Board of Executive Directors

For consideration

On or after 17 December 2014

PR-4259
2 December 2014
Original: English
Public Document
Simultaneous Disclosure

To: The Executive Directors

From: The Secretary

Subject: Trinidad and Tobago. Proposal for a loan for the "Health Services Support Program"

Basic Information:

Loan type .....Specific Investment Operation (ESP)
Borrower..... Republic of Trinidad and Tobago
Amount ..... up to US$110,000,000
Source .....Ordinary Capital

Inquiries to: Ian Ho-a-Shu (telephone Country Office in Trinidad and Tobago 868-622-8800) or Matilde Neret (extension 2794)

Remarks: This operation is included in Annex I of document GN-2756-2, "2014 Operational Program Report. Update", approved by the Board of Executive Directors on 30 July 2014. However, the loan amount exceeds the ceiling established for Group C countries. Therefore, the operation does not qualify for approval by Simplified Procedure.

Reference: GN-1838-1(7/94), DR-398-14(6/13), GN-2756-2(6/14)

DOCUMENT OF THE INTER-AMERICAN DEVELOPMENT BANK

TRINIDAD AND TOBAGO

HEALTH SERVICES SUPPORT PROGRAM

(TT-L1039)

LOAN PROPOSAL

The following project team prepared this document: Ian Ho-a-Shu, Team Leader (SPH/CTT); Tiphani Burrell-Piggott, Alternate Team Leader (SPH/CTT); Clara Alemann (SCL/GDI); Ignacio Astorga (SCL/SPH); Gregory Dunbar (FMP/CTT); Shirley Gayle (FMP/CTT); Martha Guerra (SCL/SPH); Risa Mark (consultant); Troy Parasram (ITI/CTT); Priya Ramsumair (CCB/CTT); and Bernardita Sáez (LEG/SGO).

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Electronic Links

Required

1. Project Execution Plan (PEP)
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2. Monitoring & Evaluation Arrangements
   http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=38915554
3. Procurement Plan
   http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=38916809

Optional

1. *e*-HIMS Feasibility Assessment Report
   http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=38915434
2. Detailed Budget
   http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=38915406
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4. Lessons learned: Health Sector Reform Program and June 2014 T&T Portfolio Review
   http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=38915464
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ABBREVIATIONS

AOP	Annual Operating Plan
BCC	Behavior Change Communication
CARICOM	Caribbean Community
CBA	Cost Benefit Analysis
CDAP	Chronic Disease Assistance Program
CFNI	Caribbean Food and Nutrition Institute
CS	Country Strategy
CVD	Cardiovascular Disease
DERPI	Diabetes Education Research and Prevention Institute
DHFs	District Health Facilities
EA	Executing Agency
EHR	Electronic Health Records
GDP	Gross Domestic Product
GORTT	Government of the Republic of Trinidad and Tobago
e-HIMS	Electronic Health Information Management System
HR	Human Resources
HRH	Human Resources for Health
HSSP	Health Services Support Program
IT	Information Technology
MoF	Ministry of Finance
MoH	Ministry of Health
MoHTT	Ministry of Health Technical Team
NCD	Non-communicable disease
PAHO	Pan American Health Organization
PIU	Project Implementation Unit
PMU	Project Management Unit
PROPEF	Project Preparation, Execution and Facility
PPP	Public Private Partnership
RHA	Regional Health Authority
SMF	Subject Matter Firm
T&T	Trinidad and Tobago
WHO	World Health Organization
UN	United Nations
UWI	University of West Indies

PROJECT SUMMARY

TRINIDAD AND TOBAGO

HEALTH SERVICES SUPPORT PROGRAM
(TT-L1039)

<table>
<tr><th colspan="4">Financial Terms and Conditions</th></tr>
<tr><td colspan="2" rowspan="5">Borrower: Republic of Trinidad and Tobago
Executing Agency: Ministry of Health</td><td colspan="2">Flexible Financing Facility*</td></tr>
<tr><td>Amortization period:</td><td>25 years</td></tr>
<tr><td>Original WAL:</td><td>15.25 years</td></tr>
<tr><td>Disbursement period:</td><td>5 years</td></tr>
<tr><td>Grace period:</td><td>5.5 years</td></tr>
<tr><td>Source</td><td>Amount (US$ Millions)</td><td rowspan="2">Supervision and inspection fee:</td><td rowspan="2">**</td></tr>
<tr><td>IDB (OC)</td><td>110</td></tr>
<tr><td>Local</td><td>0</td><td>Interest Rate:</td><td>LIBOR based</td></tr>
<tr><td>Other Co-financing</td><td>0</td><td>Credit fee:</td><td>**</td></tr>
<tr><td>Total</td><td>110</td><td>Currency of approval:</td><td>U.S. dollars from the Ordinary Capital</td></tr>
<tr><th colspan="4">Project at a Glance</th></tr>
<tr><td colspan="4">Project objective/description:
The objective of the Health Services Support Program (HSSP) is to prevent and control risk factors and non-communicable diseases among adults, and primary and secondary school students by strengthening the delivery of integrated primary care services; implementing behavior change programs and policies; improving health information management; ensuring adequate Human Resources for Health (HRH); and enhancing health facilities investment management through the innovative application and use of information and communication technology (ICT) including hardware, software, people, data and network.</td></tr>
<tr><td colspan="4">Special Contractual: Conditions Prior to First Disbursement:
(i) Evidence that the Borrower, through MoH, has hired a Technical Director, Program Coordinator, Procurement and Finance Officers pursuant to professional profiles satisfactory to the Bank; and (ii) Evidence that MoH has approved, with the prior non-objection of the Bank, an Operations Manual (OM) for the project, including inter alia administrative, procurement, execution arrangements including for e-Health Information Systems (e-HIMS), financial management policies, procedures and other internal control requirements to define overall project management for the project. (see paragraph 3.3).</td></tr>
<tr><td colspan="4">Exceptions to Bank policies: N/A</td></tr>
<tr><td colspan="4">Project qualifies as: SEQ [x] PTI [x] Sector [x] Geographic [ ] Headcount[ ]</td></tr>
</table>

(*) Under the Flexible Financing Facility (FN-655-1) the Borrower has the option to request modifications to the amortization schedule as well as currency and interest rate conversions, in all cases subject to the final amortization date and original WAL. In considering such requests, the Bank will take into account market conditions and operational and risk management considerations. Based on correspondence received from the Borrower, there will be no election to vary from the standard terms and conditions.

(**) The credit fee and inspection and supervision fee will be established periodically by the Board of Executive Directors as part of its review of the Bank's lending charges, in accordance with the applicable policies.

