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ARGENTINA

MULTIPHASE PRIMARY HEALTH CARE PROGRAM FOR MANAGING CHRONIC NONCOMMUNICABLE DISEASES

MEMORANDUM EVALUATING THE FIRST OPERATION (AR-L1142)

AND

LOAN PROPOSAL FOR THE SECOND OPERATION (AR-L1196)

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ABBREVIATIONS

COFESA	Consejo Federal de Salud [Federal Health Council]
ENFR	Encuesta Nacional de Factores de Riesgos [National Risk Factor Survey]
HYLL	Healthy years of life lost
INDEC	Instituto Nacional de Estadística y Censos [National Institute of Statistics and Censuses]
IRAM	Instituto Argentino de Normalización y Certificación [Argentine Standardization and Certification Institute]
MINSAL	Argentine Ministry of Health
PHCC	Primary health care center
PJI	Proyectos jurisdiccionales de inversión [jurisdictional investment projects]
QALY	Quality-adjusted life years
RFP	Request for proposals
RISS	Redes integradas de servicios de salud [integrated health services networks]
RITA	Registro Institucional de Tumores de Argentina [Institutional Tumor Registry of Argentina]
ROHA	Registro Oncopediátrico Hospitalario [Inpatient Pediatric Oncology Registry]
SITAM	Sistema de Información de Tamizaje [Screening Information System]
SPPSSC	Secretaría de Promoción, Programas Sanitarios y Salud Comunitaria [Department of Promotion, Health Programs, and Community Health]
UAI	Unidad de Auditoría Interna [Internal Audit Unit]
UFI-S	Unidad de Financiamiento Internacional de Salud [International Financing Unit of MINSAL]
UGJ	Unidades de gestión jurisdiccional [jurisdictional management units]
UHC	Universal health coverage

PROJECT SUMMARY

ARGENTINA
MULTIPHASE PRIMARY HEALTH CARE PROGRAM FOR MANAGING CHRONIC NONCOMMUNICABLE DISEASES, SECOND OPERATION
(AR L1196)

<table>
<tr><th colspan="5">Financial Terms and Conditions</th></tr>
<tr><td colspan="3" rowspan="2">Borrower: Argentine Republic</td><td colspan="2">Flexible Financing Facility[b]</td></tr>
<tr><td>Amortization period:</td><td>25 years</td></tr>
<tr><td colspan="3" rowspan="3">Executing agency: Argentine Ministry of Health (MINSAL)</td><td>Original WAL:</td><td>14.75 years</td></tr>
<tr><td>Disbursement period:</td><td>4 years</td></tr>
<tr><td>Grace period:</td><td>4.5 years</td></tr>
<tr><td>Source</td><td>Amount (US$)</td><td>%</td><td>Inspection and supervision fee:</td><td>[c]</td></tr>
<tr><td>IDB (Ordinary Capital):[a]</td><td>100 million</td><td>60.2%</td><td>Interest rate:</td><td>LIBOR-based</td></tr>
<tr><td>Local:</td><td>66 million</td><td>39.8%</td><td>Credit fee:</td><td>[c]</td></tr>
<tr><td>Total:</td><td>166 million</td><td>100%</td><td>Currency of approval:</td><td>U.S. dollars from the Bank’s Ordinary Capital</td></tr>
<tr><th colspan="5">Project at a Glance</th></tr>
<tr><td colspan="5">Project objective/description: The objective of this second operation is to help reduce morbidity and mortality caused by chronic noncommunicable diseases in Argentina, prioritizing the population with public coverage only. Specifically, this operation proposes to help: (i) prioritize the primary care level as the gateway to the health care system; (ii) increase the population’s access to screenings for classification according to health risk; and (iii) increase access to timely treatment for those with moderate or high health risk suffering from chronic conditions.</td></tr>
<tr><td colspan="5">Contractual special conditions precedent to the first disbursement of the loan proceeds: The executing agency has: (i) put the program Operating Regulations into effect by ministerial resolution on the terms previously agreed upon with the Bank; and (ii) issued a ministerial resolution (a) assigning the national management of the program to the Department of Promotion, Health Programs, and Community Health (SPPSSC); (b) forming the technical unit, reporting to the SPPSSC and including the coordinators of the REDES and Universal Health Care Coverage Medications programs and the National Cancer Institute (INC); and (c) assigning responsibility to the International Financing Unit of MINSAL (UFI-S) for the fiduciary and administrative/financial management aspects of the program (see paragraph 3.7).
Contractual special execution conditions: The executing agency has: (i) signed a management agreement with the respective jurisdiction on the terms and conditions established in the program Operating Regulations, before resources are transferred to that jurisdiction to finance the expansion of (a) jurisdictional investment projects (PJI) and innovative projects; and (b) the Institutional Tumor Registry of Argentina (RITA), Screening Information System (SITAM), and Inpatient Pediatric Oncology Registry (ROHA), as provided in Subcomponents 1.1 and 2.1, respectively; and (ii) obtained the Bank’s approval for an equipment sourcing plan for the primary care level, including at least: (a) technical justification of the type of equipment to be purchased and distributed to primary care level practitioners; (b) a strategy for equipment repair and maintenance; and (c) the technical criteria for distribution among and within jurisdictions. The Bank’s approval for the equipment sourcing plan must be obtained before the first call for bids using funds allocated to Subcomponent 1.2 (see paragraph 3.8).</td></tr>
<tr><td colspan="5">Exceptions to Bank policies: None.</td></tr>
<tr><th colspan="5">Strategic Alignment</th></tr>
<tr><td>Challenges:[d]</td><td colspan="4">SI ☑ PI ☐ EI ☐</td></tr>
<tr><td>Crosscutting issues:[e]</td><td colspan="4">GD ☑ CC ☐ IC ☐</td></tr>
</table>

[a] The disbursement of the loan proceeds will be subject to the following restrictions: (i) a maximum of 15% in the first 12 months; (ii) a maximum of 30% in the first 24 months; and (iii) a maximum of 50% in the first 36 months, counted in all instances from the date the loan operation is approved by the Board of Executive Directors of the Bank.

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

[c] The credit fee and inspection and supervision fee will be established periodically by the Board of Executive Directors as part of its review of the Bank’s lending charges, in accordance with applicable policies.

[d] SI (Social Inclusion and Equality); PI (Productivity and Innovation); and EI (Economic Integration).

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

I. PROJECT DESCRIPTION AND RESULTS MONITORING

A. Background, problem to be addressed, and rationale

1. Impact and causes of chronic diseases in Argentina

1.1 Chronic diseases were responsible for more than three-fourths of healthy years of life lost due to premature death or disability in Argentina in 2013. Nearly 40% of these losses were concentrated in cardiovascular conditions, cancers, diabetes, and chronic respiratory diseases.[1] Although these are more prevalent in the more developed regions, they are also the primary cause of early death and disability in the poorer parts of the country (Macchia, et al., 2015; Borruel, et al., 2010). Chronic diseases also impose substantial economic costs. For example, when employment income lost directly and medical expenses are combined, cardiovascular diseases alone in Argentina generate annual costs of close to half a point of GDP (IECS, 2011).

1.2 The most prevalent chronic diseases share risk factors: smoking, unhealthy diet, and sedentary lifestyle (WHO, 2009).[2] Over time, these behaviors contribute to physiological and metabolic changes such as high blood pressure, overweight and obesity, hyperglycemia (high blood sugar levels), and high cholesterol, which are biologically related to the early development of these diseases. The level and trend of these factors and their physiological manifestations are a significant concern for public policies in Argentina (see Table I.1), not only in terms of their health and economic implications but also in terms of equity. Argentina's most vulnerable population suffers disproportionately from chronic diseases: they have more predisposing factors (Fleischer, et al., 2011); a smaller proportion access screening services that would lead to treatment (Jahangir, et al., 2012); and they are more likely to incur expenses that impoverish them (Huffman, et al., 2011).

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1 Authors' calculations based on data from the Institute for Health Metrics and Evaluation. Keeping the same age structure, these four disease groups caused nearly 35% and 41% of healthy years of life lost (HYLL) in Argentine women and men, respectively.

2 In 2013, 59% of HYLL due to chronic diseases in Argentina could be attributed to behaviors and lifestyles, the environment, or metabolic conditions. Of these attributable HYLL, 71% correspond directly or indirectly to behaviors or lifestyles.

Table I.1. Prevalence of behavioral and clinical risk factors for chronic noncommunicable diseases in Argentina in 2013 (%)

Risk factor	National		Men	Women	With coverage	Without coverage	First Quintile	Fifth Quintile
Smoker	25.1	↓	29.9	20.5	-	-	28.2	23.0
Less than minimum fruit and vegetable intake	94.1	≈	95.8	94.6	-	-	96.6	93.0
Low physical activity	54.7	↑	51.8	57.4	-	-	53.4	52.2
Overweight	37.1	↑	43.3	31.3	-	-	35.5	36.3
Obesity	20.8	↑	22.9	18.8	-	-	21.4	18.8
High blood pressure	34.1	≈	31.4	36.4	-	-	38.5	29.0
Hyperlipidemia	29.8	↑	29.7	29.9	-	-	30.0	29.1
High cholesterol	9.8	↑	9.1	10.4	-	-	10.1	9.1
No blood pressure control	17.6	↓	22.2	13.4	12.8	28.8	25.8	12.6
No cholesterol control	22.5	↓	28.6	15.3	17.2	41.6	34.2	12.8
No blood sugar control	23.2	↓	29.2	17.1	16.3	39.3	34.2	13.8
No mammogram	34.4	↓	-	-	30.2	48.0	48.7	20.1
No Pap smear	28.4	↓	-	-	23.6	39.6	37.1	21.0
No colon cancer screen	75.5	-	76.8	74.3	72.5	88.8	83.5	65.7

Source: National Risk Factors Surveys, 2005, 2009, and 2013. The symbols indicate trends among the three surveys.

