups.

- b. Child health: (i) technical assistance services, training, and supplies to introduce child nutrition services into the AIN strategy for the fixed network; (ii) training and equipment to improve the quality of growth and development checkups; (iii) technical assistance for the design, and goods for gradual implementation, of a system of alternative nutritional supplements, particularly for children between the ages of 6 and 24 months; and (iv) technical assistance services and supplies to strengthen the immunization program, conduct a cold chain review, and train personnel to manage the vaccination system.
 - c. Chronic diseases: (i) supplies for screenings to detect chronic disease risk factors and spot-test equipment; (ii) technical assistance services for chronic disease management; and (iii) medications to control chronic diseases.
 - d. Oral health: (i) an optional set of oral health promotion and prevention services, based on demand in the mobile and fixed-site networks.
 - e. Technical assistance services for health education and community participation: (i) to develop a comprehensive women's health promotion and awareness strategy, including technical training for health workers in early detection of warning signs and appropriate referral; (ii) to adopt a family planning promotion and awareness strategy, with emphasis on adolescents; and (iii) to develop tools and alternatives for promoting growth and adopting healthy habits in the home. The local counterpart resources will be used to finance incentives for community personnel to make appropriate referrals to health facilities for institutional birth.
- 1.21 **Component 2. Improvement of specialized maternal and neonatal care (IDB US\$922,000; Local US\$1 million).** This component's objective is to improve the quality of, and increase demand for, specialized institutional health services, focusing on women and newborns in populations lagging behind in maternal and neonatal health indicators, by financing supplies and improvements aimed at enhancing the resolution capacity of primary and secondary care facilities in the fixed network. The loan proceeds allocated to this component will be used by the executing agency to procure the following:
- 1.22 **Subcomponent 2.1.** Utilization and quality of institutional birth services (IDB US\$567,000, Local US\$549,000): (i) refurbishment of Western birthing rooms and vertical birthing rooms through the provision of basic equipment and supplies for delivery and neonatal care units, giving priority to the areas with the largest gaps in care; and (ii) equipment and furniture for maternal waiting homes and shelters.²⁹ A portion of the local counterpart resources will be used to finance incentives, in the form of travel and per diem allowances, for mothers and those accompanying them to use institutional birth services.

²⁹ Hostels adjoining the maternal waiting homes are used by individuals accompanying the pregnant women.

- 1.23 **Subcomponent 2.2.** Obstetric and neonatal emergency care (IDB US\$355,000; Local US\$499,000): (i) technical assistance to develop referral, care, and transport protocols for obstetric emergencies; (ii) obstetric and neonatal emergency equipment as well as oxytocin and blood bags; and (iii) consulting services to develop incentives to encourage neonatology and anesthesiology specializations, and training of health workers in obstetric and neonatal emergency care.
- 1.24 **Component 3. Upgrading of health system networks (IDB US\$1.6 million; Local US\$2.3 million).** This component will strengthen the health networks by connecting the primary and secondary levels of care, implementing integrated operations management systems that improve the resolution capacity of the health services and guarantee continuity and quality of care for the target populations. The executing agency will use the loan proceeds allocated to this component to procure the following:
- 1.25 **Subcomponent 3.1.** Reinforcement of the secondary level of care in the fixed network (IDB US\$270,000; Local US\$118,000): (i) basic equipment, supplies, and materials to strengthen secondary care in the fixed network; (ii) technical assistance for review of spot-test technologies, and laboratory supplies³⁰ supporting risk detection and early diagnosis of noncommunicable chronic diseases such as breast, cervical, and prostate cancer in remote communities.
- 1.26 **Subcomponent 3.2.** Human resource management (IDB US\$160,000; Local US\$261,000): (i) technical assistance in the design of an incentive plan aimed at a more efficient geographic distribution of medical and nursing staff at the primary and secondary levels of care; and (ii) technical assistance for health workers to improve the delivery of services to indigenous and rural populations. Local counterpart resources will finance the incentives created for primary and secondary care medical and nursing personnel.
- 1.27 **Subcomponent 3.3.** Referral and counter-referral system (IDB US\$252,000; Local US\$1.2 million): (i) computer services and equipment to build the beneficiary population registry (BPR) for the fixed network; (ii) provision and maintenance of communications equipment to connect the various levels of the referral and counter-referral system, with particular emphasis on transport in the event of emergencies; (iii) technical assistance to develop a preferred care model for referred patients;³¹ (iv) technical assistance to ensure the availability of modes of communication and transportation for referred patients; and (v) technical assistance to develop a regulatory framework for long-distance medical care.
- 1.28 **Subcomponent 3.4.** Hospital management improvement (IDB US\$939,000; Local US\$700,000): (i) consulting services to prepare and implement hospital

³⁰ Lipid, glycemic, microalbumin profile; hemoglobin profile; syphilis; screening and referral for cervical cancer; screening and treatment of anemia; screening for HIV/AIDS; etc.

³¹ Under this model, patients with referrals receive preferred care over other hospital patients, except in emergencies.

management plans, emphasizing referral hospitals for indigenous comarcas and/or adjacent rural areas; (ii) technical assistance to design an integrated information system that consolidates all subsystems and improves the quality of hospital records;³² and (iii) technical assistance to strengthen the quality management system.

- 1.29 **Component 4. Program management, audits, and evaluation (IDB US\$4.1 million; Local US\$2.6 million).** This component will strengthen the capacity of MINSA, at the central level, to coordinate its national divisions involved in executing the program, as well as the DRS. The loan proceeds allocated to this component will be used by the executing agency to procure: (i) technical assistance to strengthen the MINSA team responsible for program supervision and (administrative and financial) management; (ii) contracting and supervision of an external technical audit and the financial and social audits for the program; (iii) consulting services to reinforce the program's tracking and monitoring arrangements; and (iv) consulting services to design and conduct evaluations within the program's framework. The operating costs of MINSA's Program Steering Committee (CODIPRO)³³ will also be financed.
- 1.30 **Program cost.** Table I-1 shows the cost of the program, which amounts to US\$70 million, of which US\$50 million will be contributed by the Bank as a loan from the Ordinary Capital and US\$20 million will be contributed by the local counterpart. See [itemized budget](#) link.

Table I-1 Costs (US\$)

Description of components	IDB	Local	Total
Strengthening of primary health care	43,311,285	14,058,077	57,369,362
Improvement of maternal and neonatal care	922,000	1,049,540	1,971,540
Upgrading of health system networks	1,620,715	2,303,697	3,924,412
Management, audits, and evaluation	4,146,000	2,588,686	6,734,686
TOTAL	50,000,000	20,000,000	70,000,000

C. Key results indicators

- 1.31 The program is expected to help improve the effectiveness and efficiency of the country's health and nutrition programs, and overcome barriers to access to basic preventive and primary care services for the poorest segments of the population. Expected outcomes include a reduction in: (i) maternal mortality; and (ii) child mortality and chronic malnutrition among children less than five years of age.

³² A record of causes of hospitalization currently exists, but the causes are not systematically registered.

³³ CODIPRO consists of: the Minister, Secretary-General, and Director General of Health; the National Directors of Health Planning and Health Services; and the Director of the Financial and Administrative Management Unit (UGAF).