I. DESCRIPTION AND RESULTS MONITORING

A. Background, problem addressed, justification

1.1 **Country context.** Trinidad and Tobago (T&T) is a twin island republic with a population of 1.3 million, annual household income of US$7,308, and a stable macroeconomic outlook.[1] Life expectancy is 72 years; antenatal care coverage is 96%; immunization rates exceed 90%; and the literacy rate is 99%. T&T's overall health profile can be attributed to increased public health measures; increased health sector spending; and improvements in the social determinants of health, such as education. However, non-communicable diseases (NCDs) are a growing concern, and fluctuating maternal mortality[2] continues to be a challenge.

1.2 **Epidemiological transition and high prevalence of non-Communicable Diseases (NCDs).** T&T has undergone an epidemiological and demographic transition, fuelled by an aging population structure, and characterized by a high prevalence of NCDs, which now claim more lives than infectious diseases. Recent data indicates that six common NCDs: heart disease, hypertension, cerebrovascular disease (collectively referred to as cardiovascular disease [CVD]), diabetes, cancer, and chronic respiratory illness, account for 60%[3] of all deaths in T&T; with NCDs overall accounting for 78% of all deaths.[4] T&T's CVD mortality rate is one of the highest in the Americas (289/100,000 compared to Chile 125/100,000).[5] Modifiable behavioral risk factors that cause NCDs include unhealthy diet, harmful alcohol use, tobacco use, and physical inactivity; while intermediate risk factors include elevated blood pressure, raised blood glucose levels, and being overweight or obese.[6] In T&T, 59% of females and 52% of males are overweight or obese; 27% are hypertensive (high blood pressure); and 12% are diabetic, with diabetes prevalence expected to increase by 18% in the next 10 years.[7] Further, diabetes during pregnancy (gestational diabetes) has also been identified as a major driver of maternal morbidity and mortality in T&T.[8] Harmful alcohol use, another key risk factor, is reported by 40% of the population, while 21% of adults and 10% of children report tobacco use.[9] Forty-six (46%) percent of adults are physically inactive; and more than 75% of children and adolescents have a sedentary lifestyle; while 70% of children drink one or more high-sugar beverages daily. In addition, lack of routine screening and late detection of NCDs results in a high mortality rate. For example, although cervical cancer is the easiest gynecologic cancer to prevent with regular screening, 93 of the 125 women diagnosed with this disease each year, die because the cancer is detected too late.[10]

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1 IDB. (2014). T&T Quarterly Bulletin: Expenditure, inflation and elections. July 2014.
2 UNICEF. (2010). Situation Analysis of Children and Women in T&T.
3 Healthy Caribbean Coalition. (2014). Responses to NCDs in the Caribbean Community.
4 World Health Organization (WHO). (2011). Non communicable diseases country profiles 2011. T&T.
5 de Fatima Marinho de Souza et al. (2012). CVD mortality in the Americas. Heart, 98(16), 1207-12.
6 WHO. (2010). Package of essential NCD interventions for primary health care in low-resource settings.
7 Healthy Caribbean Coalition. (2014). Responses to NCDs in the Caribbean Community.
8 Teelucksingh, S. (2013). A case for universal screening for diabetes in pregnancy in T&T. UWI.
9 T&T MoH/ PAHO. (2012). T&T Chronic Non-communicable diseases risk factor survey [STEPS].
10 Healthy Caribbean Coalition. (2014). Responses to NCDs in the Caribbean Community.

1.3 **Gender and NCDs.** Gender and life-course determinants affect NCD prevalence, exposure to risk, access to health services, and health outcomes. Men in T&T have the highest overall NCD death rates in the entire Latin America and the Caribbean region.[11] However, cancer rates are higher in T&T women during the child-rearing period (30 to 44 years old) and the number of deaths due to diabetes is higher among women 45 to 64 years old. Statistics also indicate that females have a higher prevalence of risk factors (physical inactivity and obesity), except for smoking, with a tobacco prevalence of 34% for males compared to 9% for females. This gap is considerably reduced among the youth: 20% of boys and 16% of girls 13 to 15 years old currently smoke.[12] Men in T&T are also less prone to seek preventative health services and are therefore less likely to be screened or treated for NCDs,[13] suggesting the need to explore whether there are gender-based barriers to the uptake of NCD prevention and management health services.

1.4 **Childhood obesity is a growing concern in T&T.** A study conducted by the Caribbean Food and Nutrition Institute (CFNI) over the period 2009 to 2010 found that 23% of primary school children and 25% of secondary school children in T&T were overweight or obese.[14] This finding represents an approximate 300% increase over the 8.5% of children who were found to be overweight or obese in 2001.[15] Another study conducted by the University of the West Indies (UWI) and the Diabetes Education Research and Prevention Institute (DERPI) in 2009 demonstrated a significant increase in the number of children aged 5 to 17, who were diagnosed with Type II diabetes or identified to be at high risk of developing diabetes.[16] These rate increases are significant because childhood obesity, a precursor to adult obesity, has both immediate and long-term effects on health and well-being including a heightened risk for cardiovascular diseases, cancers, diabetes, bone and joint problems, sleep apnea, and social problems.[17] Healthy lifestyle habits, including healthy eating and adequate physical activity, can reduce childhood obesity and related diseases.[18, 19]

1.5 **Spending concentrated on NCDs treatment, not prevention.** Public expenditure on health care has accounted for 2.6 percent of Gross Domestic Product (GDP) on average over the past decade.[20] Current public spending to address NCDs is concentrated more on treatment rather than on prevention.[21] For example, the data shows that annual public expenditure on the cardiac surgery grew from US$0.91 million in 2005 to US$3.01 million in 2012, while annual public expenditure

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11 WHO (2014). WHO Global Infobase. www.who.int/infobase.
12 Global Youth Tobacco Survey. Ministry of Health. 2011.
13 Babwah et al. (2006). Pan American Journal of Public Health, 19, 79–84.
14 CFNI. (2010). Interim Report on the findings of the evaluation of School Meal Options in T&T.
15 Teelucksingh, S. (2013). A case for universal screening for diabetes in pregnancy in T&T. UWI.
16 UWI. (2011). Children Now Facing Adult Type II Diabetes. UWI Today, January 2011.
17 Daniels et al. (2005). Overweight in children and adolescents. Circulation, 111, 1999–2002.
18 CDC. (2014). Adolescent and School Health. Childhood obesity facts. www.cdc.gov/healthyyouth
19 Gender considerations are important, noting that 23% of girls and 36% of boys (PAHO Global Health Survey 2011) engage in, at least, one hour of physical activity five times a week.
20 World Bank Development Indicators (2014).
21 Theodore, Karl. (2011). Chronic non-communicable diseases and the economy.