Note 1: Except for the following factors, calculations are based on the over-18 population : (i) no cholesterol control (35+ for men; 45+ for women); and (ii) no mammogram (50-70); no Pap smear (25-65); (iii) no colon cancer screen (50-75).

Note 2: For the clinical factors, measurements refer to "once" except for the following, which refer to "in the last two years:" (i) control and prevalence of high blood pressure; (ii) no mammogram; and (iii) no Pap smear.

2. Strategies for controlling chronic diseases and the challenge of implementing them in Argentina

1.3 The most cost-effective way to mitigate the impact of chronic diseases is to implement population-based public health measures promoting healthy lifestyles (e.g., tax measures to discourage consumption of unhealthy foods and control smoking). However, there are also evidence-based recommendations on how to treat those who already have or are at risk of developing a chronic disease (Cecchini, et al., 2010; Halpin, et al., 2010). These recommendations are to organize a care model with a primary health care focus through the operation of integrated health services networks, known by their Spanish-language acronym as RISS (Vasan, et al., 2013). The primary health care focus requires that low-tech and widely deployed services at the primary care level serve as the “gateway” to the health system. To do this, health networks must continually attract their patient populations so as to provide them with preventive and curative care and possess a high level of resolution capacity, referring only the more clinically complicated cases to higher levels. The RISS are an operational expression of the primary health care focus. They represent an organizational model whose primary objective is to ensure that health services are provided in a coordinated and timely manner through the different providers and levels of clinical complexity.

1.4 However, there are at least three obstacles to implementing these recommendations in Argentina. First, Argentina's health system is highly fragmented. There are three coexisting health coverage subsystems—welfare, private insurance, and public insurance only—that overlap in terms of financing and the populations they serve, with different service guarantees. At the same time, although the national government is the guarantor of the population's health, the management and financing of public health services fall mainly to subnational governments. This multiplicity of managers, sources of financing, and subsystems creates operational grey areas that hamper the implementation of public health policies and efforts to move patients smoothly, appropriately, and continuously along the lines of care according to their health condition (Tobar, et al., 2012).

1.5 Secondly, a specialized, curative approach to the treatment of chronic diseases predominates in the Argentine health system. This has fostered a disproportionate and passive routing of human and financial resources to more medically complex levels, to the detriment of primary health care. This has, in turn, reduced resolution capacity and hence demand for primary health care services (Tobar et al., 2012). This emphasis on medical complexity has also resulted in limited management capacity at subnational entities in terms of preventive care for chronic diseases. In particular, many of them do not have adequate information systems for epidemiological surveillance or evaluation of health policies for these pathologies (MSN; 2010).

1.6 Third, in addition to the fact that a significant percentage of the population does not get preventive health checkups, many of those who are diagnosed with chronic diseases or are at high risk of contracting them do not comply with pharmacological treatments that could be highly effective in controlling them (Pearson, et al., 1993). For example, a 2005 study found that 29% of adults in the city of Buenos Aires suffered from high blood pressure, and of these, 36% were unaware of their condition and only 18% was treated and controlled (Rubinstein, et al., 2014). To some extent, this is because health services are perceived as being low-quality, but also because there are information gaps among the population about the risk factors for chronic diseases, since these diseases initially develop asymptomatically, and because preventive services usually lack the flexibility to effectively serve a population with work-related constraints (IECS, 2015).[3]

1.7 In response to these challenges, the Multiphase Primary Health Care Program for Managing Chronic Noncommunicable Diseases expects that its two operations will promote the model of care for patients with chronic diseases based on a primary care approach and RISS operations.

3. Evaluation of Phase I (operation AR-L1142) and verification of Phase II triggers

1.8 In September 2012, the Board of Executive Directors approved the first operation of the multiphase program, the purpose of which is to help meet the targets for reducing morbidity and mortality caused by these pathologies under the 2011-2016 Federal Health Plan, prioritizing the population with public coverage only (without welfare or prepaid care) (29% of the population in 2013). Specifically, the operation sought to:

[3] In addition, the field of behavioral economics emphasizes the factor of "inconsistent preferences over time" for preventing chronic diseases and seeking timely care (Suhrcke, et al., 2006).

(i) prioritize primary health care as the gateway to the health system; (ii) increase the population's access to screening for classification of their health risk; and (iii) increase access to timely treatment for the population with high or moderate risk of suffering chronic diseases. The operation emphasized the detection and treatment of high blood pressure and diabetes from a primary health care perspective, considering that these diseases are tracers of the network of services involved in the health care lines for the principal chronic diseases. However, it also supported the detection of colorectal cancer on a pilot basis, with the expectation of expanding its scope in a second operation, once the evidence supporting that decision was produced. Thus far, the operation has disbursed 92% of its loan proceeds. The estimated completion date is September 2017.

1.9 The operation was structured with three components. The objective of the first component was to strengthen the clinical and health management of primary care service providers and to develop formal interfaces with higher levels of medical complexity, under the RISS model. This component financed the expansion of the REDES program,[4] seeking to cover at least 40% of the population with public coverage only. REDES financed jurisdictional investment projects (PJIs), identified jointly by the national and subnational health ministries. These PJIs were formulated based on a diagnosis of the main barriers to the operation of the health networks in specific territories and the prioritization of investments based on the resources available for each jurisdiction (allocated according to the percentage of the population with public coverage only residing in the respective jurisdiction). The PJIs financed the strengthening of primary health care centers (PHCCs), through the purchase of clinical, computer, and logistical equipment and minor building remodeling projects. The jurisdictions (23 provinces and the Autonomous City of Buenos Aires) accessed the financing for their PJIs based on meeting care targets (50%) and process targets (50%). The care targets were related to registration, classification, and monitoring of the population served by the PHCCs, based on population and epidemiological estimates done by REDES and validated with the jurisdiction. The process targets were related to improvements in clinical management (for example, shift scheduling or centers with decentralized blood sampling) or health management (for example, establishment of referral and counter-referral systems). The achievement of the jurisdictions' targets was audited externally. In addition, REDES provided training to more than 6,000 members of the PHCC health teams on the identification, classification, and treatment of chronic patients and on health planning.

1.10 The first component also financed the execution of 13 innovative projects, using the competitively awarded funds modality, presented by teams made up the directors of PHCCs and their referral hospital, seeking to identify solutions for the classification and effective monitoring of chronic patients that meet the specific challenges of their communities. Lastly, the first component financed the implementation and

[4] REDES promotes a model of care that integrates health care services along health care lines, starting with the active classification of the at-risk population and monitoring of the population at highest risk using specific treatment schemes.

evaluation of the pilot program for detection of colorectal cancer through PHCCs, belonging to the primary care level.[5]

1.11 The objective of the second component of the first operation[6] was to promote access to, and rational use of, essential medications for medical visits that can be handled in the PHCCs, specifically promoting the pharmacological treatment of patients with moderate or high total cardiovascular risk. Through the REMEDIAR program, the component financed the purchase of medications and logistical services for direct distribution to the PHCCs. The REMEDIAR protocol included second-line medications for the treatment of hyperlipidemia (statins) and high blood pressure (Amlodipine). The component also equipped more than 1,500 medication management units to improve their drug care and management. Lastly, it financed training for 8,500 members of the PHCCs teams on rational drug treatment (through university-provided courses) and on the rational use and care of medications.

1.12 The objective of the third component of the first operation was to promote the generation of timely and reliable information for clinical and healthcare management. To that end, it has computerized 547 PHCCs—prioritizing those with the most visits—for recording and dispensing medications, helping to improve the traceability of medications and their potential use for monitoring chronic patients. The component also financed the purchase of computer equipment, digitization services, and staff training for the expansion of two information systems involved in the cancer care line: the Institutional Tumor Registry of Argentina (RITA) and Screening Information System (SITAM). The RITA, expanded to include 12 hospitals, gathers demographic, diagnostic, and treatment information and information on events occurring with cancer patients. The SITAM, expanded to include 12 provinces, records the profile of results from cancer screening services and monitors the performance of services in terms of the quality of care.[7]

1.13 **Completion of Phase II triggers.** The Argentine Ministry of Health (MINSAL) demonstrated completion of the triggers for the second operation to the satisfaction of the IDB project team, including the completion of a series of studies and evaluations reporting, inter alia, on the outcomes achieved thus far by the first operation (see Table I.2).[8] These outcomes notably include:[9] (i) the effectiveness of REDES for promoting improvement in clinical and healthcare processes at the primary care level and increasing effective access to health services in general, particularly screenings and drug treatment for high blood pressure, high cholesterol, and high blood sugar (e.g., evaluation of the impact of REDES indicates a 4% increase in the percentage of those with high blood pressure who receive treatment, REDES, 2015); and (ii) the effectiveness of REMEDIAR in reducing the out-of-

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5 The first component has achieved financial execution of 91%. Extending the execution period will allow: (i) 13 of 24 jurisdictions that were late in beginning their jurisdictional projects to reach the minimum execution period of 18 months; (ii) accounting to be completed for the 13 innovative projects already begun; and (iii) the second stage of evaluation of the colorectal cancer pilot to be completed.

6 100% executed.

7 To date, this third component has achieved financial execution of 68%. It is anticipated that all its resources will be committed by October 2016, with the award from a bidding process on computer hardware, meeting the goal of 1,300 computerized PHCCs.

8 The means of verification are available in the optional electronic links (Milestones).

9 These studies are available in optional electronic links 2, 5, and 7.

pocket expenses of the population with public coverage only (REMEDIAR, 2013) and promoting equitable access to essential medications (UNLP, 2013).