- 1.32 The activities of component 1 are expected to lead to an increase in access to, and utilization and quality of, primary care services, thereby increasing the use of family planning services, the percentage of women receiving prenatal checkups from skilled personnel, and the percentage of children receiving a complete supplementation and immunization package. The activities of component 2 are expected to lead to an increase in the number of women receiving institutional birth care and in the number of referrals for obstetric emergencies and children with low weight and height for age. The activities of component 3 are expected to lead to an increase in the percentage of physicians and nurses providing care in priority areas, an improvement of supply at the secondary level of care, and an increase in laboratory services for the treatment of communicable diseases and noncommunicable chronic diseases. In the fixed network, expected improvements include the implementation of the network service nodes, reinforcement of the referral and counter-referral system, and an increase in the percentage of enrolled users.

II. FINANCING STRUCTURE AND RISKS

A. Financing instruments

- 2.1 The program will be financed through an investment loan. It will have a disbursement period of five years, with the following disbursement schedule, if the loan contract enters into effect and the first disbursement is released in 2012.

Table II-1 Disbursement schedule (US\$)

Source	2012	2013	2014	2015	2016	TOTAL
IDB	4,679,466	10,852,453	10,953,725	11,277,934	12,236,422	50,000,000
Local	1,650,310	4,018,184	3,667,614	4,849,360	5,814,532	20,000,000
TOTAL	6,329,775	14,870,637	14,621,339	16,127,294	18,050,955	70,000,000

B. Environmental and social safeguard risks

- 2.2 The program has been classified as a category “C” operation according to the Bank’s Environment and Safeguards Compliance Policy (OP-703). No negative environmental impact has been identified. Due to its characteristics, the program is not expected to create adverse social effects. The main elements involved in promoting the cultural relevance of the services include: (i) coordinating the program’s interventions in the comarcas with the indigenous authorities; (ii) providing direct support for households and communities through culturally relevant care protocols; and (iii) establishing social control, monitoring, and oversight mechanisms with significant participation by beneficiary women and indigenous representatives.

C. Fiduciary risks

- 2.3 The Bank will transfer the loan proceeds as indicated in paragraph 3.6. To mitigate potential financial management risks, the loan disbursement and accounting controls exercised by the external technical audit and financial audit will be strengthened.

D. Other risks

- 2.4 During preparation of the operation, the project risk management methodology was used to conduct a [program risk analysis](#), and the following risks and mitigation measures were identified:
- 2.5 **Financial sustainability of the program.** The Panamanian government has achieved economic stability and annual GDP growth even with the global financial crisis³⁴ and has been effective in aligning its fiscal resources and long-term commitments for its health programs. According to national accounts data computed by the World Health Organization, government health expenditures in 2008 totaled US\$1.460 billion. Thus, the amount of this program, divided by the execution period, represents close to 0.68% of the annual public health budget. In view of this, the government has sufficient fiscal room. Furthermore, the share of local resources in the program's financing structure will grow over the execution period, allowing greater national budget participation in financing the delivery of services for priority areas.
- 2.6 Recurrent costs in the fixed network, such as staffing, medications, and other basic medical supplies such as vaccines, will be financed by the local counterpart contribution.
- 2.7 **Sustainability of the interventions.** The program interventions (see paragraph 1.16 to paragraph 1.29) will yield benefits for several years. According to the [cost-benefit analysis](#), provision of the services included in the PSP is considered to be cost effective, with values estimated at US\$155.23 per prevented disability-adjusted life year, lower than annual per capita consumption in the population's poorest quintile, which is US\$480.00 (ENV 2008), or than total annual per capita consumption, which is US\$2,438.00.

III. IMPLEMENTATION AND ACTION PLAN

A. Summary of implementation arrangements

- 3.1 **Borrower and executing agency.** The borrower will be the Republic of Panama and the executing agency will be the Ministry of Health (MINSA), acting through the following: (i) the Program Steering Committee (CODIPRO), as the program's strategic and decision-making body; (ii) MINSA's national divisions, which will support program execution; (iii) the Financial and Administrative Management

³⁴ 2009: 3.2%; 2010: 7.5%; and 2011: around 8%.

Unit (UGAF), which reports to the Office of the Minister and will be responsible for program coordination; and (iv) the regional health departments (DRS), which will execute the program.

- 3.2 **Regional and local organization.** The DRS will manage the proceeds of the capitation payments in the fixed and mobile network. They will maintain a health statistics system that can generate reports on the certified beneficiary population, service production, care coverage, and indicator results. At the local level, the targeted populations will form a health sector to be assigned an external organization or institutional mobile unit that can provide PSP services and health coverage to program beneficiaries.
- 3.3 **Beneficiary populations.** The program's target population resides in poor indigenous comarca communities and adjacent rural areas. MINSA has identified priorities in selecting health regions and eligible communities. The [program targeting analysis](#) describes the criteria and targeting methodology and provides a list of selected communities.
- 3.4 **Implementation arrangements.** The external organizations and personnel in charge of the institutional mobile units or fixed-site facilities participating in the program will undertake to comply with the conditions in effect regarding service quality, including the type of services provided and associated coverage and performance indicators. They will also deliver a bimonthly report to the DRS identifying the health services provided to each beneficiary. In turn, the DRS will deliver a report every two months to MINSA's Health Services Division, with a list of communities visited, population protected, population served, and days of service (coverage achievements), as well as a report every four months on the respective performance indicators.
- 3.5 **As a special contractual condition precedent to the first disbursement of the loan proceeds, the borrower will submit, to the Bank's satisfaction, evidence that it: (a) has approved and placed into effect the Operating Manual for the program; (b) has approved and placed into effect the updated versions of the Operating Regulations used in loan contract 1867/OC-PN for the provision of PSP services at Primary Care Centers through institutional mobile units and external organizations; and (c) has approved and placed into effect the Operating Regulations for the provision of services by the DRS and the external organizations in the fixed health network.**
- 3.6 **Fiduciary agreements.** The Bank will transfer the loan proceeds as follows: (i) to a special account for the program at Banco Nacional de Panamá for components other than capitation payments, based on advances covering four months of program execution needs, in accordance with the respective financial plan; and (ii) to a special account for the program at Banco Nacional de Panamá for management of the capitation payment funds, based on a disbursement flow covering six months of program execution needs, in accordance with the respective financial plan. Funds for capitation payments for services provided via institutional

mobile units or at fixed-site facilities will be transferred directly from the Banco Nacional de Panamá account to the special program accounts at the MINSA DRS. Funds for capitation payments for services provided by external organizations will be transferred from the Banco Nacional de Panamá account to the external organizations. The disbursement flow of proceeds for capitation payments is described in [optional link 10](#).

