DOCUMENT OF THE INTER-AMERICAN DEVELOPMENT BANK

EL SALVADOR

INTEGRATED HEALTH PROGRAM

(ES-L1027)

LOAN PROPOSAL

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ANNEXES

ELECTRONIC LINKS
Required
1. Safeguard Screening Form (SSF) http://idbdocs.iadb.org/WSDocs/getdocument.aspx?DOCNUM=35137858
2. Annual Work Plan (AWP) http://idbdocs.iadb.org/WSDocs/getdocument.aspx?DOCNUM=35098280
3. Monitoring and evaluation arrangements for the operation http://idbdocs.iadb.org/WSDocs/getdocument.aspx?DOCNUM=35098260
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1. Draft Project Execution Plan (PEP) http://idbdocs.iadb.org/WSDocs/getdocument.aspx?DOCNUM=35099229
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APPENDICES

ABBREVIATIONS

AWP	Annual work plan
FESAL	Encuesta Nacional de Salud Familiar [National Family Health Survey]
FOSALUD	*Fondo Solidario para la Salud* [Solidarity Health Fund]
GDP	Gross domestic product
ICAS	Institutional Capacity Assessment System
IHSN	Integrated Health Services Networks
IHSN-PHC	Integrated Health Services Networks based on Primary Health Care
ISSS	Instituto Salvadoreño de Seguridad Social [Salvadoran Social Security Institute]
MHI	Mesoamerican Health Initiative
MSPAS	Ministry of Public Health and Social Welfare
NGO	Nongovernmental organization
PAHO	Pan American Health Organization
PCU	Program Coordinating Unit
PEP	Project Execution Plan
PHC	Primary health care
PQD	Plan Quinquenal de Desarrollo [Five-year Development Plan]
SEM	*Sistema de Emergencia Médica* [Medical Emergency System]
SNS	*Sistema Nacional de Salud* [National Health System]
SUIS	*Sistema Único de Información en Salud* [Master Health Data System]
UACI	*Unidad de Adquisiciones y Contrataciones Institucional* [Institutional Procurement and Contracting Unit]
UFI	*Unidad Financiera Institucional* [Institutional Finance Unit]
UINs	Urban informal neighborhoods

PROJECT SUMMARY

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<table>
<tr><th colspan="6">Financial Terms and Conditions</th></tr>
<tr><td colspan="3" rowspan="4">Borrower: Republic of El Salvador
Executing agency: Ministry of Public Health and Social Welfare (MSPAS)</td><td>Amortization period:</td><td>25 years</td></tr>
<tr><td>Grace period:</td><td>5 years</td></tr>
<tr><td>Disbursement period:</td><td>5 years</td></tr>
<tr><td>Deadline to begin construction work:</td><td>4 years</td></tr>
<tr><td>Source</td><td>Amount</td><td>%</td><td>Interest rate:</td><td>Variable/LIBOR</td></tr>
<tr><td>IDB (Ordinary Capital)</td><td>US$ 60 million</td><td>68.5</td><td>Inspection and supervision fee:</td><td>*</td></tr>
<tr><td>Local</td><td>US$22.7 million</td><td>31.5</td><td>Credit fee:</td><td>*</td></tr>
<tr><td>Total</td><td>US$82.7 million</td><td>100.0</td><td rowspan="2">Currency:</td><td rowspan="2">US dollars from the Bank’s Ordinary Capital Single Currency Facility</td></tr>
<tr><td colspan="3"></td></tr>
<tr><th colspan="6">Project at a glance</th></tr>
<tr><td colspan="6">Project objective/description:
The program’s objective is to help improve the health status of the people of El Salvador by implementing an integrated public health network that institutes a new management and service delivery model centered on comprehensive universal primary health care providing quality services based on a cross-sectoral and participatory approach.

Special contractual clauses:
1. Conditions precedent to the first disbursement of financing:
(i) Entry into effect of the program’s Operations Manual (paragraph 3.1); and (ii) Formalization of the Program Coordinating Unit (PCU) through a Ministerial Decision and appointment of its General Coordinator (paragraph 3.1)
2. Special execution conditions:
(i) Evidence of the progressive incorporation of recurring expenditure financing in the regular budget of the MSPAS (paragraph 2.5); (ii) Deadline to begin construction work: no later than four years after the date of entry into force of the loan contract (paragraph 2.5); (iii) Contracting of the first external evaluation: halfway through the proposed disbursement period or when 50% of the program resources are committed (whichever occurs first) (paragraph 3.4); and (iv) Contracting the final external evaluation: when 80% of program resources are committed (paragraph 3.4)
Exceptions to Bank policies: None.</td></tr>
<tr><td colspan="6">Project qualifies as: SEQ [X] PTI [X] Sector [X] Geographic [ ] Headcount [ ]</td></tr>
</table>

* The credit fee and inspection and supervision fee will be established periodically by the Board of Executive Directors as part of its review of the Bank’s lending charges, in accordance with the applicable provisions of the Bank’s policy on lending rate methodology for Ordinary Capital loans. In no case will the credit fee exceed 0.75% or the inspection and supervision fee exceed, in a given six-month period, the amount that would result from applying 1% to the loan amount divided by the number of six-month periods included in the original disbursement period.

I. PROJECT DESCRIPTION AND RESULTS MONITORING

A. Background and issues addressed

1.1 The epidemiological profile of El Salvador is not so different from that of other Latin American countries, consisting as it does of a double burden of emerging and reemerging endemic and epidemic infectious diseases, non-infectious chronic diseases, and a rising epidemic of mental illness linked to alcohol abuse and other addictions. The country's high poverty indices are further exacerbated by epidemic levels of violence and injury in a context of food insecurity, chronic malnutrition, micronutrient deficiency, as well as overweight and obesity.

1.2 Recent data indicate that the proportion of years of life lost due to communicable, maternal, perinatal, and nutritional conditions represents 37% of the total and is declining. However, noncommunicable diseases (essentially chronic diseases such as diabetes, mental illness, asthma and circulatory disorders) are rising steeply, accounting for 39% of the burden of disease. The remaining 24% is attributable to accidents and violence.

