

DOCUMENT OF THE INTER-AMERICAN DEVELOPMENT BANK

ARGENTINA

**DIGITAL TRANSFORMATION PROJECT FOR THE HEALTH SYSTEM OF THE
PROVINCE OF RÍO NEGRO
(AR-L1441)**

**SECOND INDIVIDUAL OPERATION UNDER THE CONDITIONAL CREDIT LINE
FOR INVESTMENT PROJECTS (CCLIP)
DIGITAL TRANSFORMATION IN HEALTH
(AR-O0033)**

LOAN PROPOSAL

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ABBREVIATIONS	
CCLIP	Conditional credit line for investment projects
DALYs	Disability adjusted life years
EPC	Exclusively public coverage
FFS	Fee for service
HPV	Human papillomavirus
HSI	Historia de Salud Integrada (Integrated health history)
ICAP	Institutional Capacity Assessment Platform
IPROSS	Instituto Provincial del Seguro de Salud (Provincial Health Insurance Institute)
MSRN	Ministry of Health of the Province of Río Negro
OEI	Organization of Ibero-American States for Education, Science, and Culture
PACS	Picture archiving and communication system
PHC	Primary healthcare
PYLL	Potential years of life lost
RNDHE	Río Negro digital health ecosystem
UEPEX	External loan execution unit
UPCEFE	Unidad Provincial de Coordinación y Ejecución del Financiamiento Externo (Provincial Unit for the Coordination and Execution of External Financing)
WCAG	Web Content Accessibility Guidelines

PROJECT SUMMARY

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SECOND INDIVIDUAL OPERATION UNDER THE CONDITIONAL CREDIT LINE FOR INVESTMENT PROJECTS (CCLIP)

DIGITAL TRANSFORMATION IN HEALTH

(AR-O0033)

Financial Terms and Conditions				
Borrower:			Flexible Financing Facility ^(a)	
Province of Río Negro			Amortization period:	25 years
Executing agency:			Disbursement period:	5 years
Ministry of Health of the Province of Río Negro, through the project execution unit			Grace period:	5.5 years ^(b)
Guarantor:			Interest rate:	SOFR + funding margin + OC variable lending spread ^(c)
Argentine Republic			Credit fee:	(d)
Financing instrument or modality:			Inspection and supervision fee:	(d)
CCLIP INV-ESP				
Source	Amount (US\$)	%		
IDB (Ordinary Capital):	60 million	100	Weighted average life:	15.25 years
			Approval currency:	U.S. dollars
			Sector(s):	Health; Cyberhealth
Total:	60 million	100	Socioenvironmental classification:	C
Project at a Glance				
General objective of the CCLIP: To help reduce the avoidable burden of disease and death among the population under the responsibility of Argentine subnational government healthcare systems.				
Project general and specific objectives. The project's general objective is to help reduce the avoidable burden of disease associated with the care pathways prioritized by the Province of Río Negro's healthcare system. The project's specific objectives are to: (i) strengthen the institutional capacities of the Province of Río Negro's healthcare system to systematically record structured and integrated clinical information for use in decision-making; and (ii) improve timely and comprehensive access for the population with exclusively public coverage in the Province of Río Negro's public health system to cardiometabolic and cancer care networks.				
Special conditions precedent to the first disbursement: The borrower, through the executing agency—the Ministry of Health of the Province of Río Negro (MSRN), through the project execution unit—has submitted evidence of the following: (i) the approval and entry into force of the project Operating Regulations , under the terms previously agreed on with the Bank; (ii) within the project execution unit's structure, the appointment and/or hiring, as appropriate, of a medical coordinator based on the profile set out in the project Operating Regulations; and (iii) the signing and entry into force of an interministerial agreement by the MSRN and the Ministry of Finance, specifying the functions and responsibilities of both ministries in the context of project execution (paragraph 4.5).				
Special conditions for execution: Prior to the start of the selection process for the project's individual consultants, the borrower, through the executing agency, will submit to the Bank for its no objection the project-specific supplementary agreement under the collaboration framework agreement in force between the Province of Río Negro and the Organization of Ibero-American States for Education, Science, and Culture (paragraph 4.6).				

^(a) Under the terms of the Flexible Financing Facility (FN-655-7), the borrower has the option of requesting changes to the amortization schedule as well as currency, interest rate, commodity, and catastrophe protection conversions. The Bank will take operational and risk management considerations into account when reviewing such requests.

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

^(c) Daily compounded SOFR in arrears. The IDB funding margin is determined on a quarterly basis. The IDB Ordinary Capital variable lending spread is determined by the Board of Executive Directors on an annual basis.

^(d) 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 policies.

PROJECT STRATEGIC CONTRIBUTION AND ALIGNMENT SUMMARY

Justification and links				
Poor populations	The project targets the population in Río Negro with exclusively public coverage (EPC) for healthcare. That population has an income poverty rate of 72%, according to the official methodology of the Statistics and Census Institute (third quarter of the 2025 Continuous Household Survey). Therefore, the project meets the absolute criteria (greater than 50%) and is classified as poverty-targeted.			
Institutional capacity and rule of law	This operation is aligned with Effectiveness of the State, since it addresses the limitations of the Province of Río Negro's public healthcare system to generate and use clinical and management information to improve its performance, as well as constraints to transforming healthcare and health management. These limitations affect the system's capacity to identify gaps in care, conduct population monitoring, and monitor compliance with clinical protocols. To overcome these limitations, the project includes the strengthening of digital infrastructure, the expansion of the structured clinical information record, the development of interoperability for the secure exchange of information, the implementation of dashboards and monitoring instruments, and continuous improvement of performance. It also incorporates indicators in the results matrix related to the use of information and the health system's performance.			
Digital transformation	The project supports the digital transformation of the Province of Río Negro's health system by strengthening the enabling infrastructure, expanding structured data capture in the Río Negro digital health ecosystem, enabling interoperability for the secure exchange of information, and consolidating the use of data through dashboards and performance management tools aimed at improving care and management processes.			
Gender	The project is aligned with the Gender priority by helping to improve health outcomes for women with EPC. Within this population, there are critical gaps in care for pathologies: in 2025, no woman ages 30 to 65 with EPC had a recorded human papillomavirus (HPV) screening test; only 22.4% of women ages 50 to 75 with EPC had a mammogram performed in a timely manner; and mortality rates from cervical cancer (16.2 per 100,000 women) and breast cancer (19.9 per 100,000 women) exceed the national averages (9.4 and 15.8, respectively). To close these gaps, the project will finance the transition to HPV testing (P1.1), which can increase coverage fourfold through self-collection; the expansion of the telehealth network to lower geographic barriers (P2.1); and the expansion of Sumar+ (P3.10) to cover cancer diagnosis confirmation services that are currently not funded. The project is expected to increase screening coverage (R2.3 and R2.4), improve diagnosis confirmation times (R2.5 and R2.7), and reduce mortality from cervical and breast cancer in women with EPC (I.4 and I.5).			
Diversity	Persons with disabilities ☒			
	The project helps to close diversity gaps for persons with disabilities. In Río Negro, 35% of the 10,440 people holding disability cards have EPC. A significant percentage of persons with disabilities face barriers in accessing health-related websites (following Web Content Accessibility Guidelines (WCAG)), which limits their access to information and services. The patient portal and the healthcare practitioner portal will be developed and implemented following WCAG 2.1 AA accessibility standards (P2.3 and P2.4).			
Climate change	Paris Agreement			
	Aligned with climate resilience objective: Simplified analysis (low/moderate physical risk from climate change)		Aligned with decarbonization objective: Specific analysis	
	Climate and green finance		Climate finance	
	Climate and green finance (%) of total project budget: 15.58% US\$9,346,960		Mitigation (%)	15.57%
			Adaptation (%)	0.01%
			Dual (%)	0%
			Total climate finance (%)	15.58%
	Climate adaptation and resilience indicator: ☐		Mitigation indicator: ☐	
	The operation looks to strengthen Río Negro's health system, with a focus on primary healthcare centers in areas exposed to multiple climate-related hazards. To that end, it is modernizing the digital infrastructure of the provincial healthcare system and will ensure that energy efficiency standards are in place and that resilience to climate risks is strengthened. In terms of adaptation, protocols will be developed for early warning systems and resilient communication systems to ensure the operational continuity of healthcare centers. In terms of mitigation, the project finances energy-efficient certified equipment, a data center that will operate in accordance with international energy efficiency standards, and the installation of critical renewable energy infrastructure. These actions are consistent with the Río Negro Provincial Climate Change Response Plan 2022–2030, which identifies public health as a sector vulnerable to climate change.			
Sustainable Development Goals (SDGs): SDG 3 and SDG 10				
Country strategy				
Country strategy	The project is aligned with the IDB Group Country Strategy with Argentina 2025-2028 (GN-3288), in particular with the pillar for supporting vulnerable populations and poverty reduction, and with the crosscutting issue of institution-strengthening. It contributes to the objective of improving the efficiency of spending on health and advancing toward a more equitable, efficient, and population-focused system through strengthened integrated services networks, smaller gaps in effective coverage, and digital transformation.			