- 3.7 For subcomponent 1.1 of component 1, capitation payments will be based: (i) on the external technical audit reports, which will measure [coverage achievements](#) and attainment of the [performance indicators](#); and (ii) on the [social audit](#), which will measure the degree of user satisfaction. For components 2, 3, and 4 and subcomponents 1.2 and 1.3 of component 1, disbursements will be based on expenses actually incurred.
- 3.8 **Audits.** There will be three types of audits: (i) an annual audit of the program's financial statements in accordance with the general conditions of the loan contract, and a semiannual effectiveness review of the internal controls; (ii) an external technical audit of the program, with reports submitted to the Bank within 60 days following the end of each four-month period, commencing on the first loan disbursement; and (iii) an annual social audit by the executing agency to measure the degree of user satisfaction, with reports submitted to the Bank within 60 days of the end of each calendar year. **As a further condition precedent to the first disbursement of the loan proceeds, the borrower will commission the financial audit and the external technical audit.**
- 3.9 The external technical audit will determine: (i) attainment of the coverage and performance indicators by the MINSA DRS and the external organizations; (ii) the completeness, accuracy, and consistency of the information in the reports submitted to the DRS by the external organizations and the providers comprising the institutional mobile units or fixed-site facilities, and in the reports submitted to the UGAF by the DRS, with respect to attainment of the coverage and performance indicators tied to the capitation payments; (iii) the completeness, accuracy, and consistency of the BPR; (iv) the consistency of the health services provided with the PSP, manuals, regulations, guidelines, and protocols; and (v) any act, event, indication, or omission that may be construed as a prohibited practice under the general conditions of the loan contract, alerting the Bank in such case. The external technical audit will also conduct sample surveys of the beneficiary population that inquire into the performance indicators, particularly promotion, prevention, and counseling aspects. The social audit will measure user satisfaction with the services. In the case of services provided by the MINSA DRS (via institutional mobile units and at fixed-site facilities), the external technical audit will verify the expenditures indicated in subcomponent 1.1 of component 1. In the case of services provided by external organizations, the external technical audit will only verify expenditures associated with the payment of fees and employer contributions for human resources. **As a condition precedent to disbursements of loan proceeds related to capitation payments, subsequent to the first disbursement, the borrower**

will present, to the Bank's satisfaction, the external technical audit report finding that the coverage, performance, and satisfaction indicators were met and that no prohibited practices were detected.

- 3.10 **Procurement.** The Policies for the procurement of works and goods financed by the IDB (document GN-2349-9) and the Policies for selection and contracting of consultants financed by the IDB (document GN-2350-9) will apply to components 2, 3, and 4 and to subcomponents 1.2 and 1.3 of component 1. For subcomponent 1.1 of component 1, only the relevance of the expenditure included in the capitation payment will be verified. The following services will be contracted by single-source selection: (i) the consulting firm responsible for performing the external technical audit, since this firm has satisfactorily provided similar services under World Bank loan contract 7587-PA and was competitively selected in accordance with World Bank procurement policies; (ii) renewal, for continuity of service, of three individual consultants who are conducting monitoring and oversight of the model for strengthening regional health services and providers; and (iii) the services of three external organizations that were competitively selected under IDB loan contract 1867/OC-PN and World Bank loan 7587-PA. The proposed loan would finance the renewal, for a third year, of each contract to allow the external organizations to provide the services relating to this program. Once this renewal expires, external organizations will be selected through a competitive process.

B. Summary of arrangements for monitoring results

- 3.11 **Tracking and monitoring.** The semiannual progress reports described in the general conditions of the loan contract will include monitoring of the program's results matrix (see Annex II). In addition, the semiannual progress reports will include: (i) an analysis of the results of the sample surveys conducted under the Health Coverage Extension Strategy for use as a baseline for monitoring the program indicators; (ii) evidence of progress in integrating the information systems that include the number of activities performed and the beneficiaries served by the health service providers in accordance with the PSP; and (iii) progress in the adjustments made in the methodology used by the DRS to monitor health providers.
- 3.12 **Evaluation.** The executing agency will also engage consulting services to assess the impact of the program. These services will be contracted no later than one year from the effective date of the loan contract. The evaluation will have three parts: (i) evaluation of the direct effects associated with expansion of the performance-based financing model, with the presentation of annual reports; (ii) evaluation of the impact of various supplementation alternatives on chronic malnutrition, with the presentation of outcomes before the end of the third year running from the effective date of the loan contract; and (iii) a case study on implementation of socioculturally adapted services, with the presentation of outcomes before the end of the third year running from the effective date of the loan contract.

Development Effectiveness Matrix			
Summary			
I. Strategic Alignment			
1. IDB Strategic Development Objectives	Aligned		
Lending Program	The intervention contributes to the lending program for small and vulnerable countries and poverty reduction and equity enhancement.		
Regional Development Goals	The intervention contributes to reductions in maternal and infant mortality ratios, and the percent of children under 5 whose birth was registered.		
Bank Output Contribution (as defined in Results Framework of IDB-9)	The intervention contributes to Bank output: Indigenous individuals receiving basic package of health, and incorporated into a civil or identification registry.		
2. Country Strategy Development Objectives	Aligned		
Country Strategy Results Matrix	GN-2596	Reduction in maternal mortality and reduction in chronic malnutrition.	
Country Program Results Matrix	GN-2617	The intervention is not included in the 2011 Country Program Document.	
Relevance of this project to country development challenges (If not aligned to country strategy or country program)			
II. Development Outcomes - Evaluability	Highly Evaluable	Weight	Maximum Score
	9.5		10
3. Evidence-based Assessment & Solution	9.4	25%	10
4. Ex ante Economic Analysis	8.5	25%	10
5. Monitoring and Evaluation	10.0	25%	10
6. Risks & Mitigation Monitoring Matrix	10.0	25%	10
Overall risks rate = magnitude of risks*likelihood	Not Available		
Environmental & social risk classification	C		
III. IDB's Role - Additionality			
The project relies on the use of country systems (VPC/PDP criteria)	yes	The following country systems are used: Treasury, accounting and reporting, external control, internal audit	
The project uses another country system different from the ones above for implementing the program			
The IDB's involvement promotes improvements of the intended beneficiaries and/or public sector entity in the following dimensions:			
Gender Equality	yes		
Labor			
Environment			
Additional (to project preparation) technical assistance was provided to the public sector entity prior to approval to increase the likelihood of success of the project	yes	Operational Inputs were approved which support the analytical design and provide technical inputs for the Improving Health Equity in Health through increases in coverage and improvements in quality of supply of health services project (PN L1068) and develop evidence and alternatives focused on strengthening of the primary health care system, the development of an integral nutrition scheme and strengthenin of Health Netowkrs. The diagnostics and analysis for the development of proposals for adjustment sin the health sector will have special emphasis on the following areas 9i) health policies and regulations, (ii) targeting, (iii) epidemiological profile (primarily chronic degenerative diseases), nutrition and population of poor populations in rural areas (indigenous and non-indigenous) in indigenous Comarcas; (iv) factors of supply and demand for health services that affect health outcomes; (v) set of health services for the burden of disease observed in rural areas and indigenous comarcas; (vi) nutritoin, (vii) risk factors for chronic diseases, and (viii) human resources and public expenditure.	
The ex-post impact evaluation of the project will produce evidence to close knowledge gaps in the sector that were identified in the project document and/or in the evaluation plan.	yes	The evaluation covers three pillars related to the service delivery model that the project intends to introduce, and health interventions related to chronic malnutrition and intercultural services: a) Impact evalutaion associated with expansion of results based financing, b) Impact assessment of different alternatives of micronutrients on chronic malnutrition and c) Case study of the implementation of socio-cultural adaptation of services	

This is an investment loan funded two-thirds by ordinary capital and one third local funds. The program supports the Government of Panama in improving health equity through increases in access, use and quality of health services in indigenous regions and surrounding areas. The loan is a continuation of 15 years of the National Government's efforts to address health problems in indigenous communities and rural areas. The new operation primarily expands a financing model that combines per-capita payments with pay for performance, used currently used for hard to reach populations (with mobile teams), to populations served by fixed networks.