Table 1: Distribution of years of life lost by broad cause groups

	Communicable, maternal, perinatal, and nutritional conditions	Noncommunicable conditions	Accidents
2002	41%	21%	38%
2007	37%	39%	24%

Source: WHO. The Global Burden of Disease. WHO, Geneva, 2008; and http://apps.who.int/whosis/data/Search.jsp

1.3 The Salvadoran health system is characterized in part by its fragmentation and its segmentation:[1]

a. 77% of the Salvadoran people use the public system of the Ministry of Public Health and Social Welfare (MSPAS).[2] The MSPAS is the lead agency of the Salvadoran health sector, whose functions include setting standards, enforcing regulations, and delivering public health services (controlling health risks, maintaining the laboratory network, etc.).

b. The social security system, consisting of the Salvadoran Social Security Institute (ISSS), insurance for teachers [*Bienestar Magisterial*] and Military Health, provides coverage for 23% of the total population. Under the social

[1] ***Segmentation*** is the coexistence of subsystems with different modes of financing, membership, and delivery of health care services, each of them specializing in different population segments, depending on their employment and ability to pay. ***Fragmentation*** in the service delivery system refers to "the coexistence of various units or facilities that are not integrated into the health network.

[2] The MSPAS health network consists of 377 health units, 160 *casas de salud* [health centers], 46 rural health and nutrition centers, 2 clinics, 3 emergency care centers, and 30 hospitals: *Boletín Informativo de Indicadores en Salud 2008* [Health Indicators Information Bulletin]. MSPAS, San Salvador, 2008; http://www.mspas.gob.sv/boletines_estadisticos.asp.

security system, access to health services is linked to employment status (essentially workers in the formal sector of the economy and their families).

c. Private health services are paid directly by users at the time of service (out-of-pocket expenditure) or through prepaid health insurance plans. Although 38.2% of total health spending is private, only 11.1% of private spending is financed through prepaid plans.

1.4 Table 2 shows the evolution and composition of public health financing expressed as a percentage of the gross domestic product (GDP).[3] It should be noted that the volume of resources allocated to the MSPAS—amounting to 1.5% of the country's GDP, including funding for national hospitals—is significantly below the spending of other countries in the region (Nicaragua 4.7%, Honduras 7.6%, etc). Thus, the current composition of public health expenditure, in which each ISSS participant receiving US$239 in health resources compared to US$82 received by each MSPAS user, further consolidates and deepens inequity in access to health care between different population groups, and exposes the population to a higher risk of incurring catastrophic or impoverishing health expenditure.[4]

Table 2: Evolution and composition of public health expenditure

	2005	**2006**	**2007**	**2008**
As a percentage of GDP	**3.4%**	**3.4%**	**3.3%**	**3.0%**
MSPAS – Others	0.4%	0.5%	0.9%	0.8%
MSPAS – National Hospitals	1.2%	1.2%	0.7%	0.7%
Salvadoran Social Security Institute (ISSS)	1.7%	1.7%	1.7%	1.4%
Armed Forces Pharmaceutical Center	0.1%	0.0%	0.0%	0.1%
In US$ million	**575.9**	**634.9**	**677.4**	**664.9**
MSPAS – Others	74.2	89.0	175.1	184.9
MSPAS – National Hospitals	199.6	215.2	152.8	164.8
Salvadoran Social Security Institute (ISSS)	291.6	324.0	342.1	306.7
Armed Forces Pharmaceutical Center	10.5	6.7	7.4	8.5

Source: Ministry of Finance and Central Bank of El Salvador.

1.5 About one third of the MSPAS budget is channeled to primary health care. Primary health services are also financed through the Fondo Solidario para la Salud [Solidarity Health Fund] (FOSALUD).[5] The Fund's annual budget of close to US$20 million is used primarily to cover payroll expenses for medical, technical, and administrative personnel, procure drugs and medical supplies, and fund the

[3] Murrugarra E. *Enhancing the Efficiency and Targeting of Social Expenditure in El Salvador – Public Expenditure Review*. The World Bank, in press.

[4] The high out-of-pocket spending means that 2% to 6% of Salvadoran families are at risk of incurring catastrophic health expenditure in a given year. See: Xu, Evans, Kawabata, et al. Household catastrophic health expenditure: a multicountry analysis. *The Lancet* 2003, 362, 111–117.

[5] Created in 2004, FONSALUD is financed by a specific tax on the sale of alcohol, tobacco, and weapons.

laboratories. The current administration recently improved coordination between the MSPAS and FOSALUD. However, the FOSALUD budget is not an integral part of the MSPAS regular budget, resulting in some rigidity in the sector's financing structure, and an administrative overlap.

1.6 The Primary Health Care (PHC) strategy in the past decade focused on "extending coverage" by delivering a basic package of preventive health, nutrition, and family planning services targeting the poor population through nongovernmental organizations (NGOs). This strategy, supported by the IDB and the World Bank, helped decrease mother and child mortality and childhood malnutrition, and increase coverage of preventive health care services (vaccination program, prenatal checkups, checkups for children under the age of two).[6] These advances enabled the country to progress towards achievement of some of the health-related Millennium Development Goals (MDG). On the other hand, the low quality of care at the primary level and the fragmentation of the system encourage the use of emergency and specialized care hospitals to access medical care; the hospitalization of patients whose illness could have been treated at the primary level, or the extension of hospital stays in the absence of a cross-referral system.[7,8]

1.7 In 2008, the government approved the National Health Policy creating the National Health System (SNS), which conceptually represents a first step towards reducing the system's fragmentation. However, the resulting law excluded the health provider teaching sector and the private sector from the SNS, leaving them unregulated, and did not address the segmentation and fragmentation of the system.[9]

1.8 The recent "Health Services, Capacities, and Human Resources Diagnostic Survey"[10] quantified the system shortcomings in terms of human resources, equipment, and physical infrastructure at health units, as well as the limited integration. The survey also quantified the low quality of care at the primary level. The following breakdown was identified concerning service delivery: 2% of health units provide internal medicine consultations; 9%, pediatric consultations; 11%, gynecological consultations; 5%, psychological consultations; 6%, nutrition; 8%, birth delivery; and 30%, laboratory tests. Deficiencies were also identified in the availability of equipment (blood pressure monitors, nebulizers, X-ray machines, equipped ambulances, etc), and human resources. An analysis of the central

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6 See the project completion report (PCR) on program ES-0053; 1092/OC-ES.