I. PROJECT RATIONALE AND DESCRIPTION

A. Project description

- 1.1 **Objectives.** The project's general objective is to help reduce the avoidable burden of disease associated with the care pathways prioritized by the Province of Río Negro's healthcare system. The project's specific objectives are to: (i) strengthen the institutional capacities of the Province of Río Negro's healthcare system to systematically capture structured and integrated clinical information for use in decision-making; and (ii) improve timely and comprehensive access for the population with exclusively public coverage (EPC) in the Province of Río Negro's public health system to cardiometabolic and cancer care networks.
- 1.2 **Context of the conditional credit line for investment projects (CCLIP)** ([optional link 7](#)). Argentina has health outcomes below expected levels given its investment in health: only 61% of the potential benefits in terms of reducing morbidity and mortality that would be attained were the services provided with quality in a timely manner^[1]. The probability of premature death from cardiovascular diseases, cancer, diabetes, or chronic respiratory diseases fell from 17.5% to 14.9% between 2000 and 2018, which represents insufficient progress to achieve the Sustainable Development Goal indicator on reducing premature mortality from noncommunicable diseases by one third by 2030 and ranks the country's performance below the performance of countries in the region with a similar per capita income. In a country where public health systems are mainly managed by the provinces, the lack of integration and timely exchange of information between levels of care and between provinces hinders continuity of care, causes diagnostic and treatment delays, and limits population-level surveillance. The Digital Transformation in Health CCLIP ([AR-O0033](#)) addresses this situation by scaling up digital transformation to several provinces under a common programmatic framework of standards, interoperability, and governance, with the Ministry of Health of Argentina serving as the technical coordinator. The project is framed within the National Digital Health Strategy 2025-2030, developed by the Ministry of Health of Argentina alongside the provinces, which guides interoperability and the progressive integration of the subnational digital ecosystems.
- 1.3 **Context of the project.** Located in the Argentine Patagonia, the province of Río Negro has a population of approximately 792,000 in 2026 (1.7% of the national total) and covers an area of 203,013 km² (7.3% of the national territory). Its low population density (3.7 people/km²) creates the challenge of ensuring equitable access to healthcare in remote areas. Approximately 34% of the Río Negro population has EPC. The Province of Río Negro finances and manages all public healthcare facilities: 191 primary healthcare (PHC) centers and 37 hospitals. Healthcare spending accounted for 12.4% of the provincial budget in 2025. The public system has 7,150 workers.
- 1.4 **Main problem.** The capacity of the Province of Río Negro's public health system is limited in its ability to effectively reduce the avoidable burden of disease among its population with EPC. The burden of disease is typically measured in disability

adjusted life years (DALYs), which combine potential years of life lost (PYLL) and years lived with health limitations caused by disease[1]. Argentina's burden of disease is dominated by chronic noncommunicable diseases, which in 2023 accounted for 77.08% of DALYs (72.45% among men and 81.79% among women) and 72.22% of PYLL. Cardiovascular diseases accounted for 14.92% of DALYs, cancer for 14.45%, and diabetes for 2.69%[2], although this figure underestimates the actual burden of diabetes because it does not capture its role as an intermediate cause of cardiovascular and chronic kidney disease[3]. Although there are no DALY estimates for the province of Río Negro, provincial-level PYLL estimates show a pattern consistent with the national trend: cancer accounted for 25.42% of provincial PYLL in 2023, cardiovascular diseases for 16.42%, and diabetes directly for 2.26%[4].

- 1.5 High blood pressure and hypoglycemia are predictors of the burden of disease associated with cardiovascular disease and diabetes. High blood pressure damages organs and arteries, increasing cardiovascular and kidney risk. People ages 35 to 59 with high blood pressure are 2.15 times more likely to experience premature cardiovascular mortality than those whose blood pressure remains within controlled thresholds[5]. High blood sugar levels increase the risk of kidney, vision, neurological, and cardiovascular complications; one year outside the target range is associated with 100 days of life lost[6]. Studies in Argentina show that roughly only one quarter of people who know they have high blood pressure have their blood pressure controlled, and that nearly half of those who know they have diabetes do not achieve adequate glycemic control[13][14]. In 2025, only 3.98% of adults over 18 with high blood pressure and EPC had their blood pressure controlled, as recorded in the Río Negro digital health ecosystem (RNDHE), and just 2.75% of people with diabetes and EPC had their blood sugar levels controlled. These figures reflect gaps in detection, monitoring, and systematic record-keeping.
- 1.6 Cancer-specific mortality is a direct measure of the fatal burden of disease. Breast cancer has the highest mortality rate among women, and colorectal cancer ranks second in mortality for both sexes; lung cancer ranks first among men, and cervical cancer ranks fourth among women[15]. There are proven strategies for reducing mortality from breast, colorectal, and cervical cancer through screening and early detection[7][8][9][10]. The mortality-to-incidence ratio provides an indirect measure of the system's effectiveness in combating cancer: lower values suggest better outcomes in detection, diagnosis, and treatment[11]. In 2022, Argentina recorded a mortality-to-incidence ratio of 0.25 for breast cancer and 0.50 for colorectal and cervical cancer—higher than several countries in the region[12]. In Río Negro, the projected mortality rates for these types of cancer in 2025 exceed the national rates for 2022.
- 1.7 **Determinants of the main problem.** The avoidable burden of disease associated with the prioritized care pathways—high blood pressure, diabetes, and breast, colorectal, and cervical cancer—results from the interplay of five determinants: (1) social and environmental conditions; (2) individual and behavioral factors; (3) the availability of structured, integrated, and actionable clinical information; (4) management of the timing and continuity of care trajectories; and (5) the service network's capacity to provide care and treatment. The first two operate primarily outside the healthcare system; the last three are internal to the system. Of these, the project directly addresses determinants 3 and 4 (which are

sequentially dependent and fall within the scope of action of the Ministry of Health of the Province of Río Negro (MSRN)), while determinant 5 is a complementary condition, not a gap that the operation aims to directly close.

- 1.8 **Determinant 3: Gaps in structured and integrated information.** Without available, structured, and integrated clinical information, it is not possible to manage care trajectories, identify individuals who need follow-up, or measure whether the system is meeting expected clinical targets^{[16][18]}. Limitations in the coverage and completeness of the structured clinical registry, fragmentation among the systems that make up the Río Negro digital health ecosystem (RNDHE), and insufficient interoperability with the Provincial Health Insurance Institute (IPROSS) and the private sector reduce this operational and analytic capacity. As a result, information relevant to decision-making is scattered, incomplete, or not available in a timely manner, which prevents the identification of reliable patterns, the coordination of longitudinal follow-up actions, and monitoring of the system's performance. This determinant is expressed through five interrelated problems.
- 1.9 The first is the lack of connectivity and basic equipment: only 50% of a sample of PHC centers and 23% of hospitals meet minimum digital infrastructure standards. As a result, in 2025, only 20% of people with EPC had a healthcare interaction recorded in the RNDHE in the past two years, and only 19% of PHC outpatient visits and 16% of emergency room visits were recorded electronically^[4]. This gap prevents the delivery of electronic results and the conduct of remote consultations, creating barriers to timely monitoring.
- 1.10 The second problem is that even where basic infrastructure exists, the coverage of structured clinical records is insufficient: hospital discharges are not recorded electronically, which prevents the continuity of information across levels of care and the monitoring of more complex care trajectories. Clinical study and imaging data are not available within clinical records, making it difficult to ensure timely continuity of care. Added to this is the lack of tools to assist staff with structured data entry and automatic diagnostic coding.
- 1.11 A third problem is the fragmentation of clinical information across subsectors. With more than 170,000 members, IPROSS is not interoperable with the public system, and an estimated 13.5% of its members receive care through the MSRN. Accordingly, a significant portion of their medical records remains fragmented, thus affecting continuity of care.
- 1.12 As a result of the three foregoing problems, the system lacks the capacity to transform the available information into active population management (fourth problem): without an electronic registry that identifies people who have not undergone screening, the system cannot contact them. This is reflected in the fact that in 2025, no person ages 50 to 75 with EPC who had not undergone colorectal cancer screening and no woman ages 30 to 65 who had not undergone cervical screening had been contacted to encourage them to do so. Added to this is the difficulty the population faces in accessing and participating in care trajectories, which prevents public system users from accessing their clinical information, scheduling appointments, receiving reminders about pending checkups and screenings, and completing health-related procedures remotely. Digital

accessibility barriers also persist, since many health tools hinder access for persons with disabilities. Currently, the MSRN has 10,440 people registered as disability cardholders, of whom 35% have EPC[49].

- 1.13 Lastly, the fifth problem is that the Río Negro digital health ecosystem (RNDHE) has insufficient institutional, operational, and technical capacities in information security, systems adoption, and change management. Providers lack dashboards with actionable indicators and management agreements that link observed performance to commitments for improvement, which limits the system's ability to learn and make corrections based on its own data[24]. The lack of analytic capabilities at the central level also limits the ability to turn the digital ecosystem into a strategic planning tool.
- 1.14 **Determinant 4: Management of timeliness and continuity in care trajectories.** The system's ability to actively identify individuals with high blood pressure, diabetes, and cancer risk; to ensure their long-term follow-up in accordance with clinical protocols; and to ensure appropriate timeframes between a positive screening result and a confirmed diagnosis determines the extent to which these diseases are controlled in a timely manner and preventable harm is avoided[18][25][26]. A significant proportion of deaths that could be avoided through healthcare are due to poor-quality care rather than a lack of services or difficulties accessing them[27]. This determinant relates to the quality associated with active identification, longitudinal follow-up, timely screening, diagnosis confirmation, and the management of care trajectories, and is reflected in three issues.
- 1.15 First, regarding the monitoring of high blood pressure and diabetes, in 2025 only 5.11% of people with EPC and high blood pressure and 15.42% of people with diabetes had been registered for the basic clinical monitoring package, which includes an annual medical consultation, periodic blood pressure or glycated hemoglobin measurements, and medication dispensing. The RNDHE cannot monitor treatments or detect interruptions, while the concentration of specialists in cities limits follow-up in remote areas[36]. Limited telehealth development restricts access to services, especially for those living in remote areas and persons with disabilities. In low- and middle-income countries, this population faces physical, communication, and organizational barriers in accessing PHC[48]. Added to this is the lack of site-of-care analytic tools that flag patients whose follow-up appointments are overdue or whose conditions are not controlled, support clinical decision-making, and match identified needs with the network's resources[49].
- 1.16 The second problem concerns cancer screening, where coverage is insufficient for the three priority types of cancer. For cervical cancer, approximately 6,212 Pap smears were performed in public hospitals in 2025, equivalent to 16.6% of the expected annual target, and no woman ages 30 to 65 with EPC had a recorded HPV screening test—a method with a sensitivity of over 90%, compared to a range of 30% to 87% for the Pap smear—with automated processing and the option for self-collection, which has increased coverage fourfold among vulnerable populations in Argentina[28][29]. For colorectal cancer, only 3% of people ages 50 to 75 with EPC had undergone a fecal occult blood test in the past 24 months. For breast cancer, 22.4% of women ages 50 to 75 with EPC had a mammogram in the past 12 months, representing 10.4% of the expected annual target.