Table I.2. Completion of Triggers for the Second Operation

Trigger	Completion level	Means of verification
(1) At least 50% of financing was disbursed or 75% was committed.	**Completed:** To date, 92% of financing has been disbursed and 100% is committed.	First six-monthly execution report of 2016.
(ii) The action plan for certification of critical REMEDIAR processes was approved at the ministerial level.	**Completed:** REMEDIAR achieved IRAM ISO 9001 certification for its critical processes "Receipt of medications and medical supplies" and "Shipment of logistics units (kits)."	Certificate issued by the Argentine Standardization and Certification Institute (IRAM) for both processes, effective for three years starting in January 2015.
(iii) At least 15 provinces successfully registered 80% and classified 40% of the REDES target population.	**Completed:** With a cutoff of April 2016, 15 provinces successfully registered at least 80% and classified 40% of the REDES target population. It is anticipated that by April 2017 at least 22 out of 24 jurisdictions will have exceeded these targets.	Certification of achievement of registration, classification, and monitoring targets issued by audit firm Crowe Horwath.
(iv) The priority evaluations indicated in the Agenda of Studies and Evaluations were completed.	**Completed:** All priority evaluations in the Agenda of Studies and Evaluations were completed.	Final report on the following outputs: (i) redistributive impact study of REMEDIAR; (ii) operational evaluation of logistical and internal audit processes of REMEDIAR; (iii) quanti-qualitative evaluation of the impact of REDES on the quality of care provided to those with total cardiovascular risk or high blood pressure and diabetes; and (iv) analysis of the feasibility of an evaluation on the effectiveness of different options for the classification and treatment of the population with total cardiovascular risk, within the REDES framework.
(v) At least 400 PHCCs are able to transfer nominal information on the dispensing of medications and/or monitoring of patients to the MINSAL systems.	**Completed:** 547 PHCCs are able to transfer nominal information on dispensing. Of these, 139 are already doing computerized dispensing of medication and reporting that information to the central level.	List of PHCCs with computer equipment for nominalized dispensing of medicines, including community, department, province, and remittance number.

4. Lessons learned

1.14 The principal lessons learned from execution of the first operation notably include: (i) at least half of the jurisdictions face extended delays in making the purchases provided in their PJIs or innovative projects, due to their own administrative and internal control processes, reducing the pace at which their RISS are strengthened; (ii) there is substantial room for improvement in coordination between REDES and other MINSAL programs, particularly the SUMAR program, a performance-based pay program at the PHCC level, under which coverage is gradually being extended to chronic conditions in adults; and (iii) there is potential for streamlining the movement of patients all along the health care line through innovations in the role of health care personnel.[10]

1.15 This second operation also incorporates some lessons learned from the execution of a series of loan and technical cooperation operations that the Bank has been implementing in the area of strengthening and evaluation of RISS with a focus on primary health care in Bolivia, Brazil, Colombia, Chile, and Ecuador. These lessons notably include: (i) the importance of explicitly identifying the geographic area and the population served by PHCCs; and (ii) the need to strengthen referral and

[10] As in the case of the “navigator,” originally intended to be responsible for ensuring the timely and reliable uploading of information to the RITA and SITAM, and who actually became a patient care coordinator.

counter-referral protocols and systems to ensure ongoing care for patients with chronic diseases from level to level of complexity.

1.16 Based on achievements made and lessons learned, the most important changes in the interventions planned for this second operation with respect to the first are as follows: (i) all financing for the purchase and distribution of medications will be funded with country resources and not be part of the lending program;[11] (ii) the qualifying conditions for REDES financing of the PJI will be adjusted in an effort to promote complementarity with the SUMAR program; (iii) REDES will be expanded from 40% to 70% of the population with public coverage only; (iv) purchases exceeding US$100,000 envisaged in the PJIs will be handled centrally by MINSAL, in order to streamline them; (v) implementation of the pilot colorectal cancer program will be expanded and pilots will be added for breast cancer and cervical cancer; (vi) RITA and SITAM will be fully expanded, and expansion of the Inpatient Pediatric Oncology Registry (ROHA) will be added; (vii) the position of cancer patient care coordinator (navigator) will be explicitly included as a strategy for promoting timely referral and counter-referral in the pilots and the quality of data input to the RITA, SITAM, and ROHA; and (viii) a pilot program of palliative cancer care at the PHCCs will be designed and implemented.

5. Strategic alignment

1.17 This operation is aligned with the national government's health strategy, which the Ministry of Health submitted to the Federal Health Council (COFESA) of the ministers of health from all the provinces and the Autonomous City of Buenos Aires in May of this year. The health strategy's primary objective is to promote universal health coverage (UHC). This objective, included as one of the Sustainable Development Goals, means that all people obtain the health services they need without suffering financial hardship when paying for them (WHO, 2014). The definition of the health package to be explicitly articulated within the UHC framework will be a task of the Agencia Nacional de Evaluación de Tecnologías en Salud [National Health Technologies Evaluation Agency], the bill for which is now before the National Congress. Other strategic pillars of the plan submitted to the Federal Health Council (COFESA) include extending support to the primary health care strategy and consolidation of the RISS.

1.18 This operation is consistent with the objective of the current country strategy with Argentina to strengthen and reorient services and health networks for better management of chronic noncommunicable diseases (document GN-2687).

1.19 The program is consistent with the Update to the Institutional Strategy (UIS) 2010-2020 (document AB-3008) and aligned with the development challenge of social exclusion and equality, responding directly to the challenge of adapting health systems to the changing epidemiological profiles in the population and improving equality in access to quality health services. The program is also aligned with the crosscutting area of gender equality and diversity, directly helping to respond to the challenge of reducing exclusion from effective access based on gender, in that it: (i) focuses on improving the quality of health care for the group of pathologies that

[11] The loan proposal for the first operation of the multiphase program anticipated a reduction in the percentage of Bank financing for medications, so that this recurrent cost would gradually be incorporated into the national budget.

create the greatest burden of disease on Argentine women; and (ii) addresses the challenge of closing the gap in access for men to screenings for timely detection of chronic diseases. The program will also contribute to the Corporate Results Framework 2016-2019 (CRF) (document GN-2727-6) through its expected impact on the country development results indicator of "Beneficiaries receiving health services," since over the course of the program more than 1.2 million people are expected to be screened for cardiovascular risk or breast, cervical, and colorectal cancer risk. The program is also consistent with the priority of addressing the double burden of the health transition in the Strategy on Social Policy for Equity and Productivity (document GN-2588-4). Lastly, the operation is consistent with the current Health and Nutrition Sector Framework Document (document GN-2735-3), which sets as its goal to promote better health among the population with equity, financial protection, and sustainability and, as a priority for Bank actions in the context of the region, to control the growing incidence of chronic noncommunicable diseases.

B. Objectives, components, and cost

1.20 The objective of this second operation is to help reduce morbidity and mortality caused by chronic noncommunicable diseases in Argentina, prioritizing the population with public coverage only. Specifically, this operation proposes to help: (i) prioritize the primary care level as the gateway to the health care system; (ii) increase the population's access to screenings for classification according to health risk; and (iii) increase access to timely treatment for the population with those with moderate or high health risk suffering from chronic conditions.

1.21 This second operation has two components:

1.22 **Component 1: Strengthening of primary health care.** The objective is to make the primary health care centers (PHCCs) more effective at getting their client population to seek them out for health care and addressing the reasons for their visit, either directly or through timely, formal referral and counter-referral to higher levels of clinical complexity. The component will ensure that: (i) PHCCs and other primary health care providers have better clinical, data processing, and logistical equipment and make minor building improvements; (ii) PHCC staff are better trained to care for the population in their charge and make rational use of the medications prescribed without cost to the population with public coverage only; and (iii) analytical and operational knowledge gaps are closed in relation to the treatment of patients at the primary health care level.

(i) **Subcomponent 1.1: Development of integrated health services networks (RISS).** Within the framework of the REDES program, a new phase will be financed for the jurisdictional investment projects (PJIs) to encompass communities where at least 70% of the population with public coverage only is concentrated. To enhance the impact of the PJIs, their financing will be contingent on the gradual achievement of milestones to be set in the program Operating Regulations. These milestones may include: (i) the technical and operational formulation of the PJIs and the administrative formation of networks with specific client populations and territories on the part of the jurisdictions; (ii) targets met for RISS strengthening indicators; (iii) the formulation and implementation of jurisdictional community communication strategies for the prevention and

timely detection of cardiovascular risk or hyperglycemia conditions; (iv) MINSAL certification of jurisdictional teams responsible for training and continuing education of primary health care teams in the clinical and health management of people with cardiovascular risk or hyperglycemia; and (v) MINSAL certification that a minimum number of the PHCCs carry out actions for the registration, classification, and monitoring of patients with cardiovascular risk or hyperglycemia on a regular basis and meet quality standards. Those jurisdictions will be eligible that, upon completion of the first operation of the program financed under loan contract 2788/OC-AR, have managed to achieve at least 90% and 60% of their registration and classification targets, respectively. There are also plans to train more than 4,000 members of health teams at the PHCCs in strategies related to improving the health care of the population in their charge. At least 40 innovative projects are also expected to be financed with funds awarded by competition, issuing a special request for proposals in communities with indigenous population.[12] Lastly, this subcomponent will finance the following knowledge products intended to test operational variations that could prove to be more effective for strengthening service offerings and generating behavioral changes in the population to increase their demand for screening services or adherence to treatments:[13] (i) evaluation of a PHCC certification mechanism within the REDES model; (ii) evaluation of a pilot program to promote personal responsibility for health among diabetics through personalized text messages; (iii) evaluation of a mechanism for cardiovascular risk classification in households within the REDES model; and (iv) the 2017 National Risk Factors Survey.

(ii) **Subcomponent 1.2: Equipping of primary health care providers.** Responding to the difficulties that many jurisdictions face in smoothly conducting the procurements provided in their PJIs, and seeking to produce economies of scale in those processes, the sourcing of clinical diagnostic equipment will be financed for more than 1,100 PHCCs through a centralized purchasing and distribution process.

(iii) **Subcomponent 1.3: Strengthening of the public medication management network.** Through the Universal Health Care Medications program[14] (once known as REMEDIAR), equipment will be provided to 1,300 new PHCCs to improve the pharmacological management of their patients, as well as to more than 1,500 PHCCs, medication warehouses, and hospital-based public pharmacies to improve the physical management of medications. Additionally, training will be provided to more than 15,000 members of primary health care level teams in the rational use and care of medications. Lastly, the subcomponent will finance the following knowledge products: (i) digitization of prescriptions in order to analyze the health impact of prescribing medications, inter alia; (ii) evaluation of the impact on clinical practice of training in the rational use

[12] 2.38% of Argentina's population, according to the 2010 census.