on all NCDs prevention programs decreased from US$1.01 million to US$0.08 million in the same period.[22] In addition, the beneficiaries of T&T's Chronic Disease Assistance Program (which provides free prescription medications to treat chronic diseases) grew from 200,000 beneficiaries in 2009 to 680,000 beneficiaries in 2012. Consistent with this trend is that public expenditure on drugs for CVD, diabetes, cancer, and hypertension grew from US$5 million in 2004 to US$62 million in 2011.[23] Accordingly Government wishes to shift towards an integrated NCDs prevention, and control model which has proven to be a cost effective way to address NCDs.[24]

1.6 **International evidence and best practice governing the effectiveness of population-level and primary care interventions to reduce NCDs.** Both cost-effective population-wide and individual interventions are available for the prevention and control of NCDs.[25] If delivered together, they can reduce premature mortality and health care costs, and improve population productivity.

1.7 Comprehensive, integrated primary care has been found to substantially reduce morbidity and mortality from NCDs in Australia, Brazil, Finland, and Spain.[26,27] Integrating NCD services into primary care requires reorientation[28,29] to reduce modifiable risk factors; detect NCDs early; treat long-term conditions; implement effective disease management protocols; refer for continuity of care; empower for self-care; and encourage community support. Further, the evidence suggests that a total risk approach is cost-effective, that is, rather than treat each individual risk factor, the total risk approach advocates treatment based on an assessment of all risk factors, including the predicted risk of developing an NCD.[30] International evidence also suggests that implementing NCD programs in primary care can effectively reduce NCD-related hospital admissions by 70%.[31] Further, the burden of late-diagnosed NCDs can be reduced through increased screening and early diagnosis, which is most efficiently delivered through primary care. Recent evidence indicates that; 80% of heart disease, stroke and Type II diabetes, and 40% of cancer can be avoided through active primary care screening and treatment. In addition, integrated primary care services are proven to effectively reduce behavioral risk factors such as obesity, unhealthy diets, physical inactivity, tobacco use and harmful alcohol use.

1.8 The data also demonstrates that settings-based and population-level interventions are effective NCD prevention mechanisms. For example, schools are an important program setting to help children and adolescents develop the knowledge and behavior for lifelong healthy nutrition and physical activity. A Cochrane review[32] and the

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22 Ministry of Finance, Budget Estimates of Development Program, T&T.
23 MoH (2012). Evaluation of the CDAP Programme, Final Report. Port of Spain, T&T.
24 Jamison, D. et al (2006). Disease control priorities in developing countries. World Bank/Oxford
25 WHO. (2010). Research priorities: primary healthcare approach for prevention and control of NCDs.
26 Rasella et al. (2014). Impact of primary healthcare on mortality from CVDs in Brazil BMJ;349:g4014.
27 Macinko, Dourado & Guanais. (2011). Chronic diseases, Primary Care and Health Systems. IDB-DP-189.
28 Mendis et al. (2010). Bulletin of the World Health Organization (WHO), 2010, 88:412–419.
29 Hung et al. (2007). Rethinking prevention in primary care. The Milbank Quarterly, 85, 1, 69-91.
30 WHO. (2007). Prevention of CVD: guidelines for assessment and management of total CVD risk.
31 Guanais et al. (2009). Primary care and avoidable hospitalizations: evidence from Brazil. JACM, 32(2).
32 Waters et al. (2011). Interventions for preventing obesity in children. Cochrane Database Syst Rev, 7(12).

Institute of Medicine[33] reported the effectiveness of school-based obesity prevention programs, using combined interventions, namely diet and physical activity modification, in conjunction with family and home involvement. Other population-level NCD interventions include behavior change communication (BCC) campaigns. When targeted effectively, BCC campaigns are powerful tools for increasing knowledge, shifting behavior, and motivating the population to be healthy.[34]

1.9 **Current primary care and NCD interventions, and identified gaps.** In T&T, primary care services are delivered through five Regional Health Authorities (RHAs), which manage a network of 10 hospitals, six District Health Facilities (DHFs) and 97 health centers. The healthcare system is based on universal access and primary care in the public system is free. Under the IDB financed Health Sector Reform Program (HSRP) (LO-937/OC-TT) [1996-2010], 88 primary care centers were constructed or upgraded; a 100-bed hospital was constructed; and a national ambulance service was established. The HSRP also created the decentralized RHA model to deliver primary care. Primary care centers were focused on "expanding coverage" to prevent and treat common diseases and injuries; offer basic emergency services; refer to higher levels of care; and encourage health promoting behaviors. This decentralization laid the foundation for primary care delivery, and while adequate primary care infrastructure now exists, there is a need to reorganize and strengthen primary care delivery. For instance, challenges with the current primary care system include a long wait time for some services; the need for optimization of the patient-referral system for continuity of care; and the need for standardization of primary care teams and treatment protocols. In addition, T&T's current approach to NCDs emphasizes treatment; and needs to be balanced with more prevention efforts. For example, there is a high percentage of undiagnosed hypertension in T&T (25% among males and 16% among females), which suggests that screening for risk factors and early detection of NCDs is low.

1.10 **The Government of the Republic of Trinidad and Tobago (GORTT) has recently begun to take responsive action** against NCDs,[35] and recognizes the need to deliver integrated primary care services to address NCDs. Actions include: (i) a nationwide Chronic Disease Assistance Program (CDAP); (ii) the passage of the tobacco control act; and (iii) the establishment of a NCDs Technical Advisory Committee. The MoH is implementing NCD public awareness campaigns; but in keeping with current evidence, GORTT wishes to change to strengthened BCC campaigns to target individuals, communities and the population at large.[36] The GORTT has identified that the content of meals and beverages in schools requires alignment with healthy nutrition guidelines. Accordingly, a national school health and nutrition policy has been drafted and requires revision, and approval by Cabinet. To address

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33 Institute of Medicine. (2012). Accelerating progress in obesity prevention: Solving the weight of a nation.

34 Mullin. (2010). Introduction to Media Communications. 41st Union World Conference on Lung Health.

35 GORTT commitments: 2007 CARICOM NCDs Summit; Framework Convention on Tobacco Control; 2011/2014 United Nations (UN) High Level Meeting on Prevention and Control of NCDs; 2012 65th meeting of the World Health Assembly.