- 1.17 The third problem is the delay in confirming a cancer diagnosis. In 2025, only 47% of positive mammograms were confirmed within 60 days, 39% of HPV tests within 90 days, and 16% of fecal occult blood tests within 180 days (thresholds set by the U.S. Centers for Disease Control and Prevention)[30]. Evidence shows that each month of delay between diagnosis and treatment increases mortality by 6% to 13%[31], and delays in the initial diagnostic process also increase the risk of tumor progression. One factor contributing to these delays is the lack of digital imaging management infrastructure: without digital storage and transmission, the interpretation of radiology and mammography studies requires both the study and the specialist to be in the same place, which, in a large province where specialists are concentrated in a few urban centers, leads to avoidable delays[34][35]. This is coupled with a programmatic gap: services to confirm a cancer diagnosis are not included in the Sumar program's health services plan, where the pay-for-performance arrangement determines which services are prioritized as well as the quality standards under which they are to be provided; as a result, this gap renders them invisible in healthcare programming. The project focuses its efforts on Determinants 3 and 4 because both fall directly within the MSRN's purview and are sequentially dependent. Improving management of the timeliness and continuity of care trajectories requires structured and integrated clinical information to identify individuals who need follow-up, to measure performance, and to manage care trajectories over time. Addressing both of these issues in a coordinated manner creates the conditions necessary to translate performance gains into sustainable reductions in the avoidable burden of disease among Río Negro's population with EPC.
- 1.18 **Proposed solutions and evidence of their effectiveness.** To address the eight problems identified in Determinants 3 and 4 (section 3.1, [required link 1](#)), the project will implement an integrated package[49] of seven complementary solutions, the evidence for which is outlined in section 4.1 of [required link 1](#). The causal chain operates as follows: Problem 1 is addressed by Solution 1, which strengthens the enabling conditions for PHC centers and hospitals to operate digitally. Problems 2 and 3 are addressed by Solution 2, which scales up the integrated health history (HSI), incorporates artificial intelligence for diagnostic coding, deploys interoperability platforms, and consolidates the information security strategy. Problem 4 is addressed using Solution 3 through the patient portal and telehealth network. Problem 5 is addressed in three complementary dimensions: information security, through Solution 2; continuous improvement and monitoring, through Solution 5, which emphasizes results via performance management based on integrated dashboards, peer comparators, and management agreements that drive systematic cycles of continuous improvement; and human and institutional capacities, addressed by Solution 7, which operates in a crosscutting manner, since a lack of adoption and governance is the primary cause of failure in digital health systems[24]. Problems 6, 7, and 8 are addressed in a coordinated manner by Solution 4, which installs the networked patient management system, medication traceability, the healthcare practitioner portal, and the expansion of Sumar+[47], and by Solution 6, which aligns the integrated networks and MSRN-IPOSS coordination; Solutions 4 and 5 are aligned with the HEARTS framework[49]. This chain results in a shift in the care model from a reactive system to a system of active, population-level care management that identifies, contacts, and ensures follow-up for people with EPC. Solutions 1 and 2 strengthen enabling conditions; building on that foundation, Solution 3 lowers

barriers to access; Solution 4 transforms participation into effective longitudinal management; Solution 5 establishes a pay-for-performance arrangement and continuous improvement cycles; Solution 6 aligns the organizational architecture with prioritized care trajectories; and Solution 7 ensures effective and sustained adoption. See section 4.2 in [required link 1](#) for more details.

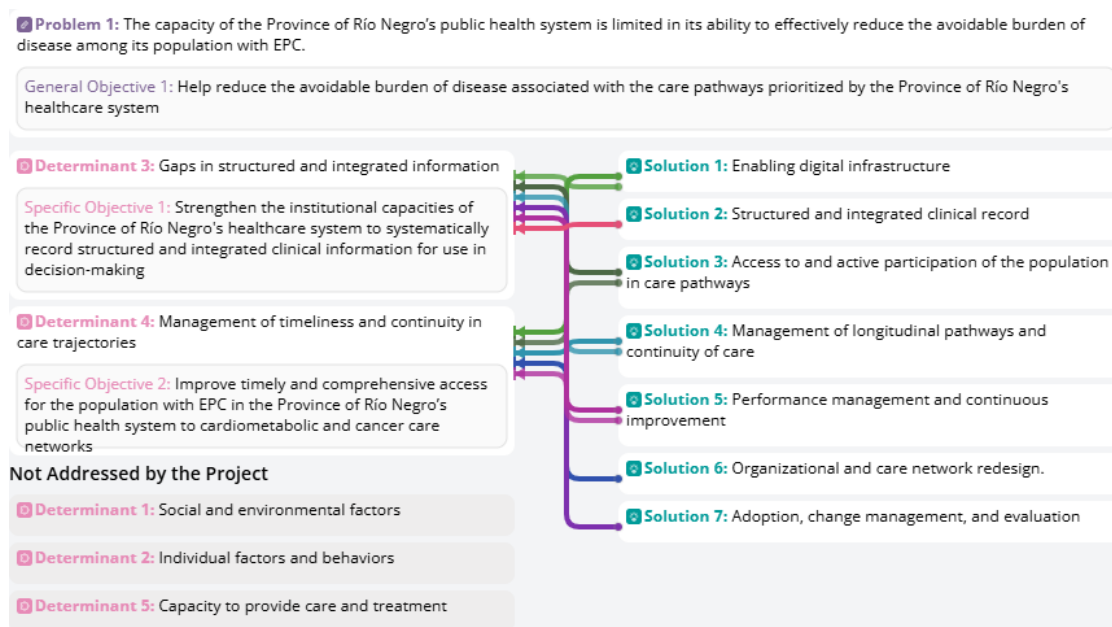
- 1.19 **Solution 1: Enabling digital infrastructure.** This involves investments in connectivity and equipment at PHC centers (P1.1) and hospitals (P1.2), as well as enhanced infrastructure at data centers (P1.3) and medical imaging servers (P1.4). With this solution, all PHC centers will be enabled as telehealth nodes (P2.1), and a subset will receive telemedicine kits and supplies for screening, which expand the range of services available to manage noncommunicable diseases (P1.1). Evidence shows that telehealth improves access to specialized care in remote areas and reduces inequities associated with the concentration of specialists in urban centers[36] and that the lack of digital imaging transmission systems causes structural delays in diagnosis in geographic contexts such as that of Río Negro [34][35].
- 1.20 **Solution 2: Structured and integrated clinical record.** This will expand the HSI with prioritized features for the cardiometabolic and cancer care trajectories (P2.2), incorporate artificial intelligence for the structured record and automatic diagnostic coding (P2.5) and interoperability platforms with IPROSS (P2.6) (P2.7), and implement an information security strategy (P3.12). The impact of electronic health records depends on their integration into care processes and effective adoption[24]; interoperability yields benefits in terms of continuity of care backed by standards and data governance[38][39]; and artificial intelligence offers opportunities to standardize the collection and analysis of clinical information in resource-limited settings[37].
- 1.21 **Solution 3: Access to and active participation of the population in care trajectories.** The provincial telehealth network (P2.1) and the patient portal (which will allow patients to schedule appointments, receive reminders, and access clinical information (P2.3)) will serve as the interface between the system and the public. Evidence shows that patient portals are associated with greater adherence to follow-up care among people with chronic diseases[42][44], and an IDB-coordinated experiment in Uruguay found that digital tools combined with citizen engagement strategies significantly increase the use of preventive services among vulnerable populations[43].
- 1.22 **Solution 4: Management of longitudinal trajectories and continuity of care.** A networked patient management system will identify, stratify, and actively monitor individuals with chronic conditions or in cancer care trajectories (P2.8); a medication traceability system will detect treatment interruptions before they result in a loss of clinical control (P2.9); a healthcare practitioner portal will centralize information and alerts at the site of care (P2.4); and the expansion of Sumar+ to public providers will add cancer diagnosis confirmation services not currently covered, thus raising awareness and creating incentives for providers to ensure the timeliness of prioritized cancer care trajectories (P3.10). Evidence shows that clinical decision support systems have a positive impact on staff performance[45], that medication adherence improves when reminders are combined with active follow-up[23], and that pay-for-performance arrangements can improve the use of

prioritized services[46], as specifically supported by the experience of the Sumar program in Argentina[47].

- 1.23 **Solution 5: Performance management and continuous improvement.** Integrated dashboards featuring actionable indicators and peer comparators for the central level, health zones, PHC centers, and hospitals (P3.5), along with management agreements to foster continuous improvement (P3.6), will link observed performance to improvement plans and be operated by a health data science unit (P3.3). Evidence shows that feedback on performance is most effective when it is repeated, specific, and supported by action plans and facilitation[41]. This solution will make it possible to monitor effective use of the information.
- 1.24 **Solution 6: Organizational and care network redesign.** The redesign of the ministry's organizational model and health zones (P3.1), the model for integrated health services networks with roles defined by level of complexity and referral and counter-referral mechanisms (P3.4), and the MSRN-IPROSS coordination model (P3.11) will ensure the continuity of healthcare for individuals moving between subsectors. The strategic planning unit (P3.2) will provide the institutional capacity to monitor and evaluate this organizational transformation.
- 1.25 **Solution 7: Adoption, change management, and evaluation.** This will fund the implementation and change management unit (P3.7), the communication strategy (P3.8), the digital literacy program for healthcare practitioners (P3.9), the ongoing evaluation of the digital strategy (P3.13), and the project impact evaluation (P3.14). This solution cuts across the others: the evidence consistently shows that the lack of adoption and governance strategies is the primary cause of failure in the implementation of digital health systems[24].
- 1.26 **Expected project contribution.** The project aims to gradually close performance gaps in the public system across the five prioritized care pathways. It seeks to increase the annual documented follow-up of people with high blood pressure from 5.11% to 35% and of people with diabetes from 15.42% to 30%. It also seeks to increase colorectal cancer screening from 3% to 40%, cervical cancer screening using HPV testing from 0% to 55%, and breast cancer screening from 22.4% to 70%. In terms of timely access to diagnosis confirmation, it seeks to increase the proportion of people with a confirmation test for colorectal cancer within 180 days from 16% to 50%, for breast cancer within 60 days from 47% to 70%, and for cervical cancer within 90 days from 39% to 75%. In terms of digitization, the project looks to ensure that 60% of people with EPC have a recorded interaction in the digital ecosystem, that 70% of PHC visits and 60% of emergency room visits are recorded in electronic health records, and that 35% of hospital discharges are recorded electronically.
- 1.27 **Beneficiaries.** This project will directly benefit approximately 320,000 residents with EPC in the province of Río Negro. It will indirectly benefit the other Río Negro residents who use public health services each year.
- 1.28 **Economic analysis.** An economic analysis ([optional link 3](#)) was conducted using a 3% discount rate to monetize the benefits from meeting the targets of specific development objective 2. The main strategy for capitalizing the benefits was to estimate the DALYs avoided as a result of improvements in monitoring and

comprehensive care for people with high blood pressure and diabetes, and reductions in the time to start treatment for the three prioritized types of cancer. Meeting the health indicator targets entails 995 DALYs avoided from chronic diseases and 6,549 DALYs avoided from cancer over an 11-year period (6 years after the project's expected completion). The project's net present value is US\$33.2 million; the internal rate of return is 11.1%; and the benefit-cost ratio is 1.3. The results are robust to the probabilistic/deterministic sensitivity analysis conducted, which tested a number of parameters. This estimate is conservative: the digital infrastructure and institutional capacities built by the project are expected to generate positive externalities on health indicators not included in the analysis; therefore, the project's actual benefits may be substantially greater.