7 See the IDB Office of Evaluation and Oversight (OVE) evaluation of the Bank's health sector activities in the 1995-2005 period (Report No. RE-324 paragraphs 4.5-4.19 and 4.56).The OVE study reported similar conclusions in its evaluation of the "coverage expansion" experiences implemented in Guatemala and Nicaragua (see RE-324 paragraphs 4.47-4.59).

8 Lewis, Eskeland and Traa-Valerezo (2005). *Primary Health Care in Practice: Is It Effective?* Centre for Global Development, Working Paper No. 55.

9 See: Espinoza and Barten. Health reform in El Salvador: a lost opportunity for reducing health inequity and social exclusion? *J Epidemiol Community Health* 2008; 62(5): 380-381.

10 The October 2009 survey gathered information from the 377 MSPAS health units.

laboratory's[11] installed capacity found significant deficiencies in its epidemiological surveillance capacity and quality control. This information was used to calculate the investment requirements for primary care so as to improve the quality of care and integrate it into health care networks.

B. Program rationale

1.9 The new administration took office in June 2009 and is implementing a Five-year Development Plan 2009-2014 (PQD 2009-14).[12] The government identified several priority strategies for the health sector:[13]

a. The SNS, based on a comprehensive primary health care strategy: redirect the entire system towards PHC guaranteeing universal coverage with high quality of care as the basis for a new comprehensive care model, integrated in health care networks including all system levels, and cross-sectoral efforts to address health determinants.
b. Strategic health data system: establish a high-quality strategic data system as a tool for evidence-based decision-making, facilitate social oversight and planning, and control and allocate resources.[14]
c. Emergency and disaster impact reduction: guarantee proper health care with a risk management approach in the case of emergencies, epidemics, and natural or man-made disasters.
d. National health research system: create a national health research system to generate knowledge about national health problems, strengthen human resource skills, generate evidence to underpin decision-making, and strengthen the capacity of the national health laboratory network.
e. Social and community participation: create structures and a broad, active, pro-positive, vigilant, and permanent citizen participation process (for accountability and social oversight).

1.10 The program will support the above-mentioned strategic lines of activity. With respect to the first strategic line "redirect the entire system towards PHC", the Pan American Health Organization (PAHO) urged its member countries to develop

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[11] The "Dr. Max Bloch" central laboratory is the benchmark institution for the country's laboratory network, providing analysis and diagnostic services, and confirmation of emerging and re-emerging diseases; detection of cervical cancer; production of biological reagents; food, water and environmental quality control.

[12] The 2009-14 PQD will redirect up to 2% of GDP to social areas, build a Universal Social Protection System, which includes *Comunidades Solidarias* cash transfer program, set up a temporary employment program, and start a special public investment program concentrated on health, education and infrastructure. http://www.imf.org/external/np/sec/pr/2009/pr09322.htm

[13] See: María Isabel Rodríguez, "*Construyendo la Esperanza, Estrategias y Recomendaciones en Salud del nuevo Gobierno, 2009-2014*", San Salvador, El Salvador, May 2009.

[14] See Stansfield , Walsh, Prata, Evans. *Information to Improve Decision Making for Health*. 1,017-1,030. 2006. New York, Oxford University Press. Disease Control Priorities in Developing Countries (2nd Edition) for a justification of interventions.

national plans of action to promote the establishment of Integrated Health Services Networks based on Primary Health Care (IHSN-PHC) as the preferred method for country-wide delivery of health services.[15] Accumulated evidence in support of the IHSN-PHC approach includes:

a. Greater quality of primary health care is associated with better health outcomes. For example, at the country level, there is a statistically significant correlation between mortality rates (all causes; premature mortality; premature mortality due to specific causes: asthma, bronchitis, emphysema, pneumonia, circulatory system diseases, and heart conditions) and the level of development of the primary health care system (geographic accessibility, continuity, coordination, and community participation).[16,17]
b. Strengthening the quality of integral primary health care is cost-effective because it reduces use of the more expensive secondary and tertiary levels of health care,[18] thus reducing total costs for the health sector.

1.11 What is more, the most cost-effective health services organizational models to manage chronic diseases (such as diabetes and circulatory disorders)–diseases with an ever increasing relative weight in the Salvadoran epidemiological profile (see Table 1)–are based on an IHSN-PHC strategy.[19] Lastly, empirical evidence shows a causal relationship between the level of development of the IHSN-PHC and the health situation in several countries.[20,21]

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15 49th Directing Council of PAHO, Resolution CD49.R22 – 13 August, 2009.

16 Starfield, Shi, Macinko. Contribution of primary care to health systems and health. *Milbank Q* 2005;83(3):457–502.

17 Starfield, Shi, Macinko. The contribution of primary care systems to health outcomes within OECD countries (1970-1998). *Health Service Research* 2003; 38(3):831–865.

18 Bindman, Grumbach, Osmond et al., Preventable Hospitalizations and Access to Health Care. *JAMA* 1995; 274:305-11.

19 Bodenheimer T, Wagner EH, Grumbach K. Improving Primary Care for Patients with Chronic Illness. The Chronic Care Model, Part 2. *JAMA* 2002; 288:1909-1914.

20 L. Shi et al., Primary Care, Income Inequality, and Stroke Mortality in the United States: A Longitudinal Analysis, 1985–1995. *Stroke* 34, No. 8 (2003): 1958–1964; L. Shi et al., Primary Care, Infant Mortality, and Low Birth Weight in the States of the USA. *Journal of Epidemiology and Community Health* 58, No. 5 (2004): 374–380; and L. Shi et al., The Relationship between Primary Care, Income Inequality, and Mortality in U.S. States, 1980–1995. *Journal of the American Board of Family Practice* 16, No. 5 (2003): 412–422.

21 Macinko, Starfield, Erinosho. The Impact of Primary Health Care on Population Health in Low- and Middle-Income Countries, *Journal of Ambulatory Care Management* 32(2): 150-171, 2009. Guanais, Macinko. The health effects of primary care decentralization in Brazil. *Health Aff (Millwood)*. 2009; 28(4):1127-35. Guanais, Macinko. Primary care and avoidable hospitalizations: Evidence from Brazil. *Journal of Ambulatory Care Management* 2009 32 (2): 114-21. Macinko, Guanais, Souza. An Evaluation of the Impact of the Family Health Program on Infant Mortality in Brazil, 1990-2002. *Journal of Epid. and Community Health* 2006 60:13-19.