36 ITAP (2012). BCC Activities and Achievements, lessons learned, best practices, promising approaches.

these gaps, Government will implement a comprehensive Prevention and Control Plan supported by a sustained governance mechanism.

1.11 **Best practice for Human Resources for Health (HRH).** The shortage of especially primary care nurses and physicians can be an impediment to addressing NCDs in primary care.[37] Evidence indicates that in addition to competitive remuneration, offering training, monetary incentives, and non-financial incentives can result in improved performance of nurses and doctors.[38]

1.12 **Current HRH situation and identified gaps in T&T.** There is currently a shortage of primary care staff, especially primary care physicians and nurses. A 2013 HRH assessment study showed a 55% vacancy among physicians and a 34% vacancy among nurses.[39] The study also indicated that the reasons for this shortage are: (i) weak recruitment due to non-competitive remuneration; and (ii) poor retention due to the absence of financial incentives and a lack of continued educational opportunities. In addition to nurses leaving the public sector for the private sector, the situation is compounded by overseas recruiters who target nurses, resulting in "a nursing brain drain"[40]. A number of short-term remedial efforts have been made over the last five years: recruiting doctors from Nigeria and India; recruiting nurses from the Philippines; and utilizing United Nations Volunteer doctors. However, the shortage persists and to address this challenge, the MoH in 2013 developed a 10 year HRH Plan. The plan will address the recruitment and retention challenges by implementing the following: (i) a competitive remuneration and benefits package; (ii) an aggressive recruitment strategy, which includes a HRH employment web portal and job database; (iii) a retention strategy which includes financial and non-financial incentives, and continued educational opportunities; and (iv) a proposal to increase the supply of nurses, physicians and pharmacists through collaborations with tertiary-level institutions in T&T and overseas territories. These measures are aligned to international evidence which shows that competitive remuneration, and professional development opportunities are key elements to hiring, retaining and boosting productivity of nurses and physicians[41] and result in improved delivery of care.[42]

1.13 **International evidence and best practice for health information management.** Health data is used as a benchmark for progress, a currency for accountability, and a critical tool for policy decision-making. International evidence demonstrates that electronic health records (EHR) and electronic health information management systems (*e*-HIMS) can improve the quality of care, enhance clinical decisions, modernize administrative processes, detect potential medical prescription errors[43] and generate significant healthcare delivery cost savings.[44,] Studies by the Rand

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37 WHO. (2006). The world health report 2006: working together for health. Geneva.
38 WHO. (2008). The world health report 2008. Primary care: now more than ever. Geneva.
39 PAHO/MoH. (2013). 2nd Assessment of T&T's Progress Towards the Achievement of the Goals for HRH.
40 OAS. (2009). Brain drain and the impact on development. Special Committee on Migration.
41 IDB. (2013). Health and Nutrition Sector Framework Document (GN-2735-3).
42 IDB. (2013). Health and Nutrition Sector Framework Document.
43 Blaya et al. (2010). E-Health Technologies Show Promise in Developing Countries. Health Affairs.
44 Girosi et al. (2005). Extrapolating Evidence of HIT Savings and Costs. Rand Corporation.

Corporation concluded that $80 billion of the $2 trillion in annual health care expenditures in the US could be saved if all providers used EHR systems. International evidence also demonstrates that health professionals require training and behavioral change to use information technology (IT), if IT is to be useful.[45]

1.14 **Current health information management situation and identified gaps.** Under the HSRP, the MoH developed an information management strategy which provided the framework to develop its current Strategic Plan for Strengthening National Health Information Systems. This plan identifies the need for an *e*-HIMS recognizing that the RHAs use paper-based medical records, which are susceptible to illegible and inaccurate patient data and the likelihood of patient data being lost. There is no standard format for the medical records at the RHAs, which prevents data comparison and reduces the ability to effectively evaluate health outcomes. There is limited data sharing among the RHAs, which poses an obstacle to service delivery, especially the provision of continuity of care. As set out in the Strategic Plan,[46] the MoH will address these challenges by implementing an integrated *e*-HIMS, in which the EHR will be the core platform.

1.15 **International evidence for health facilities investment management** calls for a transparent analysis of need, risk, and return on investment based on a lifecycle scope approach to assess resource requirements over 15 to 25 years. Elements of modern health facilities investment management include: (i) criteria for making investment decisions; (ii) standards for health facilities planning, and construction and maintenance; and (iii) financial tools to assess the sustainability of facilities.[47]

1.16 **Gaps in health facilities investment management.** Estimated at US$1 billion, GORTT as part of its five year national investment program, plans to upgrade its secondary and tertiary care health facilities. The Project Management Unit (PMU) at the MoH that oversees this upgrade is understaffed, and lacks the systems to manage this upgrade. Comprising only three staff, the PMU requires management tools and guidelines to sustain the investment portfolio's performance standards. Further, the MoH and Ministry of Finance (MOF) are exploring the public-private partnership (PPP) modality for a diagnostic services- PPP pilot.[48] MIF Operation (TT-M1019) provided technical support to MOF to execute GORTT's PPP Policy. Despite its limited PPP experience, the PMU will oversee the contracting of the PPP provider in 2015. To address these gaps, MoH is seeking to strengthen the PMU.

1.17 **Country strategy (CS) with the Republic of T&T (GN-2638).** The loan is aligned to the social protection pillar of the CS and supports GORTT's efforts to improve delivery, access and quality of the supply of health services, especially to the poor. The loan will advance health improvements through: (i) expanding NCD-focused primary care; and (ii) improving quality/availability of sector personnel. In addition,

[45] Halamka. (2011). Addressing Japan's Healthcare Challenges with IT.
[46] T&T MoH. (2012). Strategic Plan for Strengthening National HIS, 2012-2016.
[47] Joint Commission Resources. (2009). Planning, Design, and Construction of Healthcare Facilities.
[48] GORTT. (2012). National PPP Policy, Ministry of Finance, Government for the Republic of T&T.

there will be efficiency gains created by the e-HIMS which will lead to healthcare delivery cost savings.

1.18 **Alignment with IDB-9 lending priority targets.** The loan will contribute to the lending program priorities of the Ninth General Increase in the Resources of the Inter-American Development Bank (AB-2764) (GCI-9): (i) small and vulnerable countries; and (ii) poverty reduction and equity enhancement as it supports GORTT to expand integrated primary care, and to prevent and control NCDs. In TT, NCDs are the main cause of morbidity and mortality, especially among the poor. The operation is also aligned with the IDB Health and Nutrition Sector Framework Document (GN-2735) as well as the 2014 Operational Program Report (GN-2756-2).