Figure 1. Theory of change summary



Note: Detailed [theory of change](#).

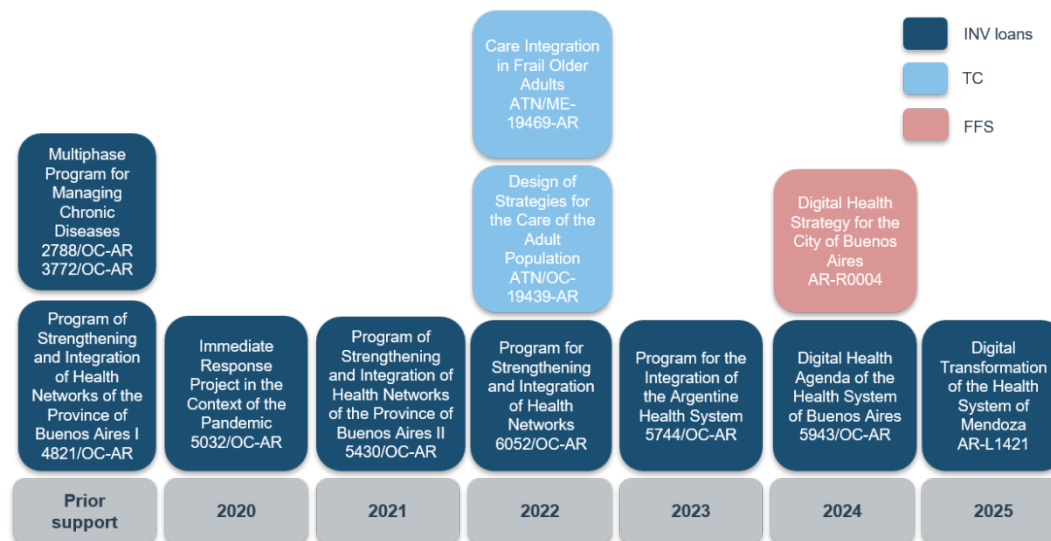
B. The Bank's additionality

1.29 **Programmatic approach.** The IDB has maintained a coherent programmatic approach in Argentina's health sector, prioritizing the strengthening of integrated service networks with a focus on PHC and the system's digital transformation. This approach has been implemented since 2012 through operations [2788/OC-AR](#), [3772/OC-AR](#), [5032/OC-AR](#), [5744/OC-AR](#), and [6052/OC-AR](#) with the national government; and [4821/OC-AR](#) and [5430/OC-AR](#) with the Province of Buenos Aires. Digital transformation was promoted in a crosscutting manner in these operations and systematically in [5032/OC-AR](#) and [5744/OC-AR](#), using the IDB's Casa Digital model as a reference. Operations [5943/OC-AR](#) with the City of Buenos Aires and [6140/OC-AR](#) with Mendoza, together with the payment for services rendered agreement with the City of Buenos Aires (AR-R0004) to design its digital transformation agenda, consolidate this approach through a combination of loan instruments and technical assistance. The operation drives the CCLIP's vision forward by promoting a replicable, results-oriented model of digital transformation

that integrates clinical management, priority care pathways, and evidence across geographically dispersed networks.

- 1.30 The project design includes lessons learned from previous IDB operations. First, focus digitization on specific use cases ([3007/OC-UR](#), [4300/OC-UR](#), [5032/OC-AR](#), [5744/OC-AR](#), and [6140/OC-AR](#)). This lesson is reflected in the inclusion of health indicators at the specific objective level in the Results Matrix, ensuring that digital investment translates into performance improvements for the national integrated health system and is not an end in itself. Second, use digital tools to expand access to and strengthen the monitoring of services ([RG-E1591](#)). This lesson was applied to the design of Component 2. Third, combine digital infrastructure with redesigned clinical processes and trained staff ([6140/OC-AR](#)). This lesson led to the division of the operation into two specific development objectives aligned with Components 1 and 2, thus avoiding exclusively technological approaches. Fourth, strengthen institutional leadership as an enabling condition for transformation ([3007/OC-UR](#)). This criterion was applied to the design of the governance arrangements in Component 3. Fifth, jointly develop strategies with subnational actors and service providers to ensure ownership and sustainability ([5032/OC-AR](#)). This approach was reflected in the participatory architecture of Component 3.

Figure 2: Timeline of Bank support



- 1.31 **Nonfinancial additionality.** The Bank provided technical assistance to the MSRN for the Provincial Digital Health Strategy and the institutional design of the Digital Health Department, thereby strengthening provincial steering capacities. For the first time in Argentina, the project incorporates telehealth and telediagnostic tools in a rural network in Patagonia with a highly dispersed population, thereby expanding the capacity of providers in remote areas to deliver care. It also links the strengthening of the digital ecosystem with health financing mechanisms under the Sumar+ program and IPROSS, reinforces the HSI as a multiprovincial digital public good, and aligns with the National Digital Health Strategy 2025–2030 through common interoperability standards.

- 1.32 **Synergies with the private sector.** Although the scope of the financed interoperability is limited to the ministry's digital ecosystem and to IPROSS, its design lays the institutional and technical groundwork for a gradual expansion into the province's private sector. This is significant because, in Río Negro, the subsectors do not operate in isolation: IPROSS procures services from private providers, and in areas where the public healthcare system is the only one available, IPROSS members and individuals with private coverage access the public system, generating cost-recovery flows that require information traceability across subsectors. The project creates a first step toward integration that, by design, is scalable and compatible with a broader provincial interoperability architecture.
- 1.33 **Collaboration with other institutions.** The IDB and Pan American Health Organization have a regional collaboration agreement in digital health under the Pan American Highway for Digital Health ([PH4H](#)) initiative, with which this project is aligned. Argentina is also a member of the Alliance for Primary Health Care in the Americas, spearheaded by the Pan American Health Organization, the IDB, and the World Bank, and the project aligns with its goal of strengthening PHC, reducing the fragmentation of services, and improving equity in access.

II. COSTS AND FINANCING STRUCTURE

A. Project components

- 2.1 **Component 1. Enabling digital infrastructure (US\$36.86 million).** This contributes to the achievement of specific development objective 1 by putting in place, at the MSRN's healthcare providers and central infrastructure, the minimum technological conditions without which it is not possible to digitally record healthcare activities or operate the provincial information ecosystem. It also contributes to specific development objective 2 by enabling PHC centers and public hospitals to operate with the service package corresponding to their functional category and with the medical and digital equipment necessary to provide services in the prioritized care pathways and by installing physical telemedicine hubs that extend access to specialized care to remote areas. Financing will be provided for building renovations, goods, and nonconsulting services for the following outputs: (i) P1.1. PHC centers in the public system with medical equipment appropriate to their level of complexity and with digital infrastructure installed (connectivity and devices); (ii) P1.2. Public system hospitals with medical equipment appropriate to their level of complexity and digital capacity installed, delivering the portfolio of services corresponding to their category within the network; (iii) P1.3. Centralized processing, storage, and cybersecurity infrastructure that supports the MSRN's provincial digital ecosystem and its digital ecosystem, strengthened in terms of capacity and compliance with international standards on availability, security, and energy efficiency; (iv) P1.4. Infrastructure for the storage and transmission of digital medical images that enables remote access to radiology, mammography, and ultrasound studies for network providers; and (v) P1.5. IPROSS operational sites equipped with technology that enables them to operate the institutional digital platform and actively participate in the provincial interoperability ecosystem.

- 2.2 **Component 2. Integrated digital ecosystem (US\$11.02 million).** This contributes to the achievement of specific development objective 1 by building an ecosystem of structured, integrated, and interoperable clinical information that transforms healthcare activities into actionable data for healthcare management and decision-making. It also contributes to specific development objective 2 by delivering information systems and digital platforms that make it possible to actively identify individuals with chronic conditions or at risk of cancer (including cervical and breast cancer), match their needs with the services offered by the network, manage their care trajectories over time, and ensure the continuity of information across levels and subsectors. Financing will be provided for goods, consulting services, and nonconsulting services for the following outputs: (i) P2.1. Provincial telemedicine network operating on a platform that enables remote consultations between healthcare providers and different levels of care, expanding access without the need for physical travel, and that includes the installation of telediagnostic kits, along with the digitization and translation of health prevention and promotion materials into Indigenous languages and the use of translation tools to generate content and facilitate digital health services for a subset of facilities that expands its range of services; (ii) P2.2. Expanded HSI with new, prioritized features for the structured recording of cardiometabolic and cancer care trajectories, integrated with the provincial ecosystem's laboratory, imaging, and other clinical systems; (iii) P2.3. Digital platform that allows users to access their clinical information, schedule appointments, receive reminders for pending checkups and screenings, and complete health-related procedures remotely, with iterative development based on real-world usage and feedback and compliant with the Web Content Accessibility Guidelines (WCAG 2.1 AA); (iv) P2.4. Platform that centralizes patient clinical information, worklists, alerts, and care management tools for site-of-care teams, with iterative development and compliant with WCAG 2.1 AA accessibility standards; (v) P2.5. Artificial intelligence tools integrated within the HSI that assist staff with the structured entry of clinical information, automatic diagnostic coding, and the generation of alerts; (vi) P2.6. Standardized infrastructure to share clinical and administrative data among systems in the provincial ecosystem (HSI, laboratory, imaging, IPROSS) that enables clinical information to follow the patient across providers and subsectors; (vii) P2.7. IPROSS information system that digitizes the management of services, authorizations, and referrals, integrates its data with the provincial public system, and includes the digital operating model; (viii) P2.8. System that identifies and stratifies individuals with chronic conditions or within cancer care trajectories, matches their needs to the service portfolio of healthcare providers, and generates alerts when follow-up is interrupted; and (ix) P2.9. System that tracks the medication supply chain from purchase, storage, and prescription through to dispensing and detects treatment interruptions.
- 2.3 **Component 3. Strengthening the care model and change management (US\$10.57 million).** This contributes to the achievement of specific development objective 1 by developing the human and institutional capacities necessary to ensure the effective and sustained adoption of the digital ecosystem, the generation and use of high-quality information, and the systematic evaluation of the strategy's performance. It also contributes to specific development objective 2 by redesigning the organization of care networks, implementing clinical performance management mechanisms, establishing cross-sector governance agreements with IPROSS, and expanding financing for services in the care