The program uses the health information system of the Ministry of Health. Indicators in the results matrix have a baseline and well defined targets. In most cases the targets are realistic. The project proposes a quasi-experimental impact evaluation to asses the impact of the expansion of the financing model to the fixed network of primary health care, and experimental evaluation to test various alternatives of micronutrients to combat chronic malnutrition. Economic analysis was performed to show the cost-effectiveness of interventions. The project has a risk matrix that identifies potential risks and mitigation measures.

RESULTS MATRIX

Project objective:	The general objective of the program is to improve health equity by increasing access to, as well as the use and quality of, health services in indigenous comarcas and adjacent rural areas. By strengthening primary care, reinforcing the priority services portfolio (PSP), and adapting health care networks, the program is expected to reduce maternal and child mortality rates and chronic malnutrition, while improving the health of the country's poorest population.							
Outcome indicators*	Baseline			Final target			Means of verification	Target population
Maternal mortality rate in indigenous comarcas and adjacent rural areas.	2.69 per 1,000 live births			2.51 per 1,000 live births			Baseline and target: Office of the Comptroller General of Panama – 2008 vital statistics.	Women of childbearing age in the certified beneficiary population registry (CBPR) in indigenous comarcas and their areas of influence.
Reduced infant mortality rate in children under the age of five in indigenous comarcas and their areas of influence.	18.0 per 1,000 live births			16.4 per 1,000 live births			Baseline and target: Office of the Comptroller General of Panama – 2008 vital statistics.	Children under five years of age in the CBPR in indigenous comarcas and their areas of influence.
Reduced prevalence of chronic malnutrition among children under the age of five in indigenous comarcas and their areas of influence.	62%			58%			Baseline: ENV 2008 Target: ENV 2013 or impact assessment report.	Children under five years of age in the CBPR in indigenous comarcas and their areas of influence.
COMPONENT 1: Strengthening primary health care								
Output indicators	2011 Baseline	2012	2013	2014	2016	2016 Cumulative target	Means of verification	Target population
Subcomponent 1.1 Implementation of capitation payments in the primary care network								
1. Number of primary care network beneficiaries (individuals listed in the BPR)	170,326	180,000	190,000	195,000	200,000	205,000	Baseline and target: Beneficiary population registry certified by the external technical audit.	BPR in indigenous comarcas and their areas of influence.
2. Number of persons served (received service) in the primary care network.	78,349	90,000	114,000	136,500	160,000	184,000	Baseline and target: MINSA health information system.	CBPR in indigenous comarcas and their areas of influence.
Subcomponent 1.2 Development of a primary care management model								
3. Number of Primary Care Centers (fixed network) with capitation model implemented.	0 out of 21	5 out of 21	10 out of 21	16 out of 21	18 out of 21	21 out of 21	Baseline and target: MINSA health information system based on management agreements.	CBPR in indigenous comarcas and their areas of influence.

Output indicators	2011 Baseline	2012	2013	2014	2015	2016 Cumulative target	Means of verification	Target population
Subcomponent 1.3 Strengthening of the primary care service portfolio								
4. Primary Care Centers provisioned in accordance with the basic schedule of medications and supplies.	0 out of 21	5 out of 21	10 out of 21	16 out of 21	18 out of 21	21 out of 21	Baseline and target: MINSA health information system. Health Services Division.	CBPR in indigenous comarcas and their areas of influence.
5. Service protocols updated and culturally adapted.	4 out of 28	12 out of 28	20 out of 28	28 out of 28	28 out of 28	28 out of 28	Baseline and target: MINSA health information system. Binary target.	CBPR in indigenous comarcas and their areas of influence.
Intermediate outcome indicators	2011 Baseline	2012	2013	2014	2015	2016 Cumulative target	Means of verification	Target population
Subcomponent 1.1 Implementation of capitation payments in the primary care network								
1. Percentage of pregnant women who have completed at least three prenatal checkups by the end of the third trimester of pregnancy (at least one per trimester).	74%	76%	77%	78%	79%	82%	Baseline and target: MINSA health information system.	Women of childbearing age in the CBPR in indigenous comarcas and their areas of influence.
2. Percentage of children with at least four growth and development checkups by their first birthday.	80%	81%	82%	83%	84%	86%	Baseline and target: MINSA health information system.	Children under the age of one in the CBPR in indigenous comarcas and their areas of influence.
Subcomponent 1.2 Development of a primary care management model								
3. Percentage of Primary Care Centers (fixed network) with updated accountability reports (one every two months)	0%	24%	48%	71%	80%	90%	Baseline and target: MINSA health information system.	CBPR in indigenous comarcas and their areas of influence.
Subcomponent 1.3 Strengthening of the primary care service portfolio								
4. Percentage of women 20 years of age and older who undergo annual cervical/vaginal cytology screenings	48%	50%	52%	54%	56%	62%	Baseline and target: MINSA health information system	Women of childbearing age in the CBPR in indigenous comarcas and their areas of influence

Intermediate outcome indicators	2011 Baseline	2012	2013	2014	2015	2016 Cumulative target	Means of verification	Target population
5. Percentage of pregnant women reached	83%	83%	84%	84%	85%	86%	Baseline and target: MINSA health information system	Women of childbearing age in the CBPR in indigenous comarcas and their areas of influence
6. Percentage of pregnant women with 2nd dosage or TT or Td booster (appropriate vaccine as recommended)	87%	87%	88%	88%	89%	89%	Baseline and target: MINSA health information system	Women of childbearing age in the CBPR in indigenous comarcas and their areas of influence.
7. Percentage of births attended by trained personnel.	41%	45%	50%	55%	60%	65%	Baseline and target: MINSA health information system	Women of childbearing age in indigenous comarcas and their areas of influence
8. Percentage of children aged one to four who have had at least four growth and development checkups during the evaluated service period.	69%	72%	74%	76%	78%	82%	Baseline and target: MINSA health information system.	Children under five years of age in the CBPR in indigenous comarcas and their areas of influence
9. Percentage of children under 24 months of age in attendance at the monthly AIN-C sessions.	60%	65%	70%	75%	80%	82%	Baseline and target: MINSA health information system.	Children under two years of age in the CBPR in indigenous comarcas and their areas of influence
10. Percentage of children aged six to 24 months enrolled in the supplemental nutrition programs.	80%	82%	84%	86%	88%	90%	Baseline and target: MINSA health information system.	Children under the age of two in the CBPR in indigenous comarcas and their areas of influence.
11. Percentage of children aged six to 24 months enrolled in supplemental nutrition programs incl. micronutrients.	80%	82%	84%	86%	88%	90%	Baseline and target: MINSA health information system.	Children under the age of two in the CBPR in indigenous comarcas and their areas of influence.
12. Percentage of children under the age of one with the complete set of vaccinations for their age.	81%	82%	84%	86%	88%	90%	Baseline and target: MINSA health information system	Children under the age of one in the CBPR in indigenous comarcas and their areas of inf.