1.12 This program is closely tied to the Comunidades Solidarias Urbanas program (ES-L1044), which supports expansion of the Comunidades Solidarias in Urban Informal Neighborhoods (UINs) en conditional cash transfer program. Program ES-L1044 will provide financial resources to strengthen the delivery of health services in UINs outside of the Component 1 intervention areas (see paragraph 1.16). The idea is for the MSPAS to co-execute operation ES-L1044 resources for the strengthening of health services delivery, based on the IHSN-PHC model supported by this program.

1.13 The program agreed upon at the programming exercise that took place in August 2009 is closely aligned with the IDB's country strategy with El Salvador,[22] which envisages support for the social protection system, as one of the country's objectives, and improved access and quality of health services and nutrition, as one of the Bank's strategic objectives.

1.14 In addition, this program seeks to complement the Mesoamerican Health Initiative (MHI) (GN-2520), which provides nonreimbursable funds to finance health interventions targeting those in the lowest income quintile. At the outset, the Mesoamerican Health Initiative is expected to support expansion of the Expanded Immunization Program with the introduction of demonstrably cost-effective vaccines. It should be noted that the program will complement investments under the Mesoamerican Health Initiative by strengthening PHC, which is essential for the expansion of the Expanded Immunization Program.

C. Objectives and components

1.15 The program's objective is to help improve the health status of the people of El Salvador by implementing an integrated public health network that institutes a new management and service delivery model centered on comprehensive universal primary health care providing quality services and universal rights based on a cross-sectoral and participatory approach. To achieve this objective, the program will finance the following components:

1. Component 1: Implementation of the comprehensive and integrated care model

1.16 This component aims to implement a health care model based on the IHSN-PHC as the preferred method to deliver health care services. The component will finance the development of a new care model and its implementation in the departments of San Miguel, Chalatenango, and Sonsonate, and the metropolitan area of San Salvador.[23] Selection of these departments was based on the following: (i) San Miguel has the vastest experience with coordination between the MSPAS and the ISSS; (ii) Chalatenango has a long tradition in health sector organization and social participation that could be replicated by the SNS; (iii) Sonsonate has

[22] The strategy is pending approval by the government and the IDB.

[23] The beneficiary population of Component 1 consists of some 2.5 million people.

alarming mother and child mortality rates; and (iv) San Salvador because of the high impact of rural-urban migration and the poor living conditions of migrants.

1.17 The following types of activities aimed at establishing health care networks (see preliminary PEP) will be financed to achieve this objective: (i) infrastructure work to expand and improve the network of health units; (ii) procurement of medical equipment and supplies for the health centers; (iii) selection, contracting, placement, and training of new health personnel and reassignment/redistribution of some existing personnel in the IHSN-PHC; (iv) definition and standardization of new management structures for integrated health networks in each region, including benchmark standards concerning environmental management (solid waste, biosafety, and environmental health); (v) development of instruments and manuals for the referral and cross-referral system; and (vi) support for the design, implementation, and control of local social participation plans concerning health determinants in the territories assigned to the health units.

2. Component 2: Strengthening of the MSPAS

1.18 This component aims to strengthen the MSPAS's core capacity, including development of the National Medical Emergency System (SEM) and the Master Health Data System (SUIS) and strengthening of the network of laboratories in the context of creating the National Health Institute.

1.19 Medical Emergency System (SEM). This subcomponent will create a national emergency system requiring substantial improvements to the Salvadoran pre-hospital system and its coordination with the hospital system, harmonizing, as a first step, the resources available at many institutions providing pre-hospital services (volunteer NGOs such as the Salvadoran Red Cross, the Comando de Salvamento [Rescue Command], the Green Cross, and the National Civil Police). It will also establish a communications system and a call coordination system. Other goals include improving hospital equipment, physical facilities, and staff training at emergency departments in 16 hospitals, gradually scaling up to nationwide coverage in four years, beginning with the Rosales, Santa Ana, San Miguel, and Santa Tecla hospitals, given their geographic location in relation to service networks; and increasing the number of fully equipped ambulances manned by trained ambulance personnel. This subcomponent will finance: (i) equipment and inputs for SEM operations; (ii) emergency department equipment and physical works; and (iii) selection, contracting, placement, and training of new SEM health personnel and training of existing personnel to be reassigned as needed.

1.20 Master Health Data System (SUIS). The objective is to establish a system to generate timely high-quality information for decision-making concerning clinical issues, patient management (including referral and cross-referral between levels of care), administration of medical facilities and hospitals, resource allocation, etc. The actions envisaged, deriving from an evaluation of the various components that make up a data system, seek to integrate the data management plans and indicators developed over time and in isolation by different programs and institutions,

agencies, or projects that resulted in a fragmented data system. The goal is also to connect those who generate data into a single network so as to facilitate data compilation, the generation of indicators on the health system and the health of citizens in El Salvador, health determinants, and timely analysis of the data. This subcomponent will finance: (i) equipment and inputs for SUIS operations in the framework of the new health care model; and (ii) selection, contracting, placement, and training of new SUIS personnel.

1.21 Strengthening of the public health laboratory network. The objective is to strengthen and modernize the network of public health laboratories to resolve some of the most serious constraints in physical infrastructure, lack of equipment, access to reagents, and human resources. The actions envisaged also seek to correct deficiencies in the implementation of biosafety and environmental health policies. To achieve this objective, financing will be provided for: (i) physical infrastructure for a new central laboratory as part of the National Health Institute; (ii) replacement of defective equipment and procurement of new equipment; (iii) procurement of reagents; and (iv) human resources selection, contracting, and training.

1.22 This component will also finance strengthening of the MSPAS units involved in program implementation (see paragraphs 2.3-2.4).

D. Cost

1.23 Table 3 presents the total program cost of US$82,745,494, of which US$60 million will be financed by the IDB and US$22,745,494 with local counterpart resources that will be used for the progressive financing of recurring costs (see paragraph 2.5 and optional electronic link 4, which consists of the table of costs by component and subcomponent).