trajectories. The component will finance consulting and nonconsulting services for the following outputs: (i) P3.1. Formal redesign of the ministry's organizational structure, with roles, functions, and coordination mechanisms aligned with the management of integrated networks and the digital health strategy; (ii) P3.2. Institutional capacity built within the ministry for the planning, monitoring, and evaluation of the provincial health strategy; (iii) P3.3. Technical team specialized in health data analysis and analytical intelligence that turns information from the digital ecosystem into inputs for decision-making and that designs management dashboards; (iv) P3.4. Design and implementation of the service network organizational model, including the roles defined by level of complexity, referral and counter-referral mechanisms, and management of longitudinal trajectories; (v) P3.5. Dashboards with clinical performance indicators available at the central level, health zones, and healthcare providers, which feed into cycles of continuous improvement; (vi) P3.6. Systematic cycles of monitoring, feedback, and improvement for healthcare providers, with agreed-on targets, peer comparators, and action plans; (vii) P3.7. Dedicated team to support the adoption of new systems, processes, and care models by providers; (viii) P3.8. Communication actions targeting the general public to promote preventive services and the use of the patient portal; targeting providers to strengthen coordination; and within the ministry to support organizational transformation; (ix) P3.9. Digital skills training program for healthcare personnel that promotes the effective and sustained use of the digital ecosystem; (x) P3.10. Transfers linked to disbursements for service delivery, as described in Annex III (Section III, Expenses not derived from procurement processes). The operational and incentive mechanism will be implemented through the Sumar+ program—a pay-for-performance system based on services reported in the HSI—with an expanded list of services that will require the Bank's no objection in accordance with the limits outlined in the project Operating Regulations; (xi) P3.11. Operational agreement between the ministry and IPROSS that promotes continuity of care for individuals moving between the public system and the provincial social health insurance program; (xii) P3.12. Health information security plan and capacity-building to detect and respond to cybersecurity incidents, as well as the design and implementation of secure software development processes; (xiii) P3.13. Institutional mechanism for ongoing evaluation that includes processes, adoption, effective use, and intermediate results of the digital ecosystem; and (xiv) P3.14. Impact evaluation using a quasi-experimental design that assigns the causal attribution of changes in outcome indicators to project interventions, thus generating evidence for institutional learning and the dissemination of Rio Negro's experience.

- 2.4 **Administration and audit (US\$1.55 million).** Expenditures associated with the project's administration, supervision, monitoring, and midterm evaluation will be financed, together with annual external financial audits.

B. Dimensioning and financing structure.

- 2.5 The second individual operation under the CCLIP will have a total cost of US\$60 million, wholly financed with the IDB's Ordinary Capital resources. No local counterpart contribution or cofinancing is anticipated. The disbursement period will be five years.

- 2.6 The dimensioning reflects gaps in digital infrastructure, geographical dispersion that drives up the cost of connectivity and equipment, and the magnitude of the interventions needed to achieve measurable health outcomes.

Table 1. Estimated project costs (US\$ thousand)

Components	IDB	Total	%
Component 1: Enabling digital infrastructure	36,863	36,863	61
Component 2: Integrated digital ecosystem	11,021	11,021	18
Component 3: Strengthening the care model and change management	10,566	10,566	18
Administration and audit	1,550	1,550	3
Total	60,000	60,000	100

C. Financing instrument or modality

- 2.7 **Eligibility of the second operation under the CCLIP.** The operation meets the following requirements for processing, as set forth in the Policy and Operational Guidelines for CCLIPs (GN-2246-13 and GN-2246-15): (i) it contributes to achievement of the CCLIP's objective, and its three components correspond to the CCLIP components focused on the health sector, as follows: Component 1 corresponds to the technological infrastructure and interoperability component; Component 2 corresponds to the components on technological infrastructure and interoperability, data analytics and health intelligence, and the redesign of clinical and administrative processes; and Component 3 corresponds to the components on change management and training of human resources, the redesign of clinical and administrative processes; and governance and institutional sustainability; and (ii) an institutional capacity analysis was conducted using the Bank's 2026 Institutional Capacity Assessment Platform (ICAP), identifying areas for improvement related to operational capacity as described in the section on risks (paragraph 3.1), along with the corresponding mitigation measures. This second operation also meets, to the Bank's satisfaction, the eligibility criteria under the agreement to establish a CCLIP for Digital Transformation in Health (AR-O0033), since: (i) the Province of Río Negro has a formally approved digital health transformation plan—the Provincial Digital Health Strategy;¹ (ii) the logic of this operation directly contributes to the CCLIP's objective by helping to reduce the avoidable burden of disease and death among the population under the responsibility of Argentina's subnational governments; and (iii) the RNDHE architecture adopts open interoperability standards that enable the secure exchange of information with other subnational agencies and between these agencies and the national level, within the framework of the National Digital Health Strategy 2025–2030.
- 2.8 **Loan instrument for the second operation under the CCLIP.** This consists of a specific investment loan (INV-ESP), which is necessary to ensure access to and improve the quality of health services, since it is an operation with a fully defined scope whose components cannot be divided without affecting its logic.

¹ Pending approval.

III. MAIN RISKS AND MANAGEMENT STRATEGY

A. Risks

- 3.1 **Capacity risks.** The 2026 ICAP methodology found that the executing agency has partially satisfactory capacity. Medium-high risks were identified: (i) a lack of specialized personnel in digital areas, procurement, and financial management, and the complexity of the approval workflows for bidding processes. To mitigate this, the teams will be reinforced with specialized personnel, and tailored planning mechanisms will be implemented for critical procurements with early technical assistance; (ii) the network's insufficient operational capacity for care and treatment to meet the additional demand identified, prioritized, and managed by the project. To mitigate this, systematic mechanisms for performance monitoring and continuous improvement will be consolidated to identify operational bottlenecks in a timely manner, and the impact will be evaluated to generate causal evidence regarding which components of the intervention produce observable improvements; (iii) a lack of sustained institutional leadership that could weaken the cycles of continuous improvement. To mitigate this, knowledge will be transferred to the permanent teams and evaluation mechanisms used to generate evidence and enable adjustments during execution; and (iv) the lack of coordination between the MSRN and the Provincial Unit for the Coordination and Execution of External Financing (UPCEFE) of the Ministry of Finance (which do not have any prior experience working together) that could lead to delays in management processes. To avoid this risk, coordination mechanisms will be set up through an interministerial agreement as a special condition precedent to the first disbursement.
- 3.2 **Project-specific risks.** The high risk is associated with the strengthening of the RNDHE, the increase in the exchange of digital clinical information between interoperable platforms, and the incorporation of artificial intelligence-enabled features, all of which heighten exposure to cybersecurity incidents, failures in data protection, and errors in personal data governance, which could affect the continuity of care and trust in the system. To mitigate this, specific cybersecurity and data protection requirements will be included in the technological components. The following medium-high risks were identified: (i) limited adoption of new clinical processes and digital tools due to cultural or institutional factors could affect the sustainability of the improvements beyond project completion. To mitigate this, the effectiveness of the change management strategy (P3.7) will be monitored so that adjustments can be made during execution; and (ii) the expansion of the Sumar+ program may not be effective in encouraging timely diagnosis confirmation in the prioritized cancer care trajectories. To mitigate this, monitoring and evaluation systems will be used to assess the effectiveness of the incentive mechanisms and make adjustments during project execution.

B. Sustainability

- 3.3 **Sustainability of results.** This is based on the MSRN's capacity to absorb the recurring costs that will arise once execution is complete. Upon projection completion, the annual costs for operating and providing support to the information systems are estimated to be close to US\$300,000; when combined with the

replacement of the technological infrastructure and computer equipment (estimated at close to US\$350,000), these costs represent approximately 0.5% of the ministry's total annual budget. This amount is modest compared to the ministry's current allocation for information and communications technologies (close to 2% of its total budget) and can reasonably be absorbed through internal reallocations within this budget line item without substantial increases to the sector's budget. Financial sustainability will be further strengthened by increased revenue from the recovery of costs for services provided to individuals covered by the social health insurance program and private insurance, which currently amount to approximately US\$6.5 million—equivalent to nearly 10% of the ministry's budget. At the same time, the ministry considers that this figure reflects only a fraction of the potential recovery, since fragmentation and the lack of traceability in the record of services create a significant gap between the services provided and those actually billed and collected. According to the Province of Río Negro, the digitization process in Mendoza and implementation in Entre Ríos yielded increases in the recovery rate of between 15% and 30% in the two years following the start of operations. According to estimates, the Province of Río Negro projects an increase of at least 15% due to the digitization of healthcare services and interoperability with IPROSS.

C. Environmental and social risks

- 3.4 In accordance with the Bank's Environmental and Social Policy Framework and based on the information available when conducting this environmental and social review summary, this has been initially classified as a Category C operation, because it is likely to cause minimal or no negative environmental or social impacts.
- 3.5 In addition, an environmental and social risk rating of moderate is considered adequate, due to the nature and magnitude of the potential environmental and social risks and impacts, which are not significant. This risk rating will be updated during execution of the operation.
- 3.6 The risk of natural disasters and climate change is classified as low, given the nature of the interventions and the province of Río Negro's exposure to hazards such as droughts, earthquakes, and heat waves.
- 3.7 The hazards identified in the operation's area are primarily droughts, landslides, water shortages, flash floods, and landslides, which are all classified as high risk. Criticality and vulnerability are classified as low, since this type of intervention does not substantially alter the environment, does not involve the construction of new infrastructure, the physical works are not significant in terms of number or complexity, and work is not carried out on critical civil, social, and/or heritage infrastructure.