Intermediate outcome indicators	2011 Baseline	2012	2013	2014	2015	2016 Cumulative target	Means of verification	Target population
13. Percentage of children aged one to four with the complete set of vaccinations for their age.	55%	58%	61%	64%	67%	72%	Baseline and target: MINSA health information system.	Children under the age of five in the CBPR in indigenous comarcas and their areas of influence.
14. Percentage of hypertension patients who have received the recommended treatment.	0%	50%	55%	60%	65%	75%	Baseline and target: MINSA health information system.	CBPR in indigenous comarcas and their areas of influence.
15. Percentage of diabetes patients who have received the recommended treatment.	0%	50%	55%	60%	65%	75%	Baseline and target: MINSA health information system.	CBPR in indigenous comarcas and their areas of influence.
16. Percentage of patients with respiratory symptoms screened for tuberculosis.	40%	50%	60%	70%	75%	83%	Baseline and target: MINSA health information system.	CBPR in indigenous comarcas and their areas of influence.
COMPONENT 2: Improvement of specialized maternal and neonatal care								
Output indicators	2011 Baseline	2012	2013	2014	2015	2016 Cumulative target	Means of verification	Target population
Subcomponent 2.1 Utilization and quality of institutional birth services								
1. Number of health facilities with delivery rooms ¹	3 out of 21	6 out of 21	9 out of 21	12 out of 21	15 out of 21	21 out of 21	Baseline and target: MINSA health information system	Women of childbearing age in the CBPR in indigenous comarcas and adjacent rural areas.
2. Number of suitable maternal waiting homes linked to health facilities with delivery rooms ²	0	1	2	3	4	5	Baseline and target: MINSA health information system	Women of childbearing age in the CBPR in indigenous comarcas and adjacent rural areas.

¹ The MINSA Health System was used as the basis for calculating the information. Preliminary data. The facilities defined as having delivery rooms include establishments equipped with a bed and a delivery area.

² The MINSA Health System was used as the basis for calculating the information. Preliminary data.

Subcomponent 2.2 Obstetric and neonatal emergency care								
3. Number of health facilities equipped for essential obstetric and neonatal functions ³	0 out of 6	1 out of 6	2 out of 6	3 out of 6	4 out of 6	6 out of 6	Baseline and target: MINSA health information system	Women of childbearing age in the CBPR in indigenous comarcas and adjacent rural areas.
Intermediate outcome indicators	2011 Baseline	2012	2013	2014	2015	2016 Cumulative target	Means of verification	Target population
Subcomponent 2.1 Utilization and quality of institutional birth services								
1. Percentage of births attended by trained personnel (disaggregated by institutional services and type of staff)	41%	45%	50%	55%	60%	67%	Baseline and target: MINSA health information system	Women of childbearing age in the CBPR in indigenous comarcas and adjacent rural areas.
Component 3: Upgrading of health system networks								
Output indicators	2011 Baseline	2012	2013	2014	2015	2016 Cumulative target	Means of verification	Target population
Subcomponent 3.1 Reinforcement of the secondary level of care in the fixed network								
1. Number of secondary care health facilities in the fixed network equipped to perform basic diagnostic tests ⁴	0	3 out of 3				3 out of 3	Baseline and target: MINSA health information system	CBPR in comarcas and adjacent rural areas.
Subcomponent 3.2 Human resource management								
2. Incentive plan for health personnel implemented in priority regions	Incentive plan to be strengthened	1 out of 4	2 out of 4	3 out of 4	3 out of 4	4 out of 4	Baseline and target: MINSA health information system	Medical and nursing staff assigned to indigenous areas and their areas of influence.
Subcomponent 3.3 Referral and counter-referral system								
3. Number of persons listed in the fixed network registry	0	10,000	20,000	25,000	30,000	40,000	Baseline and target: MINSA health information system	CBPR in comarcas and adjacent rural areas.

³ The MINSA Health System was used as the basis for calculating the information. Preliminary data. Essential obstetric and neonatal functions are defined as those relating to the capability of handling deliveries involving dystocia (Díaz, J., and Jaramillo, M., Evaluating interventions to reduce maternal mortality: evidence from Peru's PARSaLud programme. Journal of Development Effectiveness. Volume 1, Issue 4, December 2009, pages 387-412.)

⁴ At present, only three secondary care hospitals exist: two in the Kuna Yala comarca and one in the Ngöbe Buglé comarca.

Subcomponent 3.4 Hospital management improvement								
4. Number of referral hospitals in indigenous comarcas with hospital management plans formulated	0	1 out of 3	2 out of 3	3 out of 3	3 out of 3	3 out of 3	Baseline and target: MINSA health information system	CBPR in comarcas and adjacent rural areas.
Intermediate outcome indicators	2011 Baseline	2012	2013	2014	2015	2016 Cumulative target	Means of verification	Target population
Subcomponent 3.1 Reinforcement of the secondary level of care in the fixed network								
1. Percentage of Pap smears reported out of the total taken	64%	68%	72%	76%	80%	85%	Baseline and target: MINSA health information system	Women of childbearing age in the CBPR in comarcas and adjacent rural areas
Subcomponent 3.2 Human resource management								
2. Estimated gap in medical staff for priority regions ⁵	29	24	19	14	9	6	Baseline and target: MINSA health information system	CBPR in comarcas and adjacent rural areas.
Subcomponent 3.3 Referral and counter-referral system								
3. Number of health facilities that apply the model of preferred care for referred patients ⁶	0 out of 21	6 out of 21	9 out of 21	12 out of 21	15 out of 21	18 out of 21	Baseline and target: MINSA health information system	CBPR in comarcas and adjacent rural areas.

⁵ Value assigned as a function of the conversion of subcenters to health centers (8 subcenters) and expanded health center coverage (21 centers). Preliminary value.

⁶ In accordance with implementation of the health network model.



Fiduciary Agreements and
Requirements

PN-L1068

Health Equity Improvement
and Services Strengthening
Program

POD Electronic Link

June 2011

FIDUCIARY AGREEMENTS AND REQUIREMENTS

COUNTRY: Panama

PROJECT No.: PN-L1068

NAME: Health Equity Improvement and Services Strengthening Program

EXECUTING AGENCY: Ministry of Health (MINSa)

PREPARED BY: Karina Díaz Briones, Procurement Specialist (PDP/CPN); and Juan Carlos Dugand, Financial Management Specialist (PDP/CPN)

I. Executive summary

1. The fiduciary management evaluation was based on visits conducted by Country Office fiduciary specialists during preparation of this loan, as well as on an assessment of MINSa's performance as subexecuting agency for component 3 of loan contract 1867/OC-PN, currently in execution. Based on the above, the procurement risk is estimated to be low, while the financial risk is regarded as medium due to the complexity of the cash flows and the number of actors involved in component 1.
2. In the procurement area, although Panama has made significant advances, the applicable legislation is undergoing a series of changes designed to expand the scope of best-value bidding processes and increase flexibility in the use of direct contracting. The Government is just starting to execute a program to be financed by the World Bank, aimed at strengthening the public procurement system (Project ID: P121492). Regarding use of the system, the Bank agrees to the use of the information portal and the framework agreement for purchases under US\$50,000 via a pilot test conducted with the World Bank. With respect to the national financial systems, a project module is being implemented for the Integrated Financial Administration System of Panama (SIAFPA) and will be used by the project once the pilot tests are satisfactorily completed. The Financial and Administrative Management Unit (UGAF) has experience in managing this type of project.
3. The project does not include financing by other multilateral organizations. However, it should be noted that MINSa is currently negotiating another World Bank loan, with spending and execution arrangements resembling those of PN-L1068.