[13] Consult the Monitoring and Evaluation link for a description of these studies.

[14] Under Ministerial Resolution 642/2016, the name of the REMEDIAR Program was changed to CUS Medicamentos [Universal Health Coverage Medications].

of medications; and (iii) assessment of the impact of the Universal Health Care Medications program on promoting the population's access to primary health care.

1.23 **Component 2: Strengthening of the cancer care line.** This component has a two-fold objective to: (i) improve the effectiveness of the PHCCs in encouraging the population in their charge to get timely screenings for breast, cervical, and colorectal cancer; and (ii) contribute to improving oncological clinical management all along the line of care. The component will strive to ensure that (i) PHCCs have cost-effective screening tests for cervical and colorectal cancers; (ii) staff in those centers have the skills needed to perform the screens and proactively promote their population's access to them; (iii) the clinical histories of cancer patients are recorded on a timely and reliable basis; and (iv) analytical and knowledge gaps are closed with respect to the care of patients with cancer or at risk of cancer.

(i) **Subcomponent 2.1: Information systems for clinical and health management.** Under the technical direction of the Instituto Nacional del Cáncer[15] [National Cancer Institute] (INC), financing will be provided for computer equipment, data entry and management services, and training for data entry technicians so that the SITAM, RITA, and ROHA can be extended to 46, 50, and 39 new hospitals, respectively. The subcomponent will also finance a cost-effectiveness study of the interaction of health care coordinators and the SITAM, to improve the clinical management of cancer patients.

(ii) **Subcomponent 2.2: Strengthening of primary health care providers for cancer care.** Also under the technical direction of the INC and as a pilot program, financing will be provided to purchase more than 326,000 and 475,000 tests for human papilloma virus and occult blood tests and distribute them to jurisdictions where cervical and colorectal cancers are more prevalent. More than 5,000 health workers will also receive training to promote screenings for breast, cervical, and colorectal cancer and test for cervical and colorectal cancer. Lastly, this subcomponent will finance a study on the cost-effectiveness of capacity-building for the primary health care level in early detection of cancer and will design and implement a pilot program of palliative care through the PHCCs.

1.24 Table I.3 shows a breakdown of the operation's costs by component, subcomponent, and source of financing. The detailed breakdown of these costs can be consulted in the optional electronic links. The Bank financing will be disbursed according to the detailed schedule in optional electronic link 1 ("Project cost"). As established in document AB-2990, "Enhancing Macroeconomic Safeguards at the Inter-American Development Bank," the disbursement of the Bank loan proceeds will be subject to the following restrictions: (i) a maximum of 15% in the first 12 months; (ii) a maximum of 30% in the first 24 months; and (iii) a maximum of 50% in the first 36 months, running from the date the loan operation is approved by the Board of Executive Directors. These restrictions may not apply, insofar as the requirements set by the Bank with regard to them have been met, provided that the

[15] The INC is a MINSAL agency established by Presidential Decree 1286/2010.

borrower has been notified in writing. Table I.4 shows the program's projected disbursements.

Table I.3. Summary of Program Costs (rounded to US$000)

Component	IDB	Local	Total	%
Component 1	**93,848**	**37,086**	**130.934**	**78.88**
Subcomponent 1.1	54,470	16,580	71.050	42.80
Subcomponent 1.2	35,018	7,385	42.403	25.54
Subcomponent 1.3	4,360	13,121	17.481	10.53
Component 2	**4,296**	**24,141**	**28.437**	**17.13**
Subcomponent 2.1	1,810	13,888	15.698	9.46
Subcomponent 2.2	2,486	10,253	12.739	7.67
Administration and audit	**1,856**	**2,773**	**4.629**	**2.79**
Contingencies	**0**	**2,000**	**2.000**	**1.20**
TOTAL	**100,000**	**66,000**	**166.000**	**100.0**

Table I.4. Projected Disbursements

Year 1		Year 2		Year 3		Year 4		TOTAL	
IDB	Local Contribution	IDB	Local Contribution	IDB	Local Contribution	IDB	Local Contribution	IDB	Local Contribution
15,000,000	12,000,000	15,000,000	15,400,000	20,000,000	23,000,000	50,000,000	15,600,000	100,000,000	66,000,000

C. Key results indicators

1.25 Results Matrix indicators were established to measure the effective capacity of primary health care services to identify chronic conditions or risk of contracting them in their client population. These indicators are specifically designed to increase: (i) the percentage of the population with public coverage only who access screenings for high blood pressure, diabetes, and breast, cervical, and colorectal cancer; and (ii) the number of primary health care team members who demonstrate a satisfactory level (80%) of knowledge required to provide health care to the population in their charge who suffer from or at risk of suffering chronic diseases, as well as in rational use of medications. At the impact level, two types of indicators are proposed, focusing on the population with public coverage only. First, there are indicators that the literature has shown to be good approximations of successful treatment of chronic disease: (i) percentage of patients with high blood pressure and diabetics who are receiving drug treatment; and (ii) percentage of people in whom breast, cervical, or colorectal cancers are detected on a timely basis. Second, indicators related to improvement in the quality of care will be used: (i) effective access to health care services, in general; and (ii) length of time between suspected diagnosis of cancer and the start of treatment.

1.26 The "Economic analysis" annex presents a cost-benefit evaluation for the REDES program (Subcomponent 1.1) and a cost-effectiveness evaluation of the pilot for detection of colorectal cancer through the primary health care level (included in Subcomponent 2.1). The economic analysis of REDES was based on one of the conclusions from the first impact assessment: REDES successfully increases the number of people with high blood pressure and diabetes who access

pharmacological treatment (REDES, 2015). Based on this finding, the projected benefits of the program were calculated by adding: (i) health care costs savings for medical events associated with high blood pressure and diabetes to be avoided; and (ii) the net present value of years of life lost due to premature death to be avoided. Comparison of these benefits with the total cost of REDES yielded a ratio of 2.4 to 1.[16] In addition, a cost-effectiveness analysis was done for the quality-adjusted life years (QALY) lost, comparing the screening tests proposed for use in this operation, the occult blood test based on immunochemical tests (SOMFi), and the screening option based on colonoscopies. Compared with the option of no screening, the use of the SOMFi and colonoscopy have incremental cost-effectiveness rates of US$115.8 and US$179.2 per QALY, respectively (at an exchange rate of 8.46). Following the guidelines of the World Health Organization for developing countries (as well as colonoscopy) proves to be a highly cost-effective approach for Argentina (Espínola, et al., 2015).

II. Financing Structure and Main Risks

A. Financing instruments

2.1 This operation is the second in a series of two loans to be financed through a multiphase program with a total lending envelope of US$250 million. The amount financed for this second operation will be US$100 million with a local counterpart of US$66 million. This instrument has proved to be effective in providing continuity to the Bank's support for Argentina in a problem area that necessarily requires a medium-term policy intervention. In particular, it has enabled a general policy framework to be maintained that is flexible enough for technical and operational learnings to mature, so that their design can be improved and adapted as the general policy direction has changed across national government administrations.

B. Environmental and social safeguard risks

2.2 This operation has been classified as category "C." The project team will ensure compliance with the Environment and Safeguards Compliance Policy (Operational Policy OP-703) and the Operational Policy on Indigenous Peoples (Operational Policy OP-765) during execution. During the first year, REDES will issue an exclusive request for proposals (RFP) for innovative projects for health teams serving the indigenous population. The Jurisdictional Management Units (UGJ) will be responsible for promoting the RFP broadly among the health teams and indigenous communities they serve, targeting the participation of teams in remote communities. The operating regulations of the RFP will emphasize how important it is for these projects to generate lessons that can be rolled out to other communities and provide feedback for the design of the program in the years following execution of the operation.

C. Fiduciary risks

2.3 The IDB's project risk management (PRM) methodology was used to analyze the risks of the operation in general. The questionnaire from the implementation guide for the institutional capacity assessment platform was used to evaluate the executing

[16] A discount rate of 11% was used to discount the flow of future values in the economic evaluation of REDES. The sensitivity analysis showed that the estimate is robust against changes in this rate.

agency's ability to manage procurement and determine risk. The executing agency's ability to plan, execute, and implement actions to control resources (Institutional Capacity Assessment System) was assessed, yielding a medium level of risk (owing to bottlenecks at the jurisdictional level), although it should be noted that the executing agency has adequate operational, technical, and human resource capacity for satisfactory execution of the program.

2.4 A "high" development risk was identified that has fiduciary implications for Subcomponent 1.1, where the jurisdictions serve as subexecuting agencies: delay in the decentralized investments they make due to slow administrative purchasing channels and internal controls. Should this risk materialize, it would cause: (i) delays in strengthening resolution capacity at the primary care level; and (ii) delays in meeting the conditions authorizing disbursement of funds to the jurisdictions. Mitigating measures include: (i) strengthening the executing agency's ability to support the jurisdictions in their procurement processes; (ii) incorporating conditions promoting execution of the draft management agreements that the jurisdictional health ministries sign with the central level; and (iii) incorporating minimum execution conditions as criteria for monitoring the jurisdictions' eligibility to participate in REDES. Another medium-level fiduciary risk was identified in the same subcomponent relating to the delay in accounting for the funds disbursed to those implementing innovative projects. To mitigate this risk, the UGJs (implementers of the REDES program in each jurisdiction) will provide support to the implementers and will produce instructions for accounting for resources.

D. Other project risks

2.5 The project's second high-level risk corresponds to Subcomponent 1.2 (centralized purchasing of equipment). The fledgling nature of the process of defining an equipment sourcing plan taking into account potential demand at the subnational level and existing conditions for the equipment's use and maintenance, carries the risk of reducing the effectiveness of the investment. To mitigate this risk, the Bank has agreed with the executing agency to include a special execution condition as described in paragraph 3.7(ii), and technical advisory services will be provided for meeting that condition. A second, medium-level development risk was identified related to the early stage of human resources training at the primary health care level in the area of cancer care: the risk that the training sessions provided to heath care providers will not be as effective as anticipated in terms of the number of people who access screenings. To mitigate this risk, the Bank will actively support the INC in the identification of good practices and in the development of instruments for evaluating the training sessions.