1.19 **Current Bank support and Lessons Learned.** A Project Preparation and Execution Facility (PROPEF) TT-L1035 (2955/OC-TT) loan approved in June 2013 financed technical work to advance the preparation of this operation (TT-L1039).[49] Also, key lessons from the HSRP (937/OC-TT), namely ensuring user-participation in project design, planning adequate resources allocation and effective stakeholder coordination were factored into this loan design.[50] Further, buy-in from clinical staff, a participatory approach to change, and a clear HIMS project scope, were key lessons gleaned from IDB experiences in Ecuador, Dominican Republic and Brazil on improving HIMS and investment management systems.[51] Also, a consultancy provided e-HIMS best practice guidance as cited in Paragraph 1.28. These project learnings and consultancy work provided the framework to scope project components, identify risks and their mitigation actions within the TT context. These risks and mitigation actions are summarized in Paragraphs 2.4 and 2.5.

B. Objective, components and cost

1.20 The objective of the Health Services Support Program (HSSP) is to prevent and control risk factors and non-communicable diseases among adults, and primary and secondary school students by strengthening the delivery of integrated primary care services; implementing behavior change programs and policies; improving health information management; ensuring adequate HRH; and enhancing health facilities investment management through the innovative application and use of information and communication technology (ICT) including hardware, software, people, data and network. To achieve this objective, the program will finance the following:

1.21 **Component 1. Implementation of NCD Prevention and Control Plan: (US$30.79 million).** The objective of this component is to reduce the morbidity and mortality from NCDs by increasing screening, early identification, and treatment of NCDs and risk factors, as set out in the NCD Prevention and Control Plan. This component is divided into the following subcomponents:

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[49] The PROPEF funded the NCDS, Human Resources, and legislative review consultancies.

[50] See detailed description of 'HSRP lessons learned' in optional electronic link # 4.

[51] EC-L1076- Support for the Extension of Social Protection and Health Care; DR-L1067- Strengthening of Management of Results of the Health Sector; BR-L1044 – Health Modernization/Harmonization

1.22 **NCD prevention and control policies and strategies (US$0.90 million).** Consistent with accepted regional NCDs resolutions[52], the program will finance technical assistance to develop and strengthen national NCDs prevention and control policies including: (i) policy to provide routine screening and treatment for NCDs within the primary healthcare system; (ii) food and nutrition policy with dietary guidelines; (iii) policy on physical activity; (iv) policy on harmful alcohol use; and (v) primary and secondary school nutrition and physical activity policy. These policies are crucial first steps to build robust NCD programs that will complement other existing health policies and contribute to the reduction of morbidity and mortality from NCDs and prevent and control risk factors. The program will also fund the institutional strengthening of the national surveillance system through the creation and consolidation of national registries including heart attack, stroke and cancer registers.

1.23 **Reorienting and strengthening comprehensive primary healthcare services. (US$6.64 million).** The magnitude of NCD morbidity and mortality in T&T requires an aggressive approach to prevention and treatment. Reorienting primary care services to provide increased screening, early identification, and early treatment will be facilitated through multidisciplinary teams' use of the total risk approach for optimal management of risk factors and NCD treatment. Given the need to increase the uptake of preventative and treatment services for hypertension, heart disease, diabetes, and cancer, this primary care reorientation aims to increase screening and treatment of NCDs and risk factors, using evidence-based protocols, and when necessary, the referral of patients with complicated NCD cases. To achieve these objectives, the program will finance: (i**) the change management and institutional strengthening activities** to set up the necessary governance structure, monitoring and evaluation systems allow the MoH to sustain investment in the NCD programs; (ii) **two research studies**, which will provide information to increase utilization of primary care services and also inform the accurate messaging for the behavior change communication campaign. The first study will evaluate the uptake of primary care and NCD services; and provide recommendations to deliver NCDs primary care services. The second study will assess gender-based determinants of NCDs, risk factors (including a Salt study), and screening and treatment patterns; (iii) **the implementation and strengthening of clinical protocols** with associated training modules for standardized screening and management of risk factors and NCDs; (iv) the **training of primary care teams** in new protocols for standardized screening and management of NCDs and risk factors; (v) the strengthening of **guidelines** to reconfigure multidisciplinary primary care teams; (vi) the development of a **"Continuity of Care Referral Manual"**, and provision of **training for primary care teams to use the referral manual and tools**; (vii) the training of primary care staff in gender sensitivity and gender-based determinants of NCDs; and (viii) the publication of **patient self-management and education material** on NCDs and risk factors. This material will be used as self-management tools for patients to track their progress on risk factor reduction. In addition, the program will support **operating costs for screening** of

[52] Trinidad and Tobago has signed onto the resolutions adopted by WHO Member States, during the 2012 and 2013 World Health Assembly, as part of the Global framework to reduce NCDs and risk factors.

diabetes and CVD (heart disease, hypertension, and stroke) and for screening for cervical cancer (visual inspection with acetic acid) in line with new policies.

1.24 **Healthy Schools TT (US$18.95 million).** This innovative school-based child and adolescent obesity prevention program will use a combination of physical activity and nutrition initiatives to support children to eat healthier foods and to be more active.[53] Teachers and parents will also be supported to implement health promotion activities. Building on its ongoing School Health Program, the MoH, in coordination with the Ministry of Education[54], will implement the program which will comprise the following elements: Psychosocial and structural (environment) dietary intervention comprising nutrition educational activities, a water-only beverage policy in schools. Food available in schools will reflect a healthy balanced diet and be supported by nutrition educational activities. Psychosocial and structural (environment) physical activity intervention comprising curricula to educate children on the benefits of daily exercise, pedometers to assess and encourage physical activity, and curriculum-mandated physical activity sessions. To achieve these objectives, the loan will design, implement and evaluate in collaboration and cooperation with other Government agencies[55], a "Healthy Schools TT" program pilot in 50 primary and 50 secondary schools[56], (the pilot will include approximately 39,000 students) which will be done over a 10 month academic year. On completion and successful assessment of the pilot, the program will be implemented nationwide in pre-primary, primary and secondary schools (approximately 260,000 children and adolescents)[57]. The program will also finance the following outputs for both the pilot and nationwide implementation: (i) "green" durable outdoor gyms; (ii) health education materials (including medical scales and measurement equipment, pedometers, posters, workbooks); and (iii) an implementation and research teams (including a coordinator, health educators, statisticians, and research assistants).