II. Fiduciary context of the executing agency

1. Organizational and operational structure

The project's structure resembles the structure established in loan contract 1867/OC-PN, the difference being that MINSa will now be the executing, rather than the subexecuting, agency. For this purpose, MINSa has a Financial and Administrative Management Unit (UGAF) within its institutional structure that is responsible for managing special projects financed via international cooperation.

In view of the decentralized nature of care under the project, the UGAF will interact administratively, financially and technically with the Regional Health Departments (DRS) in the project's areas of intervention. The UGAF will be responsible for administrative and financial control of the project, while the DRS will be the project beneficiaries and have coordination and management responsibilities aimed at ensuring effective care for the beneficiary population.

Specifically in the case of subcomponent 1.1 of component 1, each DRS will receive capitation payments from MINSa's central level in order to provide a priority services portfolio (PSP) package through their various health care providers¹ (fixed-site and mobile networks). These payments are calculated per

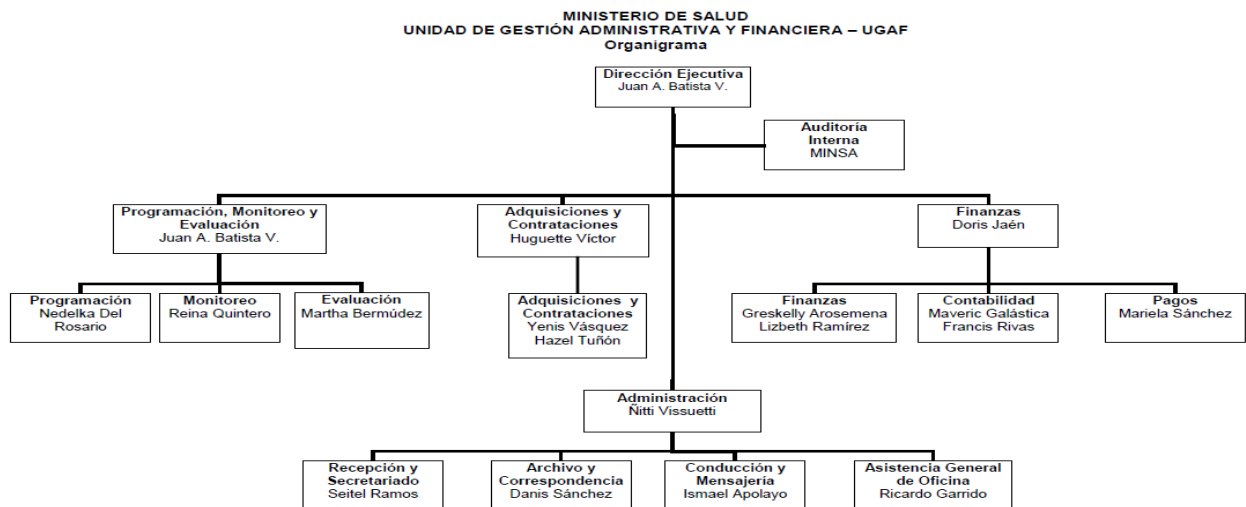
¹ External organizations are also DRS health providers but require separate mention because they are consulting firms contracted in accordance with the Procurement Policies, whereas fixed-site and mobile services are provided through the DRS.

individual included as a program beneficiary. Given the dispersed areas of care, the difficulty of expenditure planning, and the need for small-scale procurement at the local level under this type of program, it is more efficient to finance a fixed payment for a specific outcome and specific management goals (PSP) rather than finance the inputs underlying this capitation payment. This makes it possible to: (i) reduce transaction costs; (ii) verify the attainment of development objectives, which cannot be accomplished merely by financing dispersed inputs; and (iii) encourage MINSA to improve the quality and content of the primary health services it provides in remote areas.

To receive these payments, management agreements establishing the scope of the annual rounds are signed between the DRS and the central level of MINSA. At the operational level, the DRS must provide evidence of the visits (technical justification), of the payment of eligible expenses (administrative justification) for becoming an actual beneficiary of the transfer, and of attainment of the specified health care coverage and health outcome targets. All this is supervised and reviewed by UGAF with the support of external firms that perform an external technical audit, a social audit, and a financial audit. This execution mechanism is described in the project's Operating Manual. It is worth noting that this manual is actually used for project execution. When funding a fixed cost per individual beneficiary with resources provided in subcomponent 1.1 of component 1 for fixed-site facilities and mobile units, purchases related to service production inputs will be performed by MINSA in accordance with the provisions of the Public Procurement Law.

With respect to expenses associated with the traditional procurement arrangements included in the rest of the components, the procurement processes will be carried out by the UGAF, which has the proper tools, personnel, and administrative support to comply with the Bank's fiduciary policies.

2. Work team



3. Procurement planning

As observed in the execution of contract 1867/OC-PN, the UGAF actively participates in the general planning for the project; consequently, the procurement plan is developed as a tool in line with the project.

4. Procurement execution

In its capacity as the unit in charge of executing international cooperation projects, the UGAF has experience with the procurement policies of multilateral organizations and there have been no difficulties in execution.

III. Fiduciary risk assessment and mitigation measures

1. The procurement risk associated with this executing agency has been determined to be low.
2. The potential unavailability of reliable financial data on a timely basis due to factors such as the complexity of cash flows, number of actors involved, and execution in remote and inaccessible areas was identified as a project risk. As a mitigating factor, it was agreed to conduct a periodic effectiveness assessment of the internal controls implemented for project execution.

IV. Aspects to be considered in the special provisions of contracts

With a view to streamlining contract negotiations on the part of the project team, particularly LEG, the agreements and requirements that will need to be considered in the special provisions are set forth below:

- a. The Policies for the procurement of works and goods financed by the IDB (document GN-2349-9) and the Policies for selection and contracting of consultants financed by the IDB (document GN-2350-9) will apply to components 2, 3, and 4 and to subcomponents 1.2 and 1.3 of component 1. Regarding subcomponent 1.1 of component 1, only the relevance of the expenditure included in the capitation payment will be verified.
- b. The following will be contracted via single-source selection: (i) the consulting firm responsible for performing the external technical audit; (ii) renewal, for continuity of service, of three individual consultants who are conducting monitoring and oversight of the model for strengthening regional health services and providers; (iii) the services of three (3) external organizations that were competitively selected under IDB loan contract 1867/OC-PN and World Bank loan 7587-PA. The proposed loan would finance the renewal of each contract for a third year to allow the external organizations to provide the services relating to this program. Once this renewal expires, external organizations will be selected through a competitive process.
- c. No exceptions to Bank policies are anticipated.
- d. Limits on international publicity for works, goods, nonconsulting services, and consulting services consistent with the country limits established by PDP.
- e. Procurement supervision under a mixed ex ante and ex post arrangement determined on the basis of an institutional assessment of the executing agency's procurement capacity and adjustable at the Bank's discretion based on results observed.
- f. Initial Procurement Plan developed jointly with the Bank upon approval of the operation. This first Procurement Plan will be prepared using the Procurement Plan Execution System (SEPA).
- g. As a condition precedent to the first disbursement, an independent auditing firm will be contracted to audit the financial statements and issue a semiannual opinion on the effectiveness of internal controls. The auditing firm to be contracted by MINSA to audit its projects financed via international cooperation will be acceptable.
- h. As a condition precedent to the first disbursement, the external technical audit will be commissioned under a contract that requires the auditors to alert the Bank of any act, event, indication, or omission that may be construed as a prohibited practice under the general conditions of the loan contract.
- i. As a condition precedent to the first disbursement, the Operating Manual and the updated Operating Regulations for the provision of PSP services at Primary Care Centers (PCC) through institutional mobile units and external organizations will be approved.