2.6 The sustainability risk of the project's expected outcomes is low, since: (i) the program is designed to fully use the MINSAL line structure; (ii) the planned actions are directly related to the major areas of strategic focus of the government plan submitted to the COFESA; and (iii) the executing agency's high operational and analytical capacity has been demonstrated and will be consolidated in this second operation.

III. Implementation and Management Plan

A. Summary of implementation arrangements

3.1 The Argentine Republic will act through the Argentine Ministry of Health (MINSAL), which will be the project executing agency. MINSAL will perform this role through the Department of Promotion, Health Programs, and Community Health (SPPSSC)[17] in its capacity as the program's National Directorate. The technical unit will report to SPPSSC and will include the coordinators the REDES and Universal Health Care Coverage Medications programs and the National Cancer Institute (INC). In addition, the International Financing Unit of MINSAL (UFI-S),[18] reporting to the Office of the Undersecretary for Administrative Coordination, will be responsible for the fiduciary and administrative and financial management aspects of the program. The Operating Regulations will establish the organizational roles of the UFI-S and the technical unit.

3.2 The executing agency will be responsible for the general implementation of the program components, as provided in the loan contract and in the program Operating Regulations, and for implementing the program monitoring and evaluation plan. The technical unit will implement the technical activities planned in the program at the central level, including: (i) advisory services and approval of the PJIs and innovative projects; (ii) content design and implementation of training sessions for health term personnel; (iii) development of technical specifications for goods procurement, in conjunction with the UFI-S; and (iv) the design and monitoring of compliance with the terms of reference for consulting services, in conjunction with the UFI-S. The technical implementation of Subcomponents 1.1 and 1.3 will be the responsibility of REDES and Universal Health Care Coverage Medications, respectively. The SPPSSC will conduct the technical execution of Subcomponent 1.2 directly. The INC will be responsible for the technical execution of Component 2.

3.3 For the execution of Subcomponent 1.1 at the local level, the jurisdictions will set up UGJs, coordinated by a line organization official from the jurisdictional ministries. The UGJs will primarily be responsible for: (i) preparation and implementation of the jurisdictional investment projects (PJIs) with advisory support and supervision from REDES; and (ii) compliance with the eligibility and qualifying conditions for financing of the PJIs. The basic characteristics, functions, and obligations will be established in the management agreements signed by the executing agency and the respective jurisdiction and in the program Operating Regulations.

3.4 The program Operating Regulations will detail the guidelines to be followed in order for a jurisdiction to be eligible as a beneficiary of Subcomponent 1.1, which will include the following: (i) execution of the PJIs and innovative projects is included in the budgetary legal framework of the jurisdictional ministry; (ii) procurements are subject to jurisdictional oversight; (iii) the flow of funds under the PJIs is reported, and the assets acquired with them are recorded as such; (iv) the jurisdiction maintains a minimum level of commitment of transferred funds; and (v) the UFI-S certifies compliance with the Bank's procurement policies by the UGJ and with the

[17] Decree 114/2016 establishes the objectives of the SPPSSC, which include planning and coordinating actions for the prevention and control of the country's most significant diseases and health risks.

[18] The UFI-S was originally created by Resolution 28/2000.

maximum procurement amounts specified in the program Operating Regulations, to be conducted by the respective UGJ. The program Operating Regulations will also include the penalties for failure to comply with these guidelines. In addition, the program Operating Regulations will specify the milestones that the jurisdictions must meet to receive financing for their PJIs, subject to prior verification by a medical auditing firm to be engaged using the loan proceeds. Transfers made to jurisdictions that comply with the eligibility guidelines and the respective audited milestones will be directly eligible for submission to the Bank in accounting for advances.

3.5 Annex III presents the fiduciary arrangements for execution in terms of disbursement modalities, financial administration and procurement systems, and auditing arrangements. It is anticipated that the Bank will make disbursements in the form of advances of funds. The minimum percentage required to replenish the advance will be 80%. The external audit will be conducted through a Bank-eligible independent audit firm. The procurement of works and goods and the contracting of consultants, chargeable to the operation's financing, will follow Bank policies (documents GN-2349-9 and GN-2350-9, respectively).

3.6 **Single-source selection of the National Institute of Statistics and Censuses (INDEC)** is planned for oversampling of the National Risk Factor Survey (ENFR) in 2017 in communities where the REDES program is being implemented; this will enable a statistically robust evaluation of that program. INDEC conducted the ENFRs for 2005, 2009, and 2013 satisfactorily, and plans to do so again in 2017 with domestic financing that is being counted as the local contribution for this loan operation. Accordingly, consistent with the Policies for the Selection and Contracting of Consultants Financed by the Inter-American Development Bank (document GN-2350-9, paragraph 3.10.d), single-source selection of the INDEC is planned for oversampling of the 2017 ENFR, considering that: (i) INDEC has the local knowledge and experience necessary to properly perform the oversampling; (ii) INDEC is the national agency responsible for conducting the ENFRs; and (iii) the quality of the oversampling requires a sampling, operational, and technical approach analogous to the one taken by INDEC in 2005, 2009, and 2013, and again in 2017.

3.7 **Contractual special conditions precedent to the first disbursement of the loan proceeds: The executing agency has: (i) put the program Operating Regulations into effect by ministerial resolution on the terms previously agreed upon with the Bank; and (ii) issued a ministerial resolution (a) assigning the national management of the program to the Department of Promotion, Health Programs, and Community Health (SPPSSC); (b) forming the technical unit, reporting to the SPPSSC and including the coordinators of the REDES and Universal Health Care Coverage Medications programs and the National Cancer Institute (INC); and (c) assigning responsibility to the International Financing Unit of MINSAL (UFI-S) for the fiduciary and administrative/financial management aspects of the program.**

3.8 Contractual special execution conditions: The executing agency has: (i) signed a management agreement with the respective jurisdiction on the terms and conditions established in the program Operating Regulations, before resources are transferred to that jurisdiction to finance the expansion of (a) jurisdictional investment projects (PJI) and innovative projects; and (b) the Institutional Tumor Registry of Argentina (RITA), Screening Information System (SITAM), and Inpatient Pediatric Oncology

Registry (ROHA), as provided in Subcomponents 1.1 and 2.1, respectively; and (ii) obtained the Bank's approval for an equipment sourcing plan for the primary care level, including at least: (a) technical justification of the type of equipment to be purchased and distributed to primary care level practitioners; (b) a strategy for equipment repair and maintenance; and (c) the technical criteria for distribution among and within jurisdictions. The Bank's approval for the equipment sourcing plan must be obtained before the first call for bids using funds allocated to Subcomponent 1.2.

B. Summary of arrangements for monitoring results

3.9 Every six months the executing agency will submit reports with information on: (i) performance in achieving the agreed objectives and outcomes in each annual work plan (AWP) and in the project monitoring report (PMR), including analysis and monitoring of the risks affecting them and mitigation measures; (ii) execution status and status of the procurement plan; (iii) compliance with contractual conditions; and (iv) the financial execution status of the program budget. In addition, the report for the second half of each calendar year will include: (i) the AWP for the following year; (ii) the updated procurement plan; and (iii) the actions planned for implementing the recommendations of the external audit, as applicable.

3.10 The "Monitoring and evaluation" link describes the methods and data to be used in reporting on the achievement of outputs, outcomes, and impacts provided in the operation's Results Matrix. The use of national surveys and information systems for estimating the achievement of results and impacts is noteworthy.

Development Effectiveness Matrix			
Summary			
I. Strategic Alignment			
1. IDB Strategic Development Objectives	**Aligned**		
Development Challenges & Cross-cutting Themes	**-Social Inclusion and Equality -Gender Equality and Diversity**		
Regional Context Indicators			
Country Development Results Indicators			
2. Country Strategy Development Objectives	**Aligned**		
Country Strategy Results Matrix	**GN-2687**	**Strengthen and re-orient services and health networks for better management of chronic non-transmissible diseases.**	
Country Program Results Matrix	**GN-2849**	**The intervention is included in the 2016 Operational Program.**	
Relevance of this project to country development challenges (If not aligned to country strategy or country program)			
II. Development Outcomes - Evaluability	**Highly Evaluable**	**Weight**	**Maximum Score**
	9.8		**10**
3. Evidence-based Assessment & Solution	**10.0**	**33.33%**	**10**
3.1 Program Diagnosis	**3.0**		
3.2 Proposed Interventions or Solutions	**4.0**		
3.3 Results Matrix Quality	**3.0**		
4. Ex ante Economic Analysis	**10.0**	**33.33%**	**10**
4.1 The program has an ERR/NPV, a Cost-Effectiveness Analysis or a General Economic Analysis	**4.0**		
4.2 Identified and Quantified Benefits	**2.4**		
4.3 Identified and Quantified Costs	**1.5**		
4.4 Reasonable Assumptions	**1.5**		
4.5 Sensitivity Analysis	**1.5**		
5. Monitoring and Evaluation	**9.5**	**33.33%**	**10**
5.1 Monitoring Mechanisms	**2.0**		
5.2 Evaluation Plan	**7.5**		
III. Risks & Mitigation Monitoring Matrix			
Overall risks rate = magnitude of risks*likelihood	**Medium**		
Identified risks have been rated for magnitude and likelihood	**Yes**		
Mitigation measures have been identified for major risks	**Yes**		
Mitigation measures have indicators for tracking their implementation	**Yes**		
Environmental & social risk classification	**C**		
IV. IDB´s Role - Additionality			
The project relies on the use of country systems			
Fiduciary (VPC/FMP Criteria)	**Yes**	**Financial Management: Budget, Accounting and Reporting, External control. Procurement: Information System.**	
Non-Fiduciary	**Yes**	**Statistics National System.**	
The IDB's involvement promotes additional improvements of the intended beneficiaries and/or public sector entity in the following dimensions:			
Gender Equality			
Labor			
Environment			
Additional (to project preparation) technical assistance was provided to the public sector entity prior to approval to increase the likelihood of success of the project	**Yes**	**Technical assistence was provided through operation AR-T1087.**	
The ex-post impact evaluation of the project will produce evidence to close knowledge gaps in the sector that were identified in the project document and/or in the evaluation plan	**Yes**	**There are no previous expost evaluations with data on adherence to oncological screening and services response capacity in positive cases in real conditions. Through the SITAM it will be possible to carry out this sort of analyses.**	

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

The Second Operation of the Multiphase Program for Primary Health Care Management of Chronic Non-Communicable Diseases aims to contribute to reduce the morbidity and mortality caused by chronic non-communicable diseases in Argentina, giving priority to people with exclusive public coverage. Specifically, it is proposed to contribute to: (i) prioritize the first level of care (PNA) as a gateway to the health system; ii) increase access of the population to screening for health risks; and (iii) increase access of the population with moderate or high health risk suffering from chronic conditions to timely treatment.