IV. IMPLEMENTATION, MONITORING, AND EVALUATION ARRANGEMENTS

A. Summary of implementation arrangements

- 4.1 **Execution mechanism.** The borrower will be the Province of Río Negro and the guarantor, the Argentine Republic. The executing agency is the MSRN, through the project execution unit. The project execution unit will be responsible for the project's overall and technical coordination and for reporting to the Bank. Through the Provincial Unit for the Coordination and Execution of External Financing (UPCEFE), the Ministry of Finance will be responsible for project fiduciary, financial management, and monitoring considerations.
- 4.2 For the purposes of hiring individual consultants for the project, the Organization of Ibero-American States for Education, Science, and Culture (OEI) will act as the administrator and manager of the payments for these contracts, but without participating in the selection process, which will remain the UPCEFE's responsibility. The costs associated with this administration will be fully financed using the Province of Río Negro's resources under an agreement in force between the parties ([optional link 8](#)).
- 4.3 **Lessons learned for implementation.** Operations [3007/OC-UR](#), [4300/OC-UR](#), and [4668/OC-JA](#) demonstrated that digital transformation requires ongoing change management, support, and training. Furthermore, the Salud Mesoamerica Initiative demonstrated that systematic monitoring using indicators is key to identifying gaps and making timely adjustments to implementation. In line with these lessons, the project includes these types of indicators in the monitoring, evaluation, and learning plan.
- 4.4 **Planning of startup activities and key procurements.** The activities to be implemented in the initial stages are: (i) conduct a survey of the status of connectivity, equipment, and digital maturity at all PHC centers and hospitals in the RNDHE; (ii) prepare technical specifications to procure medical and computer equipment; and (iii) hold the kickoff workshop to assess the status of baseline indicators at the start of the project and verify whether they are consistent with the values recorded during preparation. The key procurement items are: (a) building renovations and improvements to accommodate the new equipment; (b) contracting of Lamansys to develop and enhance the HSI's services and features; (c) purchase of digital equipment for PHC centers and hospitals; and (d) development and implementation of the data interoperability platform.
- 4.5 **Special conditions precedent to the first disbursement:** The borrower, through the executing agency—the MSRN, through the project execution unit—has submitted evidence of the following: (i) the approval and entry into force of the project [Operating Regulations](#), under the terms previously agreed on with the Bank; (ii) within the project execution unit's structure, the appointment and/or hiring, as appropriate, of a medical coordinator based on the profile set out in the project Operating Regulations; and (iii) the signing and entry into force of an interministerial agreement by the MSRN and the Ministry of Finance, specifying the functions and responsibilities of both ministries in the context of project execution.

- 4.6 **Special conditions for execution:** Prior to the start of the selection process for the project's individual consultants, the borrower, through the executing agency, will submit to the Bank for its no objection the project-specific supplementary agreement under the collaboration framework agreement in force between the Province of Río Negro and the OEI. This condition is necessary so that the Bank can verify that the supplemental agreement between the OEI and the Province of Río Negro includes the terms and conditions agreed on with the Bank in the project Operating Regulations.
- 4.7 **Fiduciary agreements and requirements:** The Policies for the Procurement of Goods and Works and the Selection of Consultants financed by the IDB ([GN-2349-15](#) and [GN-2350-15](#), respectively) will be used, along with the Financial Management Guidelines for IDB-financed Projects (OP-273-12). The guidelines for financial management and procurement execution applicable to the project are described in Annex III.
- 4.8 **Direct contracting:** The borrower has expressed interest in proceeding with single-source selection for the development of HSI features under Component 2, which will be carried out by Lamansys SAS, a spin-off of Universidad Nacional del Centro de la Provincia de Buenos Aires. This is the second single-source selection with this supplier under the CCLIP. Annex III lays out the rationale in accordance with Bank policies.

B. Implementation arrangements for monitoring and evaluation

- 4.9 **Monitoring and evaluation considerations.** The program will adopt the Bank's supervision arrangements. Monitoring arrangements will include: (i) monitoring fulfillment of critical milestones for project development; (ii) holding quarterly meetings for the technical and operational review of the project's progress; (iii) semiannual reports on achievements and problems encountered in each of the components and project performance according to the Results Matrix, which will be submitted by the executing agency to the Bank within 60 days following the end of each six-month period throughout the loan disbursement period and any extensions thereof; and (iv) the use of the management tools indicated in the monitoring, evaluation, and learning plan in order to have instruments to plan the activities and processes required to achieve the project's outcomes, including an impact evaluation ([required link 2](#)). The project includes two impact evaluations (P3.14) aligned with outcome indicators R1.1 to R1.8 and R2.1 to R2.5. A staggered difference-in-differences strategy will be implemented, taking advantage of the project's phased implementation—specifically, outputs P1.1, P1.2, and P2.1—due to operational constraints in constructing a valid counterfactual, using PHC centers and hospitals not yet involved in the project as controls.

sgDELTA Questionnaire	
Summary AR-L1441	
Evaluability rating	Evaluable
Development Effectiveness rating	Strong
Client Ownership	Limited
Results and Impact (Contributes to evaluability)	High
Value For Money (Contributes to evaluability)	High
Knowledge (Contributes to evaluability)	Strong
<i>Note: The Development Effectiveness rating can take four possible categories: Limited, Moderate, Strong, and High.</i>	
sgDELTA Summary Note: The purpose of this note is to provide an overall assessment of the project's or program's Evaluability and Development Effectiveness at the design stage.	
I. Client Ownership	
There is a medium-high risk that the country's fiscal constraints could limit project implementation over the next years. In addition, a medium-low risk has been identified regarding the availability of appropriate human resources to support project management. Furthermore, there is a medium-high risk related to the experience and time availability of key personnel in the technical, financial, and procurement areas.	
II. Results and Impact	
Theory of Change	
The ToC presents a clear vertical logic. The diagnosis identifies gaps in structured and integrated clinical information, as well as limitations in care pathway management, as the main bottlenecks. The causal chain consistently describes how investments in digital health and population health management would strengthen the follow-up of chronic patients and oncology care pathways, thereby contributing to a reduction in the avoidable disease burden associated with hypertension, diabetes, and prioritized cancers. A key assumption underlying the ToC is that improvements in information systems and care management will translate into better health outcomes because the healthcare network will have sufficient service delivery and treatment capacity to absorb the additional demand generated by the project.	
Results Matrix	
The proposed indicators are appropriate for measuring the project's reach across the different stages of the results chain in which it intervenes, from registration and information management to its use in identifying at-risk populations and improving screening, follow-up, and diagnostic confirmation, ultimately contributing to improved health outcomes reflected in the impact indicators. In addition to capturing the relevant dimensions of the project's objectives, the indicators generally meet the SMART criteria.	
Monitoring	
All outcome indicators in the results matrix include annual targets through project completion. Their monitoring is feasible, as they are calculated using administrative records that are continuously updated, without requiring additional data collection mechanisms. In addition, the proposal identifies relevant milestones that will enable monitoring of progress toward the achievement of the specific objectives.	
III. Value for Money	
The operation includes a cost-benefit analysis that monetizes the benefits associated with reducing the burden of disease through improvements in the management of hypertension and diabetes, as well as through the early detection and timely treatment of prioritized cancers. The analysis incorporates both investment costs and incremental recurrent operation and maintenance costs over an eleven-year time horizon. The results suggest that the operation is economically viable, with an estimated economic internal rate of return of approximately 11%. In addition, sensitivity analyses were conducted on key parameters, indicating that the operation remains economically viable under most of the scenarios considered.	
IV. Knowledge	
The empirical attribution evaluation plan includes a quasi-experimental evaluation using a staggered Difference-in-Differences design to estimate the effect of telehealth services on diagnostic times, as well as a randomized controlled trial to measure the effect of digital messaging interventions on cancer screening uptake. Both evaluations will rely on administrative records from Rio Negro's digital health ecosystem and have dedicated budget allocations for their implementation.	

Annex II – Results Matrix

Statement of Project Development Objectives

General objective	Help reduce the avoidable burden of disease associated with the care pathways prioritized by the Province of Río Negro's healthcare system.
Specific objectives	(i) Strengthen the institutional capacities of the Province of Río Negro's healthcare system to systematically record structured and integrated clinical information for use in decision-making; and (ii) improve timely and comprehensive access for the population with exclusively public coverage (EPC) in the Province of Río Negro's public health system to cardiometabolic and cancer care networks.

A. General Development Objective

No.	Indicator	Type of data	Baseline		Evaluation scenario		Comments
			Value	Year	Target	Expected year measured	
I.1	Annual proportion of people ages 18 and older with EPC who have high blood pressure and have their blood pressure controlled	Percentage (persons/persons)	3.98	2025	15.0	2031	
I.2	Annual proportion of people ages 18 and older with EPC who have diabetes and have their blood sugar levels controlled	Percentage (persons/persons)	2.75	2025	13.0	2031	
I.3	Colorectal cancer-specific mortality rate in Río Negro's total population	Rate (persons/100,000 persons)	18.9	2024	15.2	2031	
I.4	Cervical cancer-specific mortality rate among Río Negro's total female population	Rate (persons/100,000 persons)	16.2	2024	13.3	2031	Aligned with Gender Equality
I.5	Breast cancer-specific mortality rate among Río Negro's total female population	Rate (persons/100,000 persons)	19.9	2024	19.5	2031	Aligned with Gender Equality

B. Specific Development Objectives

No.	Indicator	Type of data	Baseline		Execution					Evaluation scenario		Comments
			Value	Year	Year 1	Year 2	Year 3	Year 4	Year 5	Target	Year	
Specific development objective 1: Strengthen the institutional capacities of the Province of Río Negro’s healthcare system to systematically record structured and integrated clinical information for use in decision-making.												
R1.1	Proportion of people ages 18 or older with EPC who have had a healthcare interaction recorded in the Río Negro digital health ecosystem (RNDHE) in the past two years, relative to the estimated total number of people with EPC.	Percentage (persons/ persons)	20	2025	20	30	40	50	60	60	2031	
R1.2	Annual percentage of visits to public hospitals by individuals with Provincial Health Insurance Institute (IPROSS) coverage who are registered in the RNDHE	Percentage (consultations/ consultations)	21	2025	25	30	35	40	50	50	2031	
R1.3	Annual proportion of outpatient medical consultations in the public primary healthcare (PHC) system that are recorded in the RNDHE	Percentage (consultations/ consultations)	19	2025	25	40	55	65	70	70	2031	
R1.4	Annual percentage of on-call medical consultations made at public hospitals and recorded in the RNDHE	Percentage (consultations/ consultations)	16	2025	20	25	35	45	60	60	2031	

No.	Indicator	Type of data	Baseline		Execution					Evaluation scenario		Comments
			Value	Year	Year 1	Year 2	Year 3	Year 4	Year 5	Target	Year	
R1.5	Annual proportion of hospital discharges in the public health system recorded in the RNDHE	Percentage (consultations/ consultations)	0	2025	5	10	18	25	35	35	2031	
R1.6	Annual proportion of people ages 50 to 75 with EPC who have not undergone a timely colorectal cancer screening and who were contacted through a digital intervention in the past 12 months	Percentage (persons/ persons)	0	2025	10	15	25	40	55	55	2031	
R1.7	Annual proportion of women ages 30 to 65 with EPC who have not undergone a timely cervical cancer screening and who were contacted through a digital intervention in the past 12 months	Percentage (persons/ persons)	0	2025	10	15	25	40	55	55	2031	Aligned with Gender Equality
R1.8	Annual proportion of women ages 50 to 75 with EPC who have not undergone a timely breast cancer screening and who were contacted through a digital intervention in the past 12 months	Percentage (persons/ persons)	0	2025	10	15	25	40	55	55	2031	Aligned with Gender Equality