1.25 **NCDs BCC campaign (US$4.3 million).** The BCC campaign aims to encourage uptake of NCD primary care services such as screening and treatment; to sensitize the wider national community, students, and teachers and to encourage behavior change to reduce NCD risk factors. To achieve this objective, the loan will finance the design, implementation and evaluation of a life course, gender-sensitive BCC campaign and the production of relevant BCC material to address risk factors and NCDs.

1.26 **Component 2. Execution of the Human Resources for Health Plan (US$20.00 million).** The objective of this component is to implement the recruitment and retention strategy outlined in the HRH plan. Implementation will be a complex task involving the RHAs, the Ministry of Public Administration, Chief

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[53] Boys' and girls' different needs will be addressed, creating safe spaces for each to perform physical activity and learn about health issues.

[54] A MOU will be signed between the MoH and MoE defining the operational requirements of the pilot.

[55] Other Government agencies include: Education Facilities Company; Early Childhood Centers PPP Initiative.

[56] To ensure a representative sample, the schools will be randomly selected from a list provided by the Ministry of Education which includes schools from within all fifteen (15) districts of T & T. Schools on this list have indicated their willingness to part of the pilot and are located in both rural and urban areas.

[57] Once evaluated, the Project Inter Ministerial Implementation Steering Committee will approve the national roll out of the pilot.

Personnel Officer, Trade Unions and the MoF. Specifically, the program will finance the procurement of a HRH Implementation firm that will undertake two major activities: (i) **Update the design** of the following key elements of the strategy: (a) staff recruitment package for nurses, physicians and allied health professionals (including pharmacists, biomedical and project management professionals); (b) staff retentions plan for nurses, physicians and allied health professionals; and (c) HRH employment web portal and job database. (ii) **Implementation support**. The firm will guide a Counterpart Implementation Change Management Team at the MoH to carry out the step by step implementation of the HRH plan and manage stakeholder conflict. The project will also fund this MoH Counterpart Implementation Change Management Team[58]. The firm will also develop the following: (a) an implementation plan broken down into manageable segments; (b) the implementation governance structure; (c) the change management and a stakeholders' communications plan.

1.27 The project will fund short to medium term staff retention initiatives: (i) **the design, implementation and evaluation of a pilot study on "Caring for the Caregivers"**, a wellness initiative to address low morale,[59] attrition, and which aims to enhance the well-being of primary care staff at selected pilots sites across the Regional Health Authorities. The scale up to the other Regional Health Authorities will be funded from GORTT resources; and (ii**) Professional Development Training**. The project will fund post-graduate education training of healthcare providers, including physicians, nurses, district health visitors and allied health staff in metabolic disease management. The MoH will develop the selection criteria for candidates to access the training.

1.28 **Component 3. Implementation of an *e*-Health Information Management System (*e*-HIMS) (US$50.00 Million).** The objective of this component is to support the design and implementation of a nation-wide *e*-HIMS in order to generate 'real-time', quality data for decision-making on clinical matters, patient management and continuity of care, facilities administration, and resource allocation.[60] In keeping with best practice, a standardized electronic health record (EHR) will be the foundation module of the *e*-HIMS.[61, 62] The *e*-HIMS will connect the RHAs and the MoH into a single network to facilitate data compilation, the timely generation and analysis of risk factor and disease outcome data. This component will fund: (i**) a Subject Matter Firm (SMF)** which will develop: (a) the *e*-HIMS solution architecture design, (b) an EHR policy, and (c) review and refine the request for proposal scope requirements for the Turnkey Solution Vendor which are outlined in Section 4.5 of the *e*-HIMS Feasibility Report attached as optional electronic link 1; and (ii) **the Turnkey Solution Vendor** who under the supervision of the SMF will deliver: (a) an integrated *e*-HIMS solution which includes IT infrastructure, software, and hardware and incorporates

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[58] The loan will provide partial financing for the MOH Counterpart Implementation Change Management Team on a decreasing basis given that GORTT has committed to funding this team.

[59] IDB. (2014). Evidence on interventions to reduce health worker retention and performance in LMIC.

[60] New legislation is expected to be proclaimed in January 2015 for the implementation of e-HIMS.

[61] Seyon, G. (2014). *e*-HIMS Feasibility Assessment Report.

[62] The EHR will include fields for the collection of health data on prevalence, risk factors, services received, and outcomes of treatment disaggregated by sex, age, ethnicity and place of residence.

operation, maintenance and support, (b) *e*-HIMS governance model, (c) user training, and (d) institutional strengthening and change management activities required to foster user buy-in and sustain organization transformation. This component will also fund IT specialist staff at the MoH who will work alongside the Turnkey Vendor.

1.29 **Component 4. Strengthening of Health Facilities Investment Management (US$5.05 million)** to build capacity at the MoH to manage the procurement and supervision of works; and develop the financial tools to manage modern health facilities. The component will fund the following outputs: (i) a Facility Asset Management system at all public health facilities and to support new construction projects; (ii) Standard Operating Procedures for health facilities planning, design, electronic standard hospital room data sheets, construction; and (iii) a Routine Maintenance Management System. This component will also fund seven full time international consultants[63] at the PMU who in addition to transferring project management skills to PMU trainees, will refine country systems to manage facility investments, leading to efficiency gains in said country systems. The MoH in collaboration with the consultants will develop the change management plan to create the permanent institutional arrangements to ensure the quality and availability of such professional services in the future. Also, to strengthen the PMU to oversee the Diagnostic Services PPP Pilot and for future PPP projects, this component will finance the following outputs: (i) PPP governance structure; (ii) PPP contract templates; and (iii) PPP training on contract compliance. In line with the national PPP Policy, the MOF PPP Unit will have regulatory oversight of the PPP PMU.

1.30 **Cost Benefit Analysis (CBA).** The main impact of the project is on the reduction of mortality rates and more generally on overall improved quality of life of citizens. Without the program, citizens that exhibit high NCD risk factors would eventually become ill and die prematurely. The CBA counts as benefits the value of preventing deaths and improved quality of life. The costs of the project considered in the CBA include those directly related to setting up the project, with support of IDB financing but also additional complementary Government spending, and long-term recurrent annual costs. Using conservative assumptions on benefits and costs and a discount rate of 12%, the CBA estimates the Net Present Value of the project at US$647.21 million, with an Economic Rate of Return of 248.05%. The CBA tested the robustness of these results by making key changes to the main assumptions of the analysis—assuming that mortality rate targets were missed by 60%, that the present value of costs double, and that the Value of a Statistical Life is bounded by the level of GDP per capita—and in all cases the net present value of the project remains positive.[64]

C. Key results indicators

1.31 Project results are expected to contribute to: (i) A 10% mortality rate reduction in six common NCDs; (ii) a 5% reduction in the prevalence of overweight/obesity among primary school children.