Table 3: Program cost (in US$)

COST CATEGORY	IDB	LOCAL	TOTAL	%
Remuneration	**12,562,806**	**11,062,806**	**23,625,613**	**28.6%**
1.1 Strengthening of human resources for PHC	3,999,375	3,999,375	7,998,750	9.7%
2.1.3 Human resources for the SEM	4,947,400	4,947,400	9,894,800	12.0%
2.2.2 Human resources for the SUIS	1,173,000	1,173,000	2,346,000	2.8%
2.3.4 Human resources for laboratory network	943,031	943,031	1,886,063	2.3%
2.4.1 Strengthening of UFI human resources at MSPAS	300,000	-	300,000	0.4%
2.4.2 Strengthening of UACI human resources at MSPAS	300,000	-	300,000	0.4%
3.1.1 PCU staff-MSPAS	900,000	-	900,000	1.1%
Goods and services	**16,070,480**	**8,287,125**	**24,357,605**	**29.4%**
1.3 IHSN-PHC inputs and operating expenditures	6,328,125	6,328,125	12,656,250	15.3%
1.4 IHSN-PHC training, policies, and standards	5,263,355	-	5,263,355	6.4%
1.5 Strengthening of PHC social participation mechanisms	100,000	-	100,000	0.1%
2.1.2 SEM recurring expenditures on equipment	1,184,500	1,184,500	2,369,000	2.9%
2.2.4 Training for system users	980,000	-	980,000	1.2%
2.3.2 Recurring inputs	774,500	774,500	1,549,000	1.9%
2.4.2 Strengthening of filing at MSPAS's UACI	100,000	-	100,000	0.1%
3.1.2 PCU materials and inputs	240,000	-	240,000	0.3%
3.2 Midterm and final evaluations	700,000	-	700,000	0.8%
3.3 Financial audit	400,000		400,000	0.5%
Investments in fixed assets	**30,502,388**	**3,395,563**	**33,897,950**	**41.0%**
1.2 Adaptation of physical infrastructure for PHC	16,943,154		16,943,154	20.5%
2.1.1 Equipment and physical works in emergency units	768,100	-	768,100	0.9%
2.2.1 IT equipment, servers, and IP telephony	1,592,875	-	1,592,875	1.9%
2.2.3 Recurring equipment costs	3,395,563	3,395,563	6,791,125	8.2%
2.3.1 Non-recurring equipment and inputs	1,702,696	-	1,702,696	2.1%
2.3.3 Construction of building for new central laboratory	6,100,000	-	6,100,000	7.4%
CONTINGENCIES	**864,326**		**864,326**	**1.0%**
TOTAL	**60,000,000**	**22,745,494**	**82,745,494**	**100.0%**

E. Results framework and key indicators

1.24 The Results Framework (Annex II) includes the following types of indicators: (i) health indicators to quantify the program's contribution towards improving the health situation of the population: maternal, perinatal, and infant mortality due to preventable diseases and cervical-uterine cancer; (ii) indicators relating to the principal outputs of Component 1: number of primary care units with sufficient health care manpower, medical equipment, and infrastructure; the number of staff trained in the IHSN-PHC management system and the referral and cross referral system; (iii) health indicators (for outcomes) to be improved though guaranteed access to comprehensive health care services provided at the primary level of care in the project intervention areas; (iv) indicators relating to the principal outputs of Component 2: SEM, SUIS and public laboratories; and (v) outcome indicators to be improved through Component 2 interventions: mortality rate due to external causes in the first 48 hours, integration of the different health data systems and quality of the diagnostic capacity of the laboratory network.

II. FINANCIAL STRUCTURE AND PRINCIPAL RISKS

A. Financing instrument

2.1 Investment loan. An investment loan is considered the most suitable financial instrument for this operation given the program characteristics, the financing of which is highly concentrated in infrastructure investments, and the executing agency's prior experience working with the Bank. The program has a five-year disbursement period and a four-year period to begin construction work, counting from the date the loan agreement enters into effect. Table 4 presents the disbursement schedule for program resources:

Table 4: Disbursement flow (in US$ thousands)

Source	2010 (September to December)	2011	2012	2013	2014	2015 (January to August)	Total
IDB	6,000	16,000	17,000	15,500	5,000	500	60,000
Local		1,516	3,791	6,065	8,340	3,033	22,745
Total	6,000	17,516	20,791	21,565	13,340	3,533	82,745
% Annual	7%	21%	25%	26%	16%	4%	100%

The assumption is that program execution will begin on 1 September 2010.

B. Environmental risks

2.2 The Environment and Social Impact Review Committee (ESR) classified the program as a category "C" operation. The program finances small-scale infrastructure investments (remodeling and building health units and improving the laboratory network) that will have a limited environmental impact over time. In addition, during execution of the operation there may be some environmental impacts due to inappropriate management of healthcare waste: hazardous biological infectious waste, liquid effluents with pathogens, medical sharps (principally needles and scalpels), pharmaceutical waste and pathogenic chemical waste, storage of chemicals and x-ray equipment. These potential environmental impacts may be mitigated by adopting standard procedures as part of a quality management system, environmental management, occupational health and safety consistent with the practices specified in ISO 14001 and OHSA 18001. The following were reviewed as part of the program preparation activities: (i) the healthcare waste management manuals in force in El Salvador; (ii) the biosafety level of the public laboratory network; and (iii) the MSPAS's implementation and inspection capacity as the responsible government agency (OP-703-B. 16). The national standard is consistent with good international practices for the prevention and mitigation of the above-mentioned environmental risks. Moreover, deficiencies were noted in implementation of the policies, a source of risk for the environment, health sector workers, and system users. To mitigate these risks, Component 1 of the program

includes training actions focused on compliance with the reference standards both at health facilities and the laboratory network covered by the operation. Furthermore, infrastructure investments must comply with quality management, environmental management, and occupational health and safety standards consistent with the practices specified in ISO 14001 and OHSA 18001 described in the program Operations Manual to be approved by the Bank before the first disbursement. The Program Coordinating Unit (PCU) will be responsible for reporting to the Bank in the semiannual program monitoring reports, on: (i) the absolute number and percentage of health units in the areas of intervention that comply with healthcare waste management standards; and (ii) the biosafety level at the new central laboratory.