No.	Indicator	Type of data	Baseline		Execution					Evaluation scenario		Comments
			Value	Year	Year 1	Year 2	Year 3	Year 4	Year 5	Target	Year	
Specific development objective 2: Improve timely and comprehensive access for the population with EPC in the Province of Río Negro's public health system to cardiometabolic and cancer care networks.												
R2.1	Annual proportion of people ages 18 and older with EPC and diabetes who have a recorded annual medical checkup, a glycated hemoglobin (HbA1c) test, and/or antidiabetic medication dispensed	Percentage (persons/ persons)	15.4	2025	17	20	23.5	27.5	30	30	2031	
R2.2	Annual proportion of people ages 18 and older with EPC and high blood pressure who have a recorded annual medical checkup, blood pressure measurement, and antihypertensive medication dispensed	Percentage (persons/ persons)	5.11	2025	10	15	20	27	35	35	2031	
R2.3	Proportion of people ages 50 to 75 with EPC who have undergone colorectal cancer screening using the fecal occult blood test in the past 24 months	Percentage (persons/ persons)	3	2025	5	10	20	30	40	40	2031	
R2.4	Proportion of women ages 30 to 65 with EPC who have undergone cervical cancer screening using the human papillomavirus (HPV) test in the past five months	Percentage (persons/ persons)	0	2025	15	25	35	45	55	55	2031	Aligned with Gender Equality

No.	Indicator	Type of data	Baseline		Execution					Evaluation scenario		Comments
			Value	Year	Year 1	Year 2	Year 3	Year 4	Year 5	Target	Year	
R2.5	Proportion of women ages 50 to 75 with EPC who have had a mammogram in the past 12 months	Percentage (persons/ persons)	22.4	2025	25	35	45	55	70	70	2031	Aligned with Gender Equality
R2.6	Annual proportion of people ages 50 to 75 with EPC who had a diagnostic test for colorectal cancer reported within 180 days of a positive screening result using the fecal occult blood test	Percentage (persons/ persons)	16	2025	20	25	30	40	50	50	2031	
R2.7	Annual proportion of women ages 30 to 65 with EPC who had a diagnostic test for cervical cancer reported within 90 days of a positive screening result	Percentage (persons/ persons)	39	2025	45	53	60	68	75	75	2031	Aligned with Gender Equality
R2.8	Annual proportion of women ages 50 to 75 with EPC who had a diagnostic test for breast cancer performed within 60 days of a positive screening result using mammography	Percentage (persons/ persons)	47.2	2025	50	55	60	65	70	70	2031	Aligned with Gender Equality

C. Outputs

No.	Indicator	Type of data	Baseline value	Year 1	Year 2	Year 3	Year 4	Year 5	Baseline year	EOP value	Comments
Component 1: Enabling digital infrastructure											
P1.1	PHC centers operating with the services package corresponding to their functional category and equipped with active digital infrastructure	PHC centers	0	0	93	73	25	0	2026	191	
P1.2	Hospitals operating with an appropriate services package and equipped with active digital infrastructure	Hospitals	0	0	8	24	5	0	2026	37	
P1.3	Data center with expanded capacity for storing and processing information, operating in accordance with international standards on availability, security, and energy efficiency	Data centers	0	0	1	1	1	1	2026	1	
P1.4	Picture archiving and communication system (PACS) servers in operation	Servers	0	0	8	4	0	0	2026	12	
P1.5	IPROSS sites equipped	Sites	0	0	21	21	0		2026	42	
Component 2: Integrated digital ecosystem											
P2.1	Provincial telehealth nodes operating with an intercultural approach	Nodes	40	45	60	80	100	120	2026	120	
P2.2	HSI features implemented ¹	Features	0	1	3	4	1	0	2026	9	
P2.3	Versions of the patient portal that are operational and comply with WCAG 2.1 AA accessibility standards	System	0	0	1	0	1	0	2026	2	

¹ Automatic SUMAR/OS billing from HSI, HSI interoperability — laboratory, HSI interoperability — imaging, HSI interoperability — Nomivac, HSI interoperability — SNVS, HSI interoperability — Tekhne, HSI interoperability — healthcare agents tool, HSI interoperability — prehospital clinical record, HSI functionality modules: outpatient + inpatient + on-call + patient management + operating room module.

No.	Indicator	Type of data	Baseline value	Year 1	Year 2	Year 3	Year 4	Year 5	Baseline year	EOP value	Comments
P2.4	Versions of the healthcare practitioner portal that are operational and comply with WCAG 2.1 AA accessibility standards	System	0	0	1	0	1	0	2026	2	
P2.5	Artificial intelligence modules for clinical record support and automatic coding in operation	Module	0	0	1	0	1	0	2026	2	
P2.6	Versions of provincial data interoperability platforms implemented and in operation	System	0	0	1	1	0		2026	2	
P2.7	IPROSS integrated digital platform for management, interoperability, and analytics implemented	System	0	0	1	0	0		2026	1	
P2.8	Provincial networked patient management system in operation	System	0	0	0	0	1		2026	1	
P2.9	Comprehensive system for traceability and monitoring medication coverage in operation	System	0	0	0	1	0		2026	1	
Component 3: Strengthening the care model and change management											
P3.1	Organizational model for the MSRN and health zones approved	Document	0	0	1	0	0	0	2026	1	
P3.2	Strategic planning unit operating annually	Unit	0	1	1	1	1	1	2026	5	
P3.3	Health data science unit in operation annually	Unit	0	1	1	1	1	1	2026	5	
P3.4	Provincial model for managing integrated health service networks in operation	Document	0	0	0	1	0	0	2026	1	

No.	Indicator	Type of data	Baseline value	Year 1	Year 2	Year 3	Year 4	Year 5	Baseline year	EOP value	Comments
P3.5	Provincial system of integrated health management dashboards in operation	System	0	0	1	0	0	0	2026	1	
P3.6	Program to strengthen management agreements and improve the performance and quality of clinical records, implemented annually	Program	0	1	1	1	1	1	2026	5	
P3.7	Implementation and change management unit in operation annually	Unit	0	1	1	1	1	1	2026	5	
P3.8	Communication strategy implemented annually	Campaign	0	1	1	1	1	1	2026	5	
P3.9	Digital literacy program in operation annually	Program	0	1	1	1	1	1	2026	5	
P3.10	Expanded health services plan under the Sumar+ program, implemented annually	Plan	0	1	1	1	1	1	2026	5	
P3.11	Collaborative model between the MSRN and IPROSS for healthcare coverage and the procurement of services in operation	Model	0	0	1	0	0	0	2026	1	
P3.12	Health information security strategy implemented	Strategy	0	0	1	0	0	0	2026	1	
P3.13	Evaluation system for the provincial digital health strategy in operation	System	0	0	0	1	0	0	2026	1	
P3.14	Project impact evaluation implemented	Document	0	0	0	0	0	1	2026	1	

Country: Argentina **Division:** SCL/HNP **Project number:** AR-L1441 **Year:** 2026

FIDUCIARY AGREEMENTS AND REQUIREMENTS

Executing agency: Ministry of Health of the Province of Río Negro (MSRN)

Project name: Digital Transformation Project for the Health System of the Province of Río Negro

Key execution considerations and fiduciary team requirements

☒	Formation of the fiduciary team	Although the Provincial Unit for the Coordination and Execution of External Financing (UPCEFE) has staff members with fiduciary experience in Bank-financed projects, they currently hold managerial positions and work only part-time on the project. In this regard, the team responsible for fiduciary management will need to be buttressed from the start of the operation by adding at least two specialized professionals with expertise in procurement and financial management.
☒	Other topics	The borrower will be the Province of Río Negro and the guarantor, the Argentine Republic. The executing agency will act as the borrower through its project execution unit, which reports directly to the Minister of Health. The project execution unit will be responsible for the project's overall and technical coordination and for reporting to the Bank. Through the UPCEFE, the Ministry of Finance will serve as a supporting agency for the financial and accounting management of the resources and procurements necessary for project execution. The project Operating Regulations will define the duties and responsibilities of each body. For the purposes of hiring individual consultants for the project, the Organization of Ibero-American States for Education, Science, and Culture (OEI) will act as the administrator and manager of the payments for these contracts, but without participating in the selection process, which will remain the UPCEFE's responsibility. The costs associated with this administration will be fully financed using the Province of Río Negro's resources under an agreement in force between the parties (see optional link 9 - Analysis of the execution mechanism for individual consultants). The OEI's activities in Argentina are legally supported by the agreement entered into with the national government, approved by National Law 23,579, which grants it full legal capacity to enter into agreements with the various levels of government. In this context, the Province of Río Negro entered into a framework collaboration agreement with the OEI on 16 February 2022, which was ratified through a memorandum of understanding dated 22 October 2024 and approved by Provincial Decree 17/2026, stipulating that institutional cooperation is implemented, for each specific program or project, through supplementary agreements. Accordingly, a specific supplementary agreement for this project will be signed to define the responsibilities of this administration, which will be a condition for execution.

I. Fiduciary Context

1. Country and sector context

Established by Decree 1265/1996, as amended by Decree 334/2004, the UPCEFE centralizes management of the Province of Río Negro's external financing; administers procurement, budgeting, accounting, disbursements, and external audits in internationally financed programs; and represents the Province before lending agencies.

In 2024/2025, it managed a portfolio of US\$358 million. It has a staff of 25 people, organized into one executive office and four management departments: Planning; Monitoring and Evaluation; Administration and Finance; and Special Project Development and Management (<https://upcefe-dev.rionegro.gov.ar/>).

As regards the project's financial management, the UPCEFE will be responsible for accounting records, financial reports, and management of the project funds. It will use the system for external loan execution units (UEPEX) as a financial administration system; accounting will be done on a cash basis. UEPEX identifies funds by source of financing, operates on a dual-currency basis, records investments by component, and generates reports for disbursement requests and financial statements. The executing agency will enter the project's financial records into the provincial financial management and control system (SAFYC).

A private firm will conduct the external audit. The Province of Río Negro's Public Audit Office is not validated as an eligible institution to audit IDB-financed programs.

The Province of Río Negro does not have a dedicated internal audit department but is subject to reviews conducted by the Office of the Prosecutor (legal matters) and the Provincial Accounting Office (accounting matters), as well as an ex post review by the Public Audit Office.