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[63] The loan will provide partial financing for these full time consultants on a decreasing basis given that GORTT has committed to funding these consultants and any other required technical staff at the PMU.

[64] See CBA in optional electronic 3.

TABLE I-1. IMPACT INDICATORS

Impact Indicators*	Unit	Baseline Value (2014)	Target Value (2019)
Reduction in the mortality rate of six NCDs, per 100,000 population (heart disease, cerebrovascular disease, hypertensive diseases, cancers, diabetes, chronic respiratory illness)	#	Mortality rate per 100,000 population. Male: 740, Female: 417	Mortality rate per 100,000 population. Male: 667, Female: 375
Reduction in the prevalence of overweight/obesity among primary school age children (5-13 years)	%	23	21.85

NCD targets and indicators adopted in 2013 by WHO Member States. Global framework to reduce NCDS.

II. FINANCING STRUCTURE AND MAIN RISKS

A. Financing instruments

2.1 This operation will be financed from the Bank's Ordinary Capital resources. Table II-1 provides a summary budget by investment category and Table II-2 presents the project disbursement schedule. See optional link#2 detailed budget.

TABLE II-1. PROJECT COSTS

Components	IDB (US$)
Component 1: Implementation of NCDs Prevention and Control Plan	30,790,000
Component 2: Execution of Human Resources for Health Plan	20,000,000
Component 3: Implementation of *e*-Health Information Management Systems	50,000,000
Component 4: Strengthening of Health Facilities Investment Management	5,050,000
Project Administration (including audit, M&E and Final Evaluation)	2,160,000
PROPEF (TT-L1035) repayment**	1,500,000
Contingency	500,000
TOTAL	**110,000,000**

TABLE II-2 PROJECT DISBURSEMENT TIMETABLE

Component	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Component 1	3,007,500.00	1,422,500.00	9,308,998.38	16,573,501.62	477,500.00	30,790,000.00
Component 2	220,000.00	2,335,970.00	5,377,320.00	9,066,697.00	3,000,013.00	20,000,000.00
Component 3	840,000.00	575,000.00	22,409,230.77	10,156,923.08	16,018,846.15	50,000,000.00
Component 4	-	2,521,276.59	1,111,276.59	911,276.60	506,170.22	5,050,000.00
Project Administration	577,432.20	429,932.20	572,432.20	284,932.20	295,271.20	2,160,000.00
PROPEF repayment **		1,500,000.00				1,500,000.00
Contigencies			150,000.00	175,000.00	175,000.00	500,000.00
Total disbursements	**4,644,932.20**	**8,784,678.79**	**38,929,257.94**	**37,168,330.49**	**20,472,800.57**	**110,000,000.00**
Percentage%	**4.22%**	**7.99%**	**35.39%**	**33.79%**	**18.61%**	

**Costs include PROPEF repayment of US$1.5M

B. Environmental and social safeguard risks

2.2 As per the Environment and Safeguards Compliance Policy (OP-703), the safeguard policy filter categorized this loan as a "C" category, indicating that environmental and social impacts are likely to be positive for those beneficiaries who will have increased access to health services.

C. Fiduciary risk

2.3 The project has a medium fiduciary risk for project coordination, procurement and financial reporting. The mitigation actions as per Annex III, paragraph 3.1 include: (i) the development of an Operations Manual to define the roles of the MoH and the Project Implementation Unit (PIU); (ii) procurement training for the PIU; and (iii) IDB fiduciary training for the PIU.

D. Other key issues and risks

2.4 **Public Management, Governance, and Monitoring and Accountability Risks** are classified as high and along with their mitigation actions are summarized below:

Reduced Level of engagement brought about by any changes in Government. Mitigation action: Multi-year re-sensitization workshops with key stakeholders to reinforce stakeholders' priorities for the project. **Insufficient coordination between PIU and MoH**. Mitigation actions: (i) PIU will report directly to MoH Project Technical Team; (ii) PIU staff to have performance-based contracts to ensure that deliverables are achieved; and (iii) formal orientation for PIU staff, clearly defining their roles. **Lack of Knowledge Transfer**. Mitigation actions: (i) Well scoped Terms of Reference for consultancies which will include knowledge transfer; (ii) a Project Management Information System will be part of e-HIMS; and (iii) MoH/RHA counterparts to work alongside consultants (job shadowing).

2.5 There are also specific implementation risks: (i) Component 1: resistance by staff to strengthening activities; (ii) Component 2: HRH Plan implementation requires consensus among the MoH, RHAs, the Ministry of Public Administration, Chief Personnel Officer, and Trade Unions to address industrial relations and change management issues; (iii) Component 3: *e*-HIMS risks are: data privacy; limited user input; and interoperability among *e*-HIMS modules. The mitigation measures for these risks are presented below:

Risk	Risk Mitigation Action
Component 1: Resistance by physicians and nurses	A change management firm to design and implement a plan geared towards managing health provider adherence to screening and treatment protocols, and referral guidelines
Component 2: Complexity of HRH Plan implementation	The HRH Implementation firm will: (i) develop a change management and communication plan to address institutional complexities, manage stakeholder conflict, and monitor implementation progress; and (ii) breakdown implementation into manageable segments
Component 3: (i) Data Privacy; (ii) Limited buy-in from physicians and nurses; and (iii) Interoperability of *e*-HIMS modules	(i) Access controls to be part of *e*-HIMS; (ii) The *e*-HIMS Turnkey vendor will deliver a Change Management plan geared to achieving user buy-in for the *e*-HIMS, by managing their expectations, through a multi-year public stakeholder communication effort; and (iii) and in keeping with industry practice to manage risk associated with large-scale system design/IT solution projects, the Turnkey Vendor will deliver, test and implement the interoperability of the full package of modules.

2.6 **Sustainability.** The loan will support the development of the necessary governance structure, measurability and a monitoring and evaluation framework to make it feasible for the MoH to continue investment in the NCD programs. Further, the execution of the change management plans will foster organizational transformation and support the continued implementation of these new interventions.

III. IMPLEMENTATION AND MANAGEMENT PLAN

A. Summary implementation arrangements

3.1 **The Borrower** is the Republic of T&T and the Executing Agency (EA) will be the MoH. The Project Implementation Unit (PIU) established within the MoH, under the PROPEF, will execute the HSSP.