The vertical logic of the program presented in the POD and Monitoring and Evaluation Annex is adequate. The results matrix includes indicators for major outputs, outcomes and impacts of the program. The indicators in the results matrix meet the SMART criteria and include baseline values and yearly goals. The indicators of expected impact are related to: i) the percentage of hypertension and diabetes with drug treatment, ii) the percentage of women diagnosed with breast cancer, precancerous high-grade lesion or cervical cancer in early stages compared to the total of women diagnosed, iii) the percentage of people diagnosed with precancerous lesions or early-stage colorectal cancer compared with total of people diagnosed, and iv) the average time from getting a diagnosis of cancer to obtaining a definitive treatment.

The document presents an economic analysis with a cost-benefit analysis for the subcomponent of REDES and a cost effectiveness analysis for the pilot intervention of the cervical and colorectal cancer screening. According to the analysis, the interventions are profitable and cost-effective respectively.

The executing agency will be responsible for performing the monitoring and evaluation of the main products. The monitoring and evaluation activities have been budgeted and planned. Data sources for monitoring include reports, medical audits, and reports from the screening information system. Several evaluations, including impact evaluations (one experimental and one quasi-experimental), an analysis of cost-effectiveness and other qualitative assessments, are planned.

RESULTS MATRIX

Objective:	To help reduce morbidity and mortality caused by chronic noncommunicable diseases in Argentina, prioritizing the population with public coverage only.[1]

EXPECTED IMPACT

Indicators	Unit of measure	Baseline		Targets[2]		Means of verification
		Value	Year	Value	Year	
People with high blood pressure between the ages of 40 and 65 treated with drugs out of the total number of those with high blood pressure in the same age range.	%	62.3	2013	67.2	2018	REDES impact evaluation report
Diabetics between the ages of 40 and 65 treated with drugs out of the total number of diabetics in the same age range.	%	47.5	2013	52.1	2018	
Women between the ages of 50 and 69 diagnosed with early stage breast cancer[3] out of the total number of women registered in the same age range with a diagnosis of breast cancer.	%	43.2	2015	49.4	2019	Reports from Screening Information System (SITAM)
Women between the ages of 30 and 64 diagnosed with a high grade precancerous lesion or early stage cervical cancer[4] out of the estimated total number of women in the same age range with precancerous lesions and cervical cancer.[5]	%	10.0	2015	18.0	2019	SITAM reports
People between the ages of 50 and 75 diagnosed with precancerous lesions or early stage colorectal cancer[6] out of the total number of people screened in the same age range with a diagnosis of precancerous lesions or colorectal cancer.[7]	%	51	2015	60	2019	
Average time elapsed between suspected diagnosis[8] of cancer and start of definitive treatment (surgery, radiation therapy, or chemotherapy).	Days	150	2015	100	2019	

1 Uninsured population (without welfare or prepaid care). All impact and outcome indicators refer to the population with public coverage only.

2 The access, screening, and treatment goals for those with high blood pressure and diabetes were estimated by calculating their minimum detectable effect based on 2013 ENFR data. These targets are commensurate with the impacts found in the first REDES impact evaluation. The estimated targets for the cancer screening and treatment indicators reflect the National Cancer Institute's objective of improving them by 20%, which was estimated based on current and projected coverage of screening for the next three years.

3 "Early stage" breast cancer is defined as stages I and II, based on possible surgical treatment and effectiveness of treatment.

4 High grade precancerous cervical lesions are those in which atypical tissue cells occupy two thirds of the thickness of the surface layer of the cervix (CIN2). If those cells encompass the full thickness of the surface layer of the cervix but have not spread (CIN3), it is considered carcinoma in situ, i.e., it is already early stage.

5 The indicators for cervical cancer refer only to the provinces that are part of the respective pilot program: Buenos Aires, Catamarca, Chaco, Entre Ríos, Formosa, Jujuy, La Rioja, Mendoza, San Luis, Santa Fe, Santiago del Estero, and Tucumán.

6 "Precancerous lesions" are understood to mean premalignant lesions that may become cancer if not detected and removed in time (adenomas). "Early stages" are understood to mean stages I and II, when the cancer is only in the colon and/or rectum, i.e., before it spreads to nearby organs or regional lymphatic nodes.

7 This indicator refers only to the provinces that will be part of the second phase of the pilot for early detection of colorectal cancer: Misiones, Tucumán, Santa Fe, La Pampa, La Rioja, Mendoza, Neuquén, Río Negro, and Chubut.

8 Suspected diagnosis refers to suspicious clinical exam or symptom leading to the health visit.

EXPECTED OUTCOMES

Expected outcomes	Unit of measure	Baseline		Intermediate		Targets		Means of verification
		Value	Year	Value	Year	Value	Year	
People between the ages of 40 and 65 who used health services in the last month, out of the total number of people in the same age range and in the same time period who used those services or did not, with symptoms or health problems.	%	75.0	2013	-	-	79.3	2018	REDES impact evaluation report
Milestone: People who undergo at least one screening for cardiovascular risk or breast, cervical, or colorectal cancer at primary health care centers (PHCCs) covered by the program.[9]	People	0	2015	250,000	2018	450,000	2019	Six-monthly reports
People between the ages of 40 and 65 who report having had a blood pressure measurement in the last two years out of the total number of people in the same age group.	%	72.0	2013	-	-	76.5	2018	REDES impact evaluation report
People between the ages of 40 and 65 who had a blood glucose measurement once out of the total number of people in the same age group.	%	74.0	2013	-	-	78.4	2018	
Women between the ages of 50 and 69 years who have had at least one mammogram in the last 24 months out of the total number of women in the same age group.	%	8.12	2015	-	-	10	2019	SITAM reports
Women between the ages of 30 and 64 with at least one cervical cancer screening according to clinical practice guidelines[10] out of the total number of women in the same age range.	%	15	2015	-	-	18	2019	SITAM reports
People between the ages of 50 and 75 with at least one colorectal screening in the last two years out of the total number of people in the same age range in the provinces.	%	5	2015	-	-	6.6	2019	
Primary health care staff who demonstrate knowledge of at least 80% in health care improvement strategies.	People	6,070	2017	8,170	2018	10,270	2019	Evaluations of participants from the respective training sessions
Primary health care physicians who demonstrate knowledge of at least 80% in rational drug treatment.	People	1,800	2015	5,600	2018	7,600	2019	
Primary health care workers who demonstrate knowledge of at least 80% in the prevention and early detection of cancer.	People	0	2016	1,900	2018	3,645	2019	

[9] This indicator corresponds to Indicator 9 of the IDB's 2016-2019 Corporate Results Framework.

[10] If the screening is done with the human papilloma virus test, at least one in the last five years is considered. In the case of the Pap smear, at least one in the last three years is considered.

OUTPUTS

Outputs	Estimated cost (US$)	Unit of measure	Baseline	2017	2018	2019	2020	End target	Means of verification
Component 1: Strengthening of the primary health care level									
REDES projects being executed, three per year	65,129,377	Jurisdictions per year	0	20	20	4	4	48	Concurrent medical audit
Milestone: PHCCs with scheduled visits systems.		PHCCs	1,115	0	285	1,100	0	2,500	
Milestone: PHCCs able to take blood samples on a decentralized basis.		PHCCs	917	0	283	300	0	1,500	
Milestones: PHCCs that certify their processes for identifying population in their charge and risk status.		PHCCs	0	0	875	1,625	0	2,500	
Primary health care staff trained in health care improvement strategies.	4,179,731	People	6,070	0	2,100	2,100	0	10,270	Six-monthly reports
REDES innovative projects completed.	622,900	Projects	13	0	10	30	0	53	
Milestone: Innovative REDES projects being executed in localities with indigenous population.		Projects	0	0	2	3	0	5	
Evaluation of pilot certification of PHCCs in REDES completed.	110,000	Report	0	0	0	1	0	1	
Evaluation of pilot to promote personal responsibility for health among diabetics completed.	230,546	Report	0	0	0	1	0	1	
Evaluation of alternative mechanism for classification and treatment of cardiovascular risk completed.	208,000	Report	0	0	0	1	0	1	
2017 National Risk Factors Survey completed.	570,000	Report	0	1	0	0	0	1	
PHCCs equipped for improving clinical diagnosis	29,666,980	PHCCs	0	0	0	0	1,774	1,774	
PHCCs equipped for improving pharmacological management.	2,185,625	PHCCs	1,000	0	0	520	780	2,300	
PHCCs, warehouses, and hospital pharmacies equipped for improving drug management.	10,549,860	Medication management units	1,510	0	0	616	924	3,080	
Prescription batches reports completed.	902,200	Reports	0	1	1	0	0	2	
Evaluation of change in clinical practice with training in rational drug use completed.	45,000	Report	0	1	0	0	0	1	
Evaluation of universal health care coverage medications in prioritization of primary health care level completed.	250,000	Report	0	0	0	1	0	1	
Health personnel trained in rational drug treatment, care of medications, and operations of the medications program.	16,283,487	People	8,500	5,000	5,000	5,000	0	23,500	