2. Use of country system in the operation

☒ Budget	☒ Reports	☒ Information systems	☐ National competitive bidding (NCB)
☒ Treasury	☐ Internal audit	☐ Shopping	☐ Other (system use at executing agency level was validated)
☒ Accounting	☐ External control	☐ Individual consultants	☐ Other

3. Executing agency capacity and performance level

An assessment using the Institutional Capacity Assessment Platform (ICAP) concluded that the executing agency has a partially satisfactory fiduciary capacity.

The UPCEFE has recent experience in executing procurement and financial management processes for a Bank-financed operation (Federal Fiduciary Fund of Regional Infrastructure (FFFIR)) and other multilateral organizations, but limitations were identified in terms of the effective availability of personnel with experience in Bank-financed projects, the availability of specialized personnel, and the formalization of operational workflows, particularly in procurement.

To this end, the following recommendations are made: (i) bring on board, at an early stage, specialists in procurement and financial management to work full-time on the project; (ii) formalize the fiduciary flows and execution arrangements in the project Operating Regulations; (iii) update the applicable procedures manual; and (iv) monitor the timelines for procurement procedures.

4. Budget cycle and flow of funds

Programming and budget	Law H 3186 is the fundamental law governing financial management and internal control in the public sector of the Province of Río Negro. It sets out the framework for the organization and operation of the systems that manage the provincial government's resources, as well as the control mechanisms. It comprehensively regulates the budget, public credit, treasury, and accounting systems. The budget items allocated for project execution will be assigned to the MSRN. The UPCEFE will assist the Undersecretariat of Digital Health in developing and defining the project's annual budget. The MSRN will be responsible for requesting annual budget allocations from the Ministry of Finance, through the Undersecretariat of Budgeting, and for managing any changes or new allocations that may be required during the course of the year.
Flow of funds	The project will open two, UPCEFE-managed bank accounts exclusively for its funds: i. One account in U.S. dollars; ii. One account in Argentine pesos, into which the Arg\$-denominated amounts from the US\$ account will be deposited, and from which payments will be made. Disbursements will be made to the account in U.S. dollars and will pass through the account of the Central Bank of the Argentine Republic (the IDB's fund recipient). The province normally transacts with Banco Patagonia. The UPCEFE will manage the funds, record transactions in UEPEX, and issue payment instructions to the Ministry of Finance of the Province of Río Negro's Treasury Department, which will execute the payments. The UPCEFE's director will authorize payment requests and Arg\$ conversions. Once these payments have been made, the Treasury Department will forward the supporting documentation so that the UPCEFE can record the transactions in UEPEX. Bank reconciliations will be performed on a monthly basis. An agreement supplementary to the existing agreement between the Province of Río Negro and the OEI will be signed solely for the purpose of hiring the project's consultants and managing their payments. An investment of US\$5.7 million in consultants is estimated for this project (9.5% of the project's total budget). Under this arrangement, the OEI will make payments to the consultants and submit reports to the executing agency, attaching the corresponding supporting documentation; based on this documentation, the executing agency will record the payment in UEPEX. The executing agency will advance funds to the OEI into an account designated exclusively for the project payments. Initially, the executing agency will make advance payments to the OEI based on a quarterly plan, for which the OEI will then submit monthly reports to the executing agency. The reporting, reconciliation, monitoring, and accountability mechanisms for this process will be detailed in the supplementary agreement and in the project Operating Regulations. The supplementary agreement will be subject to the Bank's no objection. The Bank will disburse funds in the form of advances of funds, based on a financial plan that takes into account the project's liquidity needs, or another method set out in the OP-273-12 guidelines. Disbursements made after the first advance of funds will require justification of 80% of the balance of previous advances. Procurement planning and monitoring, disbursement requests, and expense justifications will be managed through the Client Portal platform.

5. Risks affecting fiduciary function – Indicate the risks that may have a fiduciary impact on the operation

Executing agency: Medium-high	If the coordination mechanisms between the MSRN and the UPCEFE lack clarity and a regulatory basis, procurement and financial management could be delayed. Mitigation measures: (i) the project Operating Regulations will define a clear procedure, including actions and responsibilities for each body, to strengthen governance; (ii) an interministerial agreement between the MSRN and the MHPRN will specify the roles and responsibilities of both agencies in execution. Both will be conditions precedent to the first disbursement. A dashboard is also recommended that tracks times by stage, with an emphasis on procurement.
Medium-high	If the UPCEFE does not have sufficient staff, working full-time on the project, and specialized fiduciary positions to manage this project and other new projects with international funding simultaneously, implementation could be delayed. As a mitigation measure, two specialists dedicated exclusively to this project will be hired.

II. Considerations for the Special Provisions

Special conditions precedent to the first disbursement:	Special conditions precedent to the first disbursement will be that the borrower, through the executing agency, has submitted evidence of the following: (i) the approval and entry into force of the project Operating Regulations, under the terms previously agreed on with the Bank; (ii) the appointment of a medical coordinator; and (iii) the signing and entry into force of an interministerial agreement between the MSRN and the Ministry of Finance, specifying the functions and responsibilities of both ministries in the context of project execution. As a special condition for execution, prior to the start of the selection process for the project's individual consultants, the borrower, through the executing agency, will submit to the Bank for its no objection the specific supplementary agreement for the project under the collaboration framework agreement in force between the Province of Río Negro and the OEI.
Exchange rate	For the purposes of Article 4.10 of the General Conditions, the parties agree that the exchange rate to be used will be the rate stipulated in Article 4.10(b)(i), which is the exchange rate in effect on the date of conversion of the disbursement into local currency. For the purpose of determining the equivalency of expenditures in local currency for the reimbursement of expenditures chargeable against the loan, the exchange rate will be the rate in effect on the first working day of the month in which the borrower, the executing agency, or any other person or corporation with delegated authority to incur expenditures makes the payments to the contractor, vendor, or beneficiary.
Type of external audit	The executing agency will submit audited annual financial statements in accordance with the terms of reference agreed with the Bank within 120 days after the end of the fiscal year. The project's final financial reports will be submitted within 120 days after the date of the last disbursement. The external audit of the project will be performed by an independent audit firm eligible to audit Bank-financed operations, which will be selected and contracted in accordance with the terms of references and model contract previously agreed on with the Bank.

III. Key Procurement Considerations

☒	Documents for national processes	For national competitive bidding and shopping for goods and nonconsulting services, the Bank's standard templates in Argentina and evaluation reports will be used. The project's sector specialist will be responsible for reviewing the technical specifications and terms of reference during preparation for the selection processes, which may be done on an ex ante basis, regardless of the applicable review method.
☐	Direct contracting	The following single-source selection was identified:¹ New HSI features – HSI interoperability with laboratory and imaging. Consultant: Lamansys SAS Amount: US\$2,049,808 Description: Ensure evolutionary continuity of the HSI Policy: GN-2350-15, paragraph 3.11(d) The rationale is supported by: optional link 4 - Rationale for direct contracting.
☒	Expenses not derived from procurement processes	The borrower has expressed interest in financing the Sumar+ program health services plan. This procedure will be reviewed and accepted by the Bank, provided that it does not violate the principles of economy, efficiency, and competition. Within this framework, provincial transfers will be structured in a manner consistent with the operational logic of the national program, linking disbursements to the effective delivery of health services and to previously defined quality criteria, such as timeliness in care. These definitions will be detailed in the project Operating Regulations.

¹ This is the second single-source selection under CCLIP AR-O0033.

IV. Procurement Strategy Initial Inputs

KEY procurements

Results matrix output	Procurement description	Procurement method	Estimated start date	Estimated amount (US\$)	Reasons for being key
	Goods				
P1.1	Procurement of computer equipment for the network of public health facilities (health centers and hospitals)	International competitive bidding	01/01/2027	US\$10,238,000	This procurement of equipment is essential to the project's success.
P1.2	Procurement of laboratory equipment, surgical instruments, and essential equipment for new hospitals	International competitive bidding	01/03/2028	US\$12,461,676	This procurement of laboratory equipment is essential to the project and represents the largest amount to be financed, accounting for 20.77% of the project.
	Nonconsulting services				
P1.2	Building renovations and improvements to accommodate the new equipment	International competitive bidding	01/01/2027	2,500,000	This procurement is essential for the project's launch. Digital equipment processes depend on this process.
	Firms				
P2.2	New HSI features – HSI interoperability with laboratory and imaging	Single-source selection	01/01/2027	2,049,808	The HSI's new features are essential to achieving the project's objectives. This integrates and modernizes the health ecosystem based on the HSI.
P2.2	Integrated digital platform for management, interoperability, and analytics	Quality- and cost-based selection	01/04/2027	3,171,200	Critical output for the project's success.

Indicate if any of the main procurements require a special approach and/or support:

☒	Initial procurement strategy	Combined strategy: a) International competitive bidding for larger-scale, high-criticality technology packages (for example, computer equipment and medical/technology equipment), b) Strategic single-source selection to ensure the technical and evolutionary continuity of the HSI and interoperability. This is based on a preventive model with: a) early planning and realistic sequencing of processes, aligned with the critical path; and b) early risk mitigation (competition, interoperability, service continuity, efficiency). A market survey will be conducted through periodic updates on supply, prices, and delivery times, which will inform specifications, timelines, and purchasing strategies. Procurement flows and responsibilities, including monitoring deadlines and execution timelines, need to be formalized to reduce delays and bottlenecks.
☒	Necessary activities for successful implementation	Paragraph 4.4 of the proposal for operation development.

DOCUMENT OF THE INTER-AMERICAN DEVELOPMENT BANK

PROPOSED RESOLUTION DE-___/___

Argentina. Loan ____/OC-AR to the Province of Rio Negro. Digital Transformation Project for the Health System of the Province of Rio Negro. Second Individual Operation under the Conditional Credit Line for Investment Projects (CCLIP) Digital Transformation in Health (AR-O0033)

The Board of Executive Directors

RESOLVES:

That the President of the Bank, or such representative as he shall designate, is authorized, in the name and on behalf of the Bank, to enter into such contract or contracts as may be necessary with the Province of Rio Negro, as borrower, and with the Argentine Republic, as guarantor, for the purpose of granting the former a financing aimed at cooperating in the execution of the Digital Transformation Project for the Health System of the Province of Rio Negro, which constitutes the second individual operation under the Conditional Credit Line for Investment Projects (CCLIP) Digital Transformation in Health (AR-O0033), approved by Resolution DE-___/26 on _____. Such financing will be for the amount of up to US\$60,000,000, from the resources of the Bank's Ordinary Capital, and will be subject to the Financial Terms and Conditions and the Special Contractual Conditions of the Project Summary of the Loan Proposal.

(Adopted on _____ 2026)