- j. Annual audited financial statements of the project will be requested, as well as the auditors' semiannual professional opinion on the effectiveness of the internal controls implemented for project execution and on the administrative oversight evaluations conducted by the UGAF regarding procedures for the decentralized procurement of supplies and eligibility of expenditures.
- k. In the event that the existing one-to-one parity between the balboa and the U.S. dollar is eliminated, the applicable exchange rate will be the rate in effect on the date of disbursement by the Bank.

V. Agreements and requirements for procurement execution

The procurement-related fiduciary agreements and requirements establish the applicable provisions for performing all procurements required under the project.

1. Execution of procurements

The works required for this project will not be funded with Bank resources but will instead be fully funded with local counterpart resources. Goods and services will be procured in accordance with the April 2011 GN 2349-9, and consulting firms will be selected and contracted in accordance with the April 2011 GN 2350-9. Regarding subcomponent 1 of component 1, only the relevance of the expenditure included in the capitation payment will be verified.

Procurement of goods and nonconsulting services: Goods and nonconsulting services generated under the project and subject to international competitive bidding will be procured using the Bank's Standard Bidding Documents. Bidding processes subject to national competitive bidding and shopping will be executed using models identified by the Bank for this operation.

Selection and contracting of consultants: Consulting services generated under the project will be contracted using the Bank's Standard Request for Proposals.

Selection of individual consultants: Individual consultants will be selected by comparing the relevant qualifications of at least three candidates.

The three individual consultants providing technical assistance in the monitoring and oversight of the model for strengthening regional health services and providers (health clinics and mobile units) are to have their contracts renewed. The original process was conducted competitively under Bank rules since it was being financed through loan contract 1867/OC-PN. The effective term of the contract is within the execution period of program PN-L1068, the type of service is similar, and the scope is compatible.

Operating expenses: Operating expenses will be financed with local counterpart resources.

Single-source selection: The project currently has the services of the external technical auditor and the three external organizations, which were competitively selected under loan contract 1867/OC-PN and/or the World Bank loan. In the case of the external technical auditor, single-source selection is deemed appropriate because this firm has already provided similar services under World Bank loan contract 7587-PA and was competitively selected in accordance with that institution's procurement policies. In the case of the external organizations, the original bidding processes provided for annual contracts, renewable for a period not to exceed four years. Considering that the contracts with each external organization were signed for renewable one-year periods, that the original processes were conducted on a competitive basis, and that the nature of the intervention requires at least three years of continuity in the external organizations' services to ensure the desired impact, this operation is expected to fund the third year of each external organization's contract covering the performance of services under this program. Upon the expiration of this renewal period, a competitive process will be held to select external organizations.

National preference: Not applicable.

2. Table of threshold amounts (U.S. dollars)

Ex-post review limits	
Goods	Consulting services
National competitive bidding	Consulting firms for amounts under US\$200,000. Individual consultants for amounts under US\$50,000.

Works			Goods ²			Consulting services	
Int'l competitive bidding	National competitive bidding	Shopping	Int'l competitive bidding	National competitive bidding	Shopping	Int'l publicity consulting services	Short list 100% national
US\$3,000,000 or more	Over US\$250,000 and under US\$3,000,000	Under US\$250,000	US\$250,000 or more	Over US\$50,000 and under US\$250,000	Under US\$50,000	Over USD\$200,000	US\$200,000 or less

3. Principal procurements

Following are the principal procurements to be financed by the Bank. The complete procurement plan is available at the following link: [Procurement plan](#).

PRINCIPAL PROCUREMENTS TO BE FINANCED BY THE BANK

Description of planned procurement	Estimated amount (US\$ thousands)	Selection method
Goods		
Procurement of nutritional supplements for children under two years of age. Annual procurement will not exceed US\$25,000, based on the number of beneficiaries and areas of intervention.	100	S
Nonconsulting services		
Provision of health services portfolio by means of capitation payments. Contracting of external organizations that procure basic health equipment and comply with Operating Regulations approved by MINSA and the Bank for providing services to a beneficiary population residing in remote areas.	11,000	SSS
Consulting firms		
Technical assistance in designing and implementing plans and protocols to achieve better hospital management. Contracting the services of an international consulting firm to assist MINSA in designing and implementing plans and protocols aimed at achieving better hospital management at participating health region hospitals.	1,131	QCBS
External technical audit of the primary health care strengthening model. The auditors will produce an independent opinion on compliance with program rules; this opinion will be a condition precedent to disbursements under the project.	560	SSS
Project financial audit. Consulting firm to audit the project's financial statements and verify funds reconciliation.	80	QCBS
Individual consultants		
Technical assistance to implement the service strengthening model. Contracting of international and national individual consulting services to implement the service strengthening model.	218	IICQ, NICQ
Technical assistance to strengthen the health services portfolio. Contracting of international individual consulting services to identify opportunities for strengthening the priority health services with an intercultural and gender focus.	324	IICQ
Technical assistance to strengthen institutional birth services. Contracting of international individual consulting services to identify opportunities for strengthening obstetric emergency	166	IICQ

² Includes nonconsulting services.

Description of planned procurement	Estimated amount (US\$ thousands)	Selection method
and neonatal care and to identify needs for making birthing rooms, maternal waiting homes, and hostels available in accordance with the relevant protocols.		
Technical assistance to strengthen the referral system. Contracting of international individual consulting services to design protocols for transporting patients from their communities in emergencies and to design a model of preferred care for referred patients.	134	IICQ
Technical assistance in designing an organizational model for the specialized mobile units. Contracting of international individual consulting services to assist MINSA in developing an organizational model for the mobile units.	32	IICQ
Technical assistance for monitoring and oversight of the primary health care strengthening model. Renewal of national individual consulting contracts with three consultants who assist MINSA in monitoring, overseeing, and evaluating the performance of health regions and their providers (fixed-site facilities and mobile units) and who were originally selected through a competitive process.	154	SSS
Technical assistance to conduct other evaluation studies. Contracting of international individual consulting services to evaluate priority interventions under the program.	193	IICQ

4. Procurement supervision

The threshold amounts established for ex post review purposes are based on the executing agency's fiduciary capacity and may be modified by the Bank in line with any changes in such capacity. Only the procurements included in the Procurement Plan are subject to ex post review. Direct contracting is always reviewed on an ex ante basis. Ex post reviews will be performed every 12 months in accordance with the project supervision plan. Ex post review reports will include at least one physical inspection, selected from among the procurement processes subject to ex post review.