Outputs	Estimated cost (US$)	Unit of measure	Baseline	2017	2018	2019	2020	End target	Means of verification
Component 2: Strengthening of the cancer care line									
Hospitals recording in the Screening Information System.	11,279,228	Hospitals	115	12	18	16	0	161	Six-monthly reports
Hospitals recording in the Institutional Tumor Registry of Argentina	4,011,162	Hospitals	18	12	24	14	0	68	
Hospitals recording in the Inpatient Pediatric Oncology Registry	362,536	Hospitals	35	10	14	15	0	74	
Evaluation of cost-effectiveness of the Screening Information System and the use of navigators completed	45,000	Report	0	0	0	1	0	1	
HPV tests distributed.	7,597,910	Tests	0	84,000	105,270	136,800	0	326,070	SITAM
Occult blood tests distributed.	2,679,135	Tests	40,000	45,000	90,000	300,000	0	475,000	
Health workers trained in prevention and early detection of cancer at the primary health care level.	1,421,700	People	739	1,450	1,565	2,100	0	5,854	Six-monthly reports
Evaluation of cost-effectiveness of strengthening the capacity of primary health care level for early detection of cancer completed.	45,000	Report	0	0	0	1	0	1	
Report on evaluation of Palliative Care Pilot Project	995,691	Report	0	0	0	1	0	1	

FIDUCIARY AGREEMENTS AND REQUIREMENTS

Country:	Argentina
Project number:	AR-L1196
Name:	Program for Managing Chronic Noncommunicable Diseases (Phase II)
Executing agency:	Argentine Ministry of Health (MINSAL) – International Health Financing Unit
Prepared by:	Marisol Pinto Bernal (FMP/CAR); Teodoro Noel (FMP/CAR); and Carlos Carpizo (FMP/CAR)

I. EXECUTIVE SUMMARY

1.1 MINSAL will execute the program through the Department of Promotion, Health Programs, and Community Health (SPPSSC) in its capacity as the program's National Directorate. The International Financing Unit (UFI-S), reporting to MINSAL's Office of the Undersecretary for Administrative Coordination, will be responsible for the fiduciary aspects and administrative and financial management of the program.

1.2 The questionnaire from the implementation guide for the institutional capacity assessment platform (ICAP) was used to determine the operation's risk in the procurement area. The executing agency's ability to plan, execute, and implement actions to control resources (Institutional Capacity Assessment System) was assessed in terms of financial risk, and it was determined that the executing agency has adequate operational, technical, and human resource capacity for satisfactory execution of the program. However, it was determined that, while the conditions for execution are guaranteed at the central level, given the degree of procedural autonomy, at the provincial level these conditions are not a given, primarily due to internal channels and controls that slow down the processes. Based on the foregoing, there is clearly much room for improvement at the provincial level in terms of the internal processes currently used in the procurement cycle.

II. FIDUCIARY CONTEXT OF THE EXECUTING AGENCY

2.1 Execution of the Program to Strengthen the Primary Health Care Strategy (loan 1903/OC-AR) was completed last year, and the Bank is currently financing the first operation of the Multiphase Primary Health Care Program for Managing Chronic Noncommunicable Diseases (loan 2788/OC-AR). It should be noted that the nature of Component 1 of loan 2788/OC-AR is the same as that of operation AR-L1196.

2.2 The fiduciary systems used for program execution are the Budget system, through the Integrated Financial Information System (SIDIF), and the Information and Accounting System (UEPEX).

2.3 For actions related to the procurement of goods and services, the UFI-S uses the Bank's policies for centralized purchases and verifies that they are used for purchases made at the provincial level.

2.4 However, while it has been possible to determine that execution conditions are guaranteed at the central level, these conditions are not a given at the provincial level owing to the degree of procedural autonomy, primarily due to internal channels and controls that slow down the processes. Based on the foregoing, there is clearly much room for improvement in terms of the processes currently used in the procurement cycle.

III. Fiduciary Risk Evaluation and Mitigation Measures

3.1 The institutional capacity analysis was done with the participation of executing agency staff currently responsible for the execution of loan 2788/OC-AR. The analysis yielded a medium level of risk, due to the complexity of a decentralized execution structure.

3.2 Based on these identified risks, the method of supervision applicable for financial management and procurement management has been determined. The supervision method initially established may vary during program execution based on the evaluations performed.

3.3 Based on the Institutional Capacity Assessment System (ICAS) analysis, no observations have been identified that would represent fiduciary risks for project execution, since the project is decentralized and the Bank would be recognizing the investment with the transfer of resources to the provinces.

Institutional capacity and fiduciary risk				
Institutional capacity		*ICAP (procurement) and ICAS (financial management)*	**Tool:**	*ICAP questionnaire (procurement) and ICAS (financial management)*
Fiduciary risk		*Medium*	**Tool:**	*ICAS/ICAP*
Type of risk[1]	**Risk**	**Rating**	**Mitigation measures**	
Dev. and Fin. Mgmt.	Delays in the financial execution of transfers to the provinces	HIGH	Establish the eligibility criteria in the Operating Regulations for provinces to receive loan proceeds.	
			Ensure that eligible provinces are using the UEPEX system to record their planning, contractual commitments, and accounting for expenditures.	
			Maintain control of flows of funds with the provinces.	
Proc.	Delays in procurement at the provincial level	MEDIUM	Analyze internal processes (through the UFI-S) at the provincial level to help teams to identify main bottlenecks.	
			Strengthen the teams of the UGIs with fiduciary staff to guarantee timely and substantive execution of procurements conducted in the context of transfers.	
			UFI-S support to the provinces for conducting and monitoring procurement processes.	

[1] Development (Dev.); Financial management (Fin. Mgmt.); Procurement (Proc.).

IV. Considerations for the Special Provisions of the Contract

4.1 To streamline contract negotiation by the project team, and especially the Legal Department, below are the agreements and requirements to be considered as applicable in the Special Provisions or in the Sole Annex, which may be updated or amended during program execution, as applicable, and with prior documentation and authorization from the Bank:

a. **Management of disbursements.** The executing agency must submit the financial planning for the program in accordance with the guidelines agreed upon between the Bank and the country. The minimum percentage required to replenish the advance will be 80%.

b. **Exchange rate.** For the purposes of Article 4.10 of the General Conditions, the parties agree that the applicable exchange rate will be the rate stipulated in Article 4.10(b)(i). For the purpose of determining the equivalency of expenditures incurred in local currency chargeable against the local contribution, the agreed exchange rate will be the rate in effect on the first business 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 respective payments to the contractor, vendor, or beneficiary. For the purpose of determining the equivalency of the reimbursement of expenditures against the local proceeds, the agreed exchange rate will be the rate in effect on the first business day of the month in which the reimbursement request is submitted. Additionally, in view of the limitations of the UEPEX system, the exchange rate stipulated in Article 4.10(b)(i) of the General Conditions will be used to determine the equivalency of expenditures incurred in local currency chargeable against the loan proceeds and the local contribution.

V. Agreements and Requirements for Procurement Execution

1. Procurement execution

5.1 The various types of procurements of goods, works, nonconsulting services, and consulting services executed under the program will be conducted in accordance with policy documents GN-2349-9 and GN-2350-9 of March 2011, respectively. As mentioned earlier in this document, the UFI-S has experience in the management of Bank operations and, according to the analysis done, also possesses knowledge and experience in handling the above-mentioned policies.

5.2 The proceeds from transfers made under the program will be managed on a decentralized basis under the supervision of the UFI-S, according to the breakdown established in the program Operating Regulations.

a. **Procurement of works, goods, and nonconsulting services.** Contracts for works, goods, and nonconsulting services[2] under the project and subject to international competitive bidding (ICB) will be executed using the standard bidding documents (SBDs) issued by the Bank. Those subject to national

[2] Policies for the Procurement of Goods and Works Financed by the Inter-American Development Bank (document GN-2349-9), paragraph 1.1: Nonconsulting services are treated as goods.

competitive bidding (NCB) will be executed using country bidding documents agreed upon with the Bank. No direct contract is envisaged in these categories, but any established during the course of the program will be identified in the procurement plan with the respective justification, identifying any selection procedures requiring prequalification of bidders.

b. **Selection and contracting of consultants.** Consulting services contracts under the project will be included in the procurement plan and executed using the standard request for proposals (SRP) issued by the Bank.

- **Single-source selection of the National Institute of Statistics and Censuses (INDEC)** is planned for oversampling of the National Risk Factor Survey (ENFR) in 2017 in communities where the REDES program is being implemented; this will enable a statistically robust evaluation of that program. INDEC conducted the ENFRs for 2005, 2009, and 2013 satisfactorily, and plans to do so again in 2017 with domestic financing that is being counted as the local contribution for this loan operation. Accordingly, consistent with the Policies for the Selection and Contracting of Consultants Financed by the Inter-American Development Bank (document GN-2350-9, paragraph 3.10.d), single-source selection of the INDEC is planned for oversampling of the 2017 ENFR, considering that: (i) INDEC has the local knowledge and experience necessary to properly perform the oversampling; (ii) INDEC is the national agency responsible for conducting the ENFRs; and (iii) the quality of the oversampling requires a sampling, operational, and technical approach analogous to the one taken by INDEC in 2005, 2009, and 2013, and again in 2017.

- **Selection of individual consultants.** In cases identified in the procurement plan, the contracting of individual consultants will be governed by the provisions of document GN-2350-9, Section V, paragraphs 5.1 to 5.4. For the operation of the UFI-S, the single-source selection method may be used to contract consultants then performing activities under contracts financed by other programs executed by the UFI-S.