C. Fiduciary risk

2.3 Financial management. Resources will be disbursed using the advance payments modality, and managed through the Integrated Financial Management System, which integrates budget, accounting, and cash management for all government entities. The Institutional Finance Unit (UFI) of the MSPAS will be responsible for keeping project records and will request that the Ministry of Finance open a special account at the Central Reserve Bank of El Salvador and an operating account at a commercial bank from which it will make all payments. The evaluation of the MSPAS's institutional capacity shows a low fiduciary risk, although the UFI will have to be strengthened with a specialist due to insufficient staffing. Disbursements will be reviewed ex post with the support of a firm of auditors acceptable to the Bank contracted for the program's financial audit (see paragraph 3.4).

2.4 Procurement. During preparation of the operation, the institutional capacity of the executing agency's Institutional Procurement and Contracting Unit (UACI) was evaluated applying the ICAS methodology and tool to the Goods and Services Administration System. The analysis showed that the total project risk associated with the management of procurements was low and that the areas reviewed present a medium level of development all in all. The main weaknesses identified and corrective actions agreed upon are summarized below.

Table 5: UACI weaknesses identified and agreed-upon corrective actions

Weaknesses	Corrective action	Completion date
Insufficient knowledge of Bank operating policies and procedures concerning the selection and contracting of goods and/or services	Continuing training for staff in the matters relating to the administration of goods and services	When the project startup workshop takes place
The UACI does not have a single filing system to properly identify all documents belonging to each step of the procurement process	Establish and maintain a secure single filing system for the procurement unit	As the program is implemented
Insufficient staff	Reinforce the MSPAS UACI with full-time staff exclusively dedicated to program procurement	As the program is implemented

D. Other issues and risks

2.5 Sustainability of interventions. Program interventions (paragraphs 1.15-1.22) will finance investment costs expected to generate benefits for many years (investments in medical equipment, infrastructure, etc.) and recurring expenditures (contracting human resources, purchasing drugs and other medical inputs), identified with an I or an R, respectively, in the cost table by component and subcomponent (optional electronic link 4). The additional recurring costs amount to US$11.37 million per year, of which US$5.16 (relating to Component 1) will be used to implement the IHSN-PHC model in the four departments. These additional annual recurring expenditures represent an increase in the MSPAS budget equivalent to 0.05% of GDP, which is in line with MSPAS budget trends (see Table 2). To ensure program sustainability and guarantee financing for recurring expenditures, the government committed to gradually assuming their financing during the program execution period. As a special condition for program execution, evidence must be presented showing the gradual incorporation in the MSPAS regular budget of financing to cover recurring expenditures, based on the following sliding scale: Year 1: IDB 100%, Local 0%; Year 2: IDB 75%, Local 25%; Year 3: IDB 50%, Local 50%; Year 4: IDB 25%, Local 75%; Year 5: IDB 0%, Local 100%.[24] Another special condition for execution is the period to begin construction work (no later than four years after the date of entry into effect of the loan agreement).

III. Implementation Plan and Management

A. Summary of the execution plan

3.1 Borrower and executing agency. The borrower is the Republic of El Salvador and the executing agency is the Ministry of Public Health and Social Welfare (MSPAS). The program execution model is based on the following principles: creation of a Program Coordinating Unit (PCU), reporting directly to the head of the Ministry of Health, whose chief duties include: (i) general and financial administration of the program ensuring efficient use of the resources; (ii) planning of program execution, including preparation and implementation of annual work plans (AWP); (iii) monitoring of program progress and compliance with specified goals; (iv) planning and monitoring of the procurement processes for goods, services and works, ensuring they are in conformity with the Bank's policies on procurement and contracting; (v) preparation and processing of payments; (vi) maintenance of a suitable accounting and financial system to record financial transactions carried out with program resources, prepare the financial statements, and process requests for advances; and (vii) preparation of semiannual progress reports to be sent to the Bank. The structure of the PCU and the profiles of its key staff will be defined in the program Operations Manual. The PCU will coordinate program execution with the MSPAS's UFI, which will be responsible for keeping

[24] For these purposes, year 1 includes the first 12 months of program execution, starting from the effective date of the loan contract.

the project records and for the financial management of the operation (see paragraph 2.3), and with the UACI, which will be responsible for the selection and contracting processes for the procurement of goods and/or services with program resources (see paragraph 2.4). **The formalization of the PCU by means of a Ministerial Decision and the appointment of its General Coordinator will be a contractual condition precedent to the first disbursement.** The Operations Manual will describe program activities and the responsibilities of the participating entities in greater detail. **The entry into effect of the Operations Manual is a contractual condition precedent to the first disbursement.**

B. Procurement

3.2 The procedures applicable to each type of procurement, in accordance with the Policies for the Procurement of Goods and Works Financed by the Inter-American Development Bank (GN-2349-7) and the Policies for the Selection and Contracting of Consultants Financed by the Inter-American Development Bank (GN-2350-7) are summarized in Table 6. Bank supervision of procurement charged to program resources will be carried out as described in Table 6 and in accordance with the Procurement Plan and Appendix I of GN-2349-7 and GN-2350-7.

Table 6. Procurement procedures

Category	Threshold amount (in US$ thousands)	Procurement procedure	Type of review
Works	5,000 or more 350 or more and less than 5,000 Less than 350	International competitive bidding National competitive bidding Price comparison	Ex ante Ex post Ex post
Goods and nonconsulting services	250 or more 50 or more and less than 250 Less than 50	International competitive bidding National competitive bidding Price comparison	Ex ante Ex post Ex post
Individual consulting services	No limit	Rating of individual consultants	Ex post
Consulting services Firm of consultants	200 or more Less than 200	Shortlist with broad geographic representation Shortlist of national consultants	Ex ante Ex post

3.3 **External audit.** Throughout the program execution period, the PCU will submit the program's annual consolidated financial statements to the Bank duly audited by an independent firm of auditors selected and contracted in accordance with Bank procedures.