5. Special provisions

Include a clause in the external technical audit contract requiring the auditors to alert the Bank of any act, event, indication, or omission that may be construed as a prohibited practice under the general conditions of the loan contract.

6. Records and files

The Financial and Administrative Management Unit (UGAF) is responsible for the custody and handling of the procurement files and will appoint an officer specifically for this activity. In the project under execution, auditors have not issued any observations regarding the tasks and controls being performed by the UGAF.

VI. Financial Management

1. Programming and budget

The Ministry of Economy and Finance is responsible for formulating and overseeing the budget. Prior to July 31 of each fiscal period it must submit a proposal to the National Assembly for approval, as well as any subsequent increase. The budget is annual and includes all public sector investments, revenue, and expenditures. Because the draft budget is prepared far in advance, it repeatedly undergoes multiple changes, losing validity as a planning tool. All public sector payments are recorded in the budget. The expenses to be incurred under the project are included in the 2012 draft budget submitted to the Ministry of Economy and Finance by the Ministry of Health (MINSA), which provides for US\$4.5 million in IDB funding and US\$2 million in local counterpart resources. For purposes of component 1, budgetary execution of the capitation payments transferred to the regions takes place at the time of such transfers.

2. Accounting and information systems

The Integrated Financial Administration System of Panama (SIAFPA) was adopted in 2000 as the official system for recording accounting and budget information. SIAFPA includes budget, treasury, accounting, and public debt modules. Development of a project module has recently started and is now at the pilot test stage. Once tests are completed, this module could be used for financial management of the project. MINSA uses SIAFPA and reports and consolidates budgetary execution for its Regional Health Departments, which will be involved in the execution of the project.

MINSA currently has an application known as SAFF, which is being used to execute loan 1867/OC-PN. However, the executing agency considers that the system is operating at capacity, and is studying the possibility of replacing it with PENTAGON, which is used by MINSA to execute loans 1719/OC-PN and 1719/OC-PN-1. Plans call for SAFF or PENTAGON to be used initially; the SIAFPA project module is to be brought in on a parallel basis at a subsequent stage and ultimately is to be used exclusively.

Accounting practices will follow the accrual basis standards issued by the Office of the Comptroller General of the Republic which are derived from, but not the same as, the International Public Sector Accounting Standards. Audited financial statements of the project will be required on an annual basis.

3. Disbursements and cash flow

The concept of a single treasury account is not applicable in Panama, where more than 6,000 bank accounts exist at Banco Nacional de Panamá. There is a one-to-one parity between the balboa and the U.S. dollar.

The Bank will transfer the loan proceeds as follows: (i) to a special account for the program at Banco Nacional de Panamá for components other than capitation payments, based on advances covering four months of program execution needs, in accordance with the respective financial plan, net of any funds available in the account; and (ii) to a special account for the program at Banco Nacional de Panamá for management of the capitation payment funds, based on the disbursement flow described in Table 1, covering six months of program execution needs, in accordance with the respective financial plan, net of any funds available in the account.

Funds for capitation payments for services provided through institutional mobile units or at fixed-site facilities will be transferred directly from the Banco Nacional de Panamá account to the special accounts for the program at the MINSA DRS. Funds for capitation payments for services provided by external organizations will be transferred from the special account at Banco Nacional de Panamá to the external organizations.

Table 1

Capitation Breakdown										
Initial Payment 20%	Round 1 Payment 15%	Round 2 Payment 10%	Four-month Indicators 10%	Round 3 Payment 10%	Round 4 Payment 10%	Four-month Indicators 10%	Round 5 Payment 10%	Round 6 Payment 10%	Four-month Indicators 10%	Social Audit 5%
Total: 100%										

The initial payment shown in Table 1 will be amortized in the payments corresponding to the various rounds as follows:

Table 2

Payment itemization	% Gross payment	% Amortization	% Net payment
Initial payment			20%
Round 1	15%	25%	10%
Round 2	10%	15%	7%
Round 3	10%	15%	7%
Round 4	10%	15%	7%
Round 5	10%	15%	7%
Round 6	10%	15%	7%
	65%	100%	65%

Upon termination of the management agreements or contracts with the external organizations, the bank account for capitation payments should have a zero balance and any difference should be refunded to the IDB, with the corresponding adjustments made to the Bank and program records.

For subcomponent 1 of component 1, capitation payments will be based (a) on the external technical audit reports, which will measure coverage achievements and attainment of the performance indicators; and (b) on the social audit, which will measure the degree of user satisfaction. For components 2, 3, and 4 and for subcomponents 2 and 3 of component 1, advances will be based on expenses actually incurred; provided, however, that 80% of expenses paid with an advance will have to be substantiated before a new advance may be requested.

The concept of capitation on a protected population, where there is no expectation that the entire population will be assisted, makes any attempt to control this component's expenses based on inputs both inapplicable and inefficient.

The following electronic link shows the [project's cash flows](#).

4. Internal controls and internal audits

The UGAF, the unit responsible for project execution, has adequate internal controls according to the audit reports for loan 1867/OC-PN, currently in execution. MINSA needs to strengthen its internal control system, which is currently inadequate. The ex ante control function performed by the Office of the Comptroller General was eliminated, although it has recently been reinstated.³

In view of the complexity of the project's cash flows, the involvement of multiple actors, the use of the capitation concept, and the weaknesses of MINSA's internal control system, there is a need for the external auditors to evaluate the internal controls associated with project execution on a semiannual basis.

5. External controls and reports

As the Office of the Comptroller General performs an ex ante control function, it lacks the independence required to handle external control of the project. The complex nature of the project requires the services of an independent auditing firm to issue a semiannual professional opinion (ISAE 3000) on the effectiveness of the internal controls implemented for execution purposes and to audit the project's financial statements on an annual basis. The cost of such audit, which is estimated at US\$40,000 per year for a total of US\$200,000 over the five years of project execution, will be financed from the loan proceeds. Contracting an independent auditing firm will be a condition precedent to the first disbursement.

In addition, the program requires an external technical audit aimed primarily at reviewing the major aspects of delivery of the priority services portfolio (PSP), including, at a minimum, review of the

³ Resolution 133 of March 2011.

following: (i) attainment of the coverage and performance indicators by the MINSA DRS and the external organizations; (ii) the completeness, accuracy, and consistency of the information in the reports submitted to the DRS by the Primary Care Centers (PCC) (mobile units, external organizations, or fixed-site facilities), and in the reports submitted to MINSA by the DRS, with respect to attainment of the coverage and performance indicators tied to the capitation payments; (iii) the completeness, accuracy, and consistency of the Beneficiary Population Registry as recorded by the PCC; (iv) the consistency of the health services provided with the PSP, manuals, guidelines, and protocols; and (v) any act, event, indication, or omission that may be construed as a prohibited practice under the general conditions of the loan contract, alerting the Bank in such case. Lastly, the program also requires a social audit to assess the satisfaction of PAISS+N and PSPV beneficiaries through community participation.

The program will also include a social audit to measure the degree of user satisfaction.

6. Financial supervision plan

Financial supervision will focus on verifying the internal controls that allow a reasonable conclusion to be drawn that the funds are being used for their intended purposes under the project, with particular emphasis on component 1. Supporting documentation for the disbursements will be reviewed ex post by the auditors or at the financial inspection visits to be conducted at least once a year.