- **Training.** The procurement plan describes the processes applied to project components. This includes training components that are contracted as consulting services or nonconsulting services, as applicable in each case.

c. **Recurrent expenditures.** Recurrent expenditures or operation and maintenance expenditures required during the program will be: travel, per diems, transportation, service and equipment rental, office maintenance, stationery and training expenses, graphic arts products, printing, publications and reproduction, courier and mail service, cleaning services, data processing inputs, insurance, telephone service, and incidentals necessary to operate the technical unit and UFI-S. These expenses will be financed by the program counterpart and executed according to the executing agency's administrative procedures, which will be described in the program Operating Regulations. Operating costs do not include wages for civil servants.

d. **Advance procurement/Retroactive financing:** No advance procurement or retroactive financing is envisaged.

e. **Relevance of expenditure.** The relevance of expenditure, i.e., the terms of reference (TOR), technical specifications, and the budget for procurement under the program, will be the responsibility of the Project Team Leader and will always require prior no objection with respect to initiating the purchase itself and according to the operational criteria of the Project Team Leader.

1. Thresholds for International Competitive Bidding and International Short List (US$)

Method	ICB Works	ICB Goods and nonconsulting services	International short list for consulting services
Threshold	≥ 5,000,000	≥ 500,000	≥ 500,000

Note: In addition, contracts for more than US$200,000 equivalent must be posted on the websites of the UNDB Online and the Bank.

2. Main procurements

The following table summarizes the list of main procurements identified for the program up to this point.

MAIN PROCUREMENTS

Activity	Selection method	Estimated date of solicitation/ invitation	Estimated amount
Goods			
Equipment to strengthen diagnostic capacity at primary health care level	ICB	9/30/2017	29,666,980.00
REDES data processing equipment	ICB	7/15/2017	533,860.00
Data processing equipment for managing pharmaceutical services for dispensing and subsequent digitization of prescriptions (year 1)	ICB	11/20/2016	874,250.00
Data processing equipment for management of pharmaceutical services and dispensing and subsequent digitization of prescriptions (year 2)	ICB	11/20/2017	1,311,375.00
Logistical facilities and equipment for warehouse and pharmacies (year 1)	ICB	11/20/2016	4,219,944.00
Logistical facilities and equipment for warehouse and pharmacies (year 2)	ICB	11/16/2017	6,329,916.00
Firms			
Risk factors survey/oversampling	Single-source selection of INDEC	4/30/2017	570,000.00
Medical audit service	QCBS	3/30/2017	2,158,230.63

* To access the 18-month procurement plan, click here.

3. Procurement supervision

The supervision method will be ex post for processes within the NCB thresholds for works, goods, consulting services, and nonconsulting services. Processes corresponding to ICB, single-source selection, and those that justify ex ante supervision based on their complexity or risk will be subject to ex ante review.

In the case of individual consultants, any contracting for more than US$50,000 will be subject to ex ante review. For contracting below that amount, review will be on an ex post basis.

For contracting done within the context of transfers, the UFI-S will ensure compliance with the provisions of the loan contract and the program Operating Regulations. No procurement process carried out by a province on a decentralized basis may exceed the following limits: (i) Goods: amounts less than US$100,000; and (ii) Works (remodeling): amounts less than US$350,000.

Ex post review will be performed every 12 months in accordance with the project supervision plan with respect to a sample drawn from all processes carried out since the start of the program in the first review and since the prior review performed for subsequent reviews. Ex post review reports will include at least one physical inspection visit,[3] selected from the procurement processes subject to ex post review.

Ex post review thresholds		
Works	**Goods and nonconsulting services**	**Consulting services**
< 5,000,000	< 500,000	< 500,000

Note: 1. The thresholds established for ex post review are applied on the basis of the executing agency's fiduciary execution capacity and may be modified by the Bank to the extent that this capacity changes. 2. Procurement processes for goods for an amount less than US$100,000 may be conducted according to the shopping method, as may works for an amount less than US$350,000. In both cases, review will be on an ex post basis.

4. Special provisions

a. **Measures to reduce the likelihood of corruption.** Compliance with policy documents GN-2349-9 and 2350-9 as they relate to prohibited practices. The executing agency will also have the duty to review the list of firms and persons prohibited from participating in processes financed by the multilateral banks.

b. **Other special procedures.** Update the procurement plan according to the needs of the project and integrate it with the project planning.

5. Records and files

The contracting area will be responsible for maintaining the project procurement files for purchases made in the UFI-S, while purchases made in the provinces will be maintained in the original files.

[3] The inspection verifies the existence of procurements, leaving the sector specialist to verify quality and compliance with specifications.

VI. Agreements and Requirements for Financial Management

A. Programming and budget

6.1 The executing agency is responsible for formulating and programming the annual budget and responsible for all procedures leading to consolidation of the annual budget for approval. As needs arise for additions or reallocations of budget line items, the executing agency requests revisions, assuming responsibility for managing their approval. Budgetary appropriations are executed through accrued quarterly and monthly commitment instalments, which are allocated by the National Budget Office of the Ministry of Finance.

6.2 No problems are anticipated in terms of budgetary management, timeliness of local counterpart funds, or delays affecting execution.

B. Cash flow and management of disbursements

6.3 The National Treasury transfers the local counterpart funds to the execution unit, crediting an account opened by the program for the exclusive use of this loan, as this is a program cofinanced with Bank funds.

6.4 Disbursements will be made based on a detailed financial plan, the format for which has been agreed upon with officials of the Ministry of Finance and the Office of the Cabinet Chief.

C. Accounting, information systems, and reports

6.5 The executing agency will use the UEPEX system as the financial management system. Accounting will be on a cash basis, following International Financial Reporting Standards (IFRS) when applicable in accordance with established national criteria. The financial reports required will be: (i) financial execution plan for up to 180 days following the request for an advance; (ii) audited annual financial statements; and (iii) other reports to be requested by the fiduciary specialists.

D. Internal control and internal audit

6.6 Argentina's national internal control body is the Sindicatura General de la Nación [General Accounting Office] (SIGEN). Internal audit of each executing agency is conducted through the Unidad de Auditoría Interna [Internal Audit Unit] (UAI). The UAI, reporting directly to the Minister, is responsible for conducting audits and making recommendations in accordance with the powers conferred under Law 24156 (Financial Administration and Control Systems Act of 30 September 1992). The UAI of MINSAL conducts the internal audits of the program.

E. External control: External financial audit and project reports

6.7 In 2011 the Bank concluded a diagnostic assessment of the governmental audit practices of the Auditoría General de la Nación [General Audit Office] (AGN), in accordance with the Bank's guide for determining the development of public financial management systems. The evaluation concluded by validating the AGN as the auditor for Bank projects. However, based on the history of timeliness in the AGN's submission of audited financial statement (AFS) in recent years, agreement was reached with Argentina in October 2014 to reduce its portfolio in keeping with its actual compliance capabilities.

6.8 Based on the foregoing and given the complexity of the operation's execution mechanism, it is recommended that bids be solicited for the audit so that an independent auditing firm (IAF) can audit the program.

6.9 The audit will be performed based on the new terms of reference prepared by the Bank, 2014 version.

F. Financial supervision of the project[4]

6.10 The initial financial supervision plan is based on the risk and fiduciary capacity evaluations performed on the basis of onsite and desk reviews planned for the program, and includes the scope of operational, financial, and accounting activities, compliance and legality, frequency, and identification of the parties responsible.

6.11 In addition to the reports required for processing disbursements and the annual audit, a detailed financial plan will be sought to provide effective monitoring of projected disbursements.

G. Execution mechanism

6.12 The executing agency will be responsible for the general implementation of the program components and for implementing its monitoring and evaluation plan. For the execution of Subcomponent 1.1 at the local level, the jurisdictions will set up UGJs, the basic characteristics, functions, and duties of which will be established in the management agreements signed by the executing agency and the respective jurisdiction and in the program Operating Regulations. The UGJs should be coordinated by a line organization officer from the jurisdictional ministries.

6.13 The Operating Regulations will detail the guidelines to be followed in order for a jurisdiction to be eligible as a beneficiary of Subcomponent 1.1, which will include the following: (i) execution of the PJIs and innovative projects is included in the budgetary legal framework of the jurisdictional ministry; (ii) procurements are subject to jurisdictional oversight; (iii) the flow of funds under the PJIs is reported, and the assets acquired with them are recorded as such; (iv) the jurisdiction maintains a minimum level of commitment of transferred funds; and (v) the UFI-S certifies compliance with the Bank's procurement policies.

6.14 The program Operating Regulations will also include the penalties for failure to comply with these guidelines. In addition, the program Operating Regulations will specify the milestones that the jurisdictions must meet to receive financing for their PJIs, subject to prior verification by a medical auditing firm to be engaged using the loan proceeds. Transfers made to jurisdictions that comply with the eligibility guidelines and the respective audited milestones will be directly eligible for submission to the Bank in accounting for advances.

6.15 Transfers made to jurisdictions that comply with the eligibility guidelines and the respective audited milestones will be directly eligible for submission to the Bank in accounting for advances.

[4] See "Financial Management Guidelines for IDB-financed Projects" (document OP-273-6), Annex I, Application of Financial Management Principles and Requirements, Requirement 4, Financial supervision.

DOCUMENT OF THE INTER-AMERICAN DEVELOPMENT BANK

PROPOSED RESOLUTION DE-___/16

Argentina. Loan ____/OC-AR to the Argentine Republic
Multiphase Primary Health Care Program for Chronic,
Non-Transmissible Disease Management
Second Operation

The Board of Executive Directors

RESOLVES:

That the President of the Bank, or such representative as he shall designate, is authorized, in the name and on behalf of the Bank, to enter into such contract or contracts as may be necessary with the Argentine Republic, as Borrower, for the purpose of granting it a financing to cooperate in the execution of the Multiphase Primary Health Care Program for Chronic, Non-Transmissible Disease Management - Second Operation. Such financing will be for an amount of up to US$100,000,000 from the Ordinary Capital resources of the Bank, 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 ___ _____ 2016)

LEG/SGO/CSC/IDBDOCS: 40567711
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