C. Summary of the monitoring and evaluation system

3.4 Instead of creating an ad hoc monitoring and evaluation system, the program will use the following sources of information: (i) the MSPAS administrative records enhanced through the creation of the SUIS; (ii) information from public surveys produced by the MSPAS and the Dirección General de Estadística y Censos [Statistics and Census Bureau] (DIGESTYC), such as the annual Multipurpose

Household Survey, and the National Family Health Survey, conducted every five years since 1998; (iii) information on health units based on the "Health Services, Capacities, and Human Resources Diagnostic Survey" carried out in October 2009, that will serve as baseline for several indicators, and will be repeated annually; and (iv) the "Survey to Monitor Health Services Expenditures and Delivery," to be conducted in the first six months of 2010 to map the flow of resources in the system and analyze the execution of public spending at the local level. In the semiannual progress reports, the PCU will report on overall program performance, the advances achieved in execution of each component in terms of attaining the indicators specified in the Results Framework, and the use of resources allocated to attain the targets. In addition, the program will finance two external evaluations as a special condition for program execution. The first evaluation will be carried out halfway through the disbursement period or once 50% of the program resources are committed (whichever occurs first). The final evaluation will be commissioned once 80% of program resources are committed and will review: (i) the program outcomes measured against the targets and performance of the indicators specified in the Results Framework; (ii) the relevance and effectiveness of processes and interventions; and (iii) handling of the loan resources.

D. Significant post-approval design activities

3.5 The following activities will be carried out prior to the entry into force of the loan contract: (i) review the Program Execution Plan (PDP), the Annual Work Plan (AWP) for the first year of execution, and the Procurement Plan; and (ii) finalize the program Operations Manual.

3.6 The project team will also develop the following knowledge products in 2010: (i) analysis of out-of-pocket health expenses in El Salvador: changes in equity and incidence of catastrophic and impoverishing health expenditure; and (ii) international experiences with integrated health services networks based on primary health care (IHSN-PHC); analysis of technical viability factors and benefits.

Development Effectiveness Matrix
Summary

Indicator	Score	Maximum Score
I. Strategic Relevance	Low-High	
1. IDB Strategic Development Objectives	6.6	10
Country Diversification	2.0	2
Corporate Initiatives	0.0	2.5
Harmonization and Alignment	1.6	3.5
Beneficiary Target Population	3.0	2
2. Country Strategy Development Objectives	4.6	10
Country Strategy Sector Diagnosis	1.8	6
Country Strategy sector objective & indicator	2.8	4
II. Development Outcomes - Evaluability	Partial Satisfactory	
3. Evidence-based Assessment & Solution	8.2	10
4. Evaluation & Monitoring Plan	4.8	10
5. Cost-benefit or Cost-effectiveness	0.0	10
6. Risks & Mitigation Monitoring Matrix	7.5	10
III. IDB´s Role - Additionality		
7. Additionality	7.0	10
Technical Assistance provided prior to the project	**3.0**	**3**
Improvements in management of financial, procurement, monitoring or statistics internal controls	**4.0**	**4**
Improvements in environmental, health and labor performance	0.0	3

I. Strategic Relevance: This operation will be carried out through an investment loan. Its objective is related to strengthening primary health care systems for the poorest population groups in a Group C/D country—El Salvador. The project will use country procurement, financial administration, and environmental management systems.

II. Evaluability: The project is based on a very rigorous diagnostic assessment of the main problems in the health sector, in particular to cover the poorest population groups. There is evidence to support the model chosen and lessons learned from previous interventions. The project has a well-defined intervention logic and indicators for monitoring achievement of results. The project has an evaluation plan, which is to be completed when the details of the implementation are set out in the plan of operations. The annex includes general elements about the information to be gathered to verify improvement in the delivery of services in the health sector.

III. Additionality: The main additionality of the intervention involves improvements in the use of information and monitoring in areas of the sector but outside the project itself. In addition, a technical-cooperation operation has supported several areas of sector planning that underpin, but go beyond, this operation.

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RESULTS FRAMEWORK

Program objective	The program's objective is to help improve the health status of the people of El Salvador by implementing an integrated public health network that institutes a new management and service delivery model centered on comprehensive universal primary health care providing quality services and universal rights based on a cross-sectoral and participatory approach.		
Outcome indicators[1]	**Baseline 2009**	**Final goal 2015**	**Comments and source**
Maternal mortality in the priority departments[2] and nationwide in hospital setting[3]	57.7 per 100,000 live births (national 2006-2009)	52 per 100,000 live births	Source: Active search for Maternal Mortality Surveillance data in institutional and City Hall records using RAMOS prospective methodology. Standardized by MSPAS
Perinatal mortality in the priority departments and nationwide [4]	Nationwide 19/1000 live births	15/1000 live births	Source: FESAL 2008 and FESAL 2013; FESAL data will be compared against the information regularly produced by the SUIS-MSPAS
Infant mortality (<1 year) in the priority departments and nationwide	Nationwide 16/1000 live births	13/1000 live births	Source: FESAL 2008 and FESAL 2013; FESAL data will be compared against the information regularly produced by the SUIS-MSPAS
Mortality due to pneumococcal pneumonia in children under the age of 5 (as tracer for immune-preventable diseases) in the priority departments and nationwide	27.5 per 100,000 children under age 5 (priority departments)	18 per 100,000 children under age 5 due to pneumonia	Source: MSPAS data system
Mortality rate due to cervical-uterine cancer diagnosed at MSPAS establishments	51 deaths	- 25%	Source: MSPAS data system

[1] Indicators reflect the Health Sector Five-Year Development Plan indicators.

[2] The MSPAS is in the process of estimating baselines for each department (region). Data broken down by department will be available in time for the operation's startup workshop and the targets for each department will be calculated after estimating the baselines. The indicator will be available regularly through the SUIS as of 2010.

[3] The enhanced health data system could result in recording a higher mortality rate. The baseline will be revised in late 2010 to take this into account.

[4] Two sources were used (FESAL and SUIS-MSPAS). Their convergence will be another indicator of an improved data system.

Component I: Strengthen primary care of the integrated public health network in the priority departments	**Baseline 2009**	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Comments**
Outputs							
Number of primary care units with sufficient quality human resources and suitable and adequate quality of care (equipment, medication, transportation, diagnostic means) and adequate physical infrastructure, to deliver the guaranteed services in Metropolitan San Salvador, Sonsonate, Chalatenango, and San Miguel	0	15 units	23 units	39 units	29 units	0	Sources: Health Services, Capacities and Human Resources Diagnostic Survey
Number of health care providers trained in the IHSN-PHC management system, the referral and cross-referral system, and the new IHSN care and management protocols	0	2,400	4,400 + reinforced training for 2,400	2,630 + reinforced training for 6,800	Continuing education for 9,430	Continuing education for 9,430	Sources: semiannual execution reports
Outcomes							
Improved health indicators relating to illness and health problems thanks to guaranteed access to comprehensive health care services delivered by a strengthened primary care in the project intervention areas: 1. Prenatal care coverage in accordance with protocol (**) in the prioritized departments 2. Percentage of primary care users referred to secondary and tertiary care	1. National prenatal registration coverage in 2009: 63.3% of pregnant women (**) 2. Will be available at the program startup workshop (*)	1. 40% of pregnant women 2. (*)	1. 55% of pregnant women 2. (*)	1. 70% of pregnant women 2. (*)	1. 80% of pregnant women 2. (*)	1. 80% of pregnant women 2. (*)	Coverage: Percentage of the population receiving the desired health care Source: SUIS-MSPAS (*) Data available at the MSPAS. However, information needs to be reprocessed manually to estimate the 2009 baseline. Targets will be calculated subsequently. Starting in 2010, the indicator will be available regularly through the SUIS. (**) National coverage of prenatal registration in 2009 was 63.3% of pregnant women. The MSPAS is developing a methodology to document the quality indicator in 2010 and processing available data to serve as baseline.

Component II: Strengthening of the MSPAS	Baseline 2009	Year 1	Year 2	Year 3	Year 4	Year 5	Comments
Outputs							
Number of ambulances equipped with life-support equipment operating with trained personnel	0	10 (operated by Red Cross under agreement for use by MSPAS)	15 (acquire 5 and maintain the existing 10)	25 (acquire 10 and maintain existing 15)	32 (acquire 7 and maintain existing 25)	32 (maintain existing 32)	Sources: semiannual execution reports
Number of hospitals with operational emergency departments (minimum 4 beds per hospital)	0	4	8	12	16	16	Sources: semiannual execution reports
Number of hospitals incorporated in the SUIS-MSPAS data network	0	3	12	21	30	30	Sources: semiannual execution reports
Number of health care units incorporated in the SUIS-MSPAS data network	0	5	20	35	50	50	Sources: semiannual execution reports
New Central Laboratory built and operational	0	0	0	0	1	1	Sources: semiannual execution reports
Outcomes							
SEM: Mortality rate due to external causes in the first 48 hours at the 16 hospitals involved in implementation of the SEM hospital care	The baseline will be available at the program startup workshop	- 3% nationally	- 7% (cumulative) nationally	- 11% (cumulative) nationally	- 15% (cumulative) nationally	- 15% (cumulative) nationally	Source: SUIS-MSPAS (*) Data available at the MSPAS. However, information needs to be reprocessed manually to estimate the 2009 baseline. Starting in 2010, the indicator will be available regularly through the SUIS.
SUIS: Number of health data systems operating in parallel	40	36	24	12	1	1	Sources: semiannual execution reports

Network of public laboratories: Diagnostic capacity of the laboratory network in some priority areas: 1. Quality of pap smear tests to detect cervical-uterine cancer (full cycle: taking of a smear, transport, processing, interpretation, and timely communication of results) 2. Coverage of first-time pap smear screening tests to detect cervical-uterine cancer 3. Laboratory coverage and diagnostic quality to detect epidemiologically relevant diseases according to standards, in particular dengue, meningitis, pneumonia, rotavirus and tuberculosis 4. Diagnostic tests for diphtheria 5. Diagnostic tests for Listeria monocytogenes and Escherichia coli 0157:H7 (in food and humans) 6. Surveillance for pesticides in blood, water, and bottled drinking water, fruits and vegetables	1. 60% of pap smear tests correctly processed; 80% of tests delayed 2. Very low (*) 3. Low (*) 4. 0 5. Very low (*) 6. Practically zero surveillance for pesticides in water and bottled water; very low coverage in blood, fruits and vegetables	1. 70% of pap smear tests properly processed and in good time 2. (*) 3. (*) 4. (*) 5. (*) 6. (*)	1. 80% of pap smear tests properly processed and in good time 2. (*) 3. (*) 4. (*) 5. (*) 6. (*)	1. 90% of pap smear tests properly processed and in good time 2. (*) 3. (*) 4. (*) 5. (*) 6. (*)	1. 90% of pap smear tests properly processed and in good time 2. (*) 3. (*) 4. (*) 5. (*) 6. (*)	1. 90% of pap smear tests properly processed and in good time 2. (*) 3. (*) 4. (*) 5. (*) 6. (*)	Sources: Pap smear tests: Database of the Pap Smear Test Quality Control Unit, Central Laboratory, MSPAS (*) Data available at the MSPAS. However, information needs to be reprocessed manually to estimate the 2009 baseline. Targets will be calculated subsequently. Additional data: Database of the Laboratory Surveillance Unit, Central Laboratory, MSPAS.

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INITIAL PROCUREMENT PLAN

	Description of the planned procurement	Estimated amount US$000	Procurement method	Prequalified Yes / No
WORKS	Improve the existing server rooms	500,000	NCB	No
	Development of the local network, power supply, and infrastructure	1,009,000	NCB	No
	Construction of the new central laboratory and biological facilities	5,600,000	ICB	No
	Upgrading of physical infrastructure for PHC	7,500,000	ICB	No
	Physical works in the emergency units	400,000	NCB	No
GOODS	Procurement of medical equipment	9,500,000	ICB	No
	Procurement of fixed information technology equipment	10,346,000	ICB	No
	Procurement of portable information technology equipment	927,000	ICB	No
	Procurement of IP computer hardware	1,366,000	NCB	No
	Procurement of servers	500,000	NCB	No
SERV	Training for all system users	1,580,000	NCB	No
	IHSDN-PHC training, policies, and standards	3,500,000	NCB	No
FIRMS	Design the network management system, with emphasis on an optimized level of primary care based on redefined existing structures	TBD	QCBS	No
	Design and put into service the standardized referral and cross-referral system	TBD	QCBS	No
	Design primary care based on mechanisms for social participation, work across sectors with an effect on the social determinants, and development of a social oversight system	TBD	QCBS	No
INDIV	TBD			

Key: ICB: International competitive bidding
NCB: National competitive bidding
QCBS: Quality- and cost-based selection
TBD: to be determined