3.2 **PIU Responsibilities.** As per Section G, Paragraphs 6.8 and 6.9 of Annex III, the PIU will be responsible for managing loan financing and procurement processes. The PIU will comprise a Technical Director, Project Coordinator, Financial Specialist, Procurement Specialist, and Administrative Assistant. Specific PIU

duties include: (i) preparation, and implementation of Annual Operating Plans (AOPs); (ii) preparation of budgets, and disbursements; (iii) preparation of the Procurement Plan; (iv) hiring the external audit and ensuring that the approved recommendations are implemented; and (v) program liaison with the Bank.

3.3 **Special Conditions Prior to First Disbursement**. As per Paragraph 4.1A,(i) – (ii) in Annex III, **conditions to first disbursement are as follows: (i) Evidence that the Borrower, through MoH, has hired a Technical Director, Program Coordinator, Procurement and Finance Officers pursuant to professional profiles satisfactory to the Bank; and (ii)Evidence that MoH has approved, with the prior non-objection of the Bank, an Operations Manual (OM) for the project, including inter alia administrative, procurement, execution arrangements including for *e*-HIMS, financial management policies, procedures and other internal control requirements to define overall project management for the project.**

3.4 **A Project Inter-Ministerial Implementation Steering Committee**, chaired by the Ministry of Health, and comprising the Ministries of Education, Public Administration, and Finance and other relevant Ministries will be established to resolve execution problems. The **MoH Technical Team (MoHTT)** which provided oversight in project design will be expanded to include the RHAs, Ministry of Education, and the MoF. This Team will manage inter-institutional coordination. Comprising members from Government Ministries and the national community, the **NCDs Technical Advisory Committee,** chaired by the Ministry of Health will monitor progress and broker involvement of all key stakeholders.

B. Summary of arrangements for monitoring results

3.5 **The PIU** will monitor project execution and report on the results matrix indicators. The PIU will also submit to the Bank: semi-annual reports; AOP; Procurement Plan; AFS within 120 days following close of EA fiscal year and within the financing disbursement period; and final AFS, within 120 days of the date stipulated for the final disbursement of financing measures.

3.6 **Monitoring and Evaluation (M&E).** Loan resources will fund a consultant to conduct a project mid-term and a final evaluation. The M&E Plan will be used to guide the evaluation of the project's five year implementation period. This plan outlines the use of the Bank's monitoring tools such as the Results Matrix; AOP; semi-annual progress reports; and the PMR. Using the random assignment methodology supported by the collection of baseline data through interviews and questionnaires, the M&E consultant will also lead impact evaluations of the Healthy Schools TT pilot, BCC campaign and Caring for the Caregivers pilot, in order to assess whether behavioural changes among beneficiaries can be attributed to these interventions. See detailed M&E plan as a required link#3.

Development Effectiveness Matrix			
Summary			
I. Strategic Alignment			
1. IDB Strategic Development Objectives	Aligned		
Lending Program	i) Lending to small and vulnerable countries; ii) Lending for poverty reduction and equity enhancement.		
Regional Development Goals			
Bank Output Contribution (as defined in Results Framework of IDB-9)			
2. Country Strategy Development Objectives	Aligned		
Country Strategy Results Matrix	GN-2638	To improve the effectiveness and efficiency of social safety net programs.	
Country Program Results Matrix	GN-2756-2	The intervention is included in the 2014 Operational Program.	
Relevance of this project to country development challenges (If not aligned to country strategy or country program)			
II. Development Outcomes - Evaluability	Evaluable	Weight	Maximum Score
	8.2		10
3. Evidence-based Assessment & Solution	9.0	33.33%	10
3.1 Program Diagnosis	2.4		
3.2 Proposed Interventions or Solutions	3.6		
3.3 Results Matrix Quality	3.0		
4. Ex ante Economic Analysis	7.0	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	0.0		
4.3 Identified and Quantified Costs	0.0		
4.4 Reasonable Assumptions	1.5		
4.5 Sensitivity Analysis	1.5		
5. Monitoring and Evaluation	8.6	33.33%	10
5.1 Monitoring Mechanisms	1.5		
5.2 Evaluation Plan	7.1		
III. Risks & Mitigation Monitoring Matrix			
Overall risks rate = magnitude of risks*likelihood	High		
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/PDP Criteria)	Yes	Financial Management: Budget, Treasury, Accounting and Reporting, External control, Internal Audit. Procurement: Information System, Shopping Method, Contracting individual consultant, National Public Bidding (Use of some National Sub-System).	
Non-Fiduciary			
The IDB's involvement promotes improvements of the intended beneficiaries and/or public sector entity in the following dimensions:			
Gender Equality	Yes	As part of the institutional strengthening activities for Component 1, a research study will be done to explore whether there are gender-based barriers to the uptake of NCD prevention and management health service. This study will inform training of primary care staff in gender sensitivity and gender-based determinants of NCDs. The loan will finance a gender-sensitive Behavioral Change Communication program to address risk factors and NCDs.	
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 Cooperation PROPEF TT-L1035 was approved.	
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	Two experimental evaluations will contribute to the knowledge base on (1) how to address NCD risk factors in school age populations and (2) How to improving caregiver wellbeing and retention.	

The Health Services Support Program (HSSP) aims to prevent and control risk factors and non-communicable diseases (NCDs) among adults, and primary and secondary school students with the ultimate objective of reducing mortality and morbidity from NCDs. To accomplish these goals, the program implements an NCD prevention and control plan, a human resource plan and an e-health information management system, and strengthens health facilities investment management. The project is expected to benefit the entire country through strengthened primary care services, 268,000 school children through the Health Schools initiative, and over 3000 health personnel through training, recruitment and the Caring for Caregivers pilot.

The logical framework presented in the POD is consistent, covering inputs, outputs, outcomes and impacts. The results matrix includes indicators for major outputs, outcomes and impacts of the program, including mortality rate of six NCDs and prevalence of overweight/obesity among primary school age children. The indicators in the results matrix meet SMART criteria and include baseline values and targets.

The Ministry of Health (MOH), through an internal Project Implementation Unit (PIU), will be responsible for monitoring and evaluation activities, which will be coordinated with the Bank. The monitoring and evaluation activities have been planned and budgeted. Data sources for monitoring include Primary Health Center and Hospital statistical reports, primary evaluation surveys to be collected by the program, Pan-American STEPS data and component specific monitoring reports and notes. The program proposes two experimental impact evaluations and one reflexive evaluation. The first experiment will identify the causal link between the Healthy Schools intervention and student level outcomes, health and nutrition related knowledge and habits, as well as BMI. The second experiment evaluates the impact of the caring for caregivers pilot on worker morale, workplace satisfaction and intervention related knowledge and services. The Behavior Change Communication campaign evaluation will assess the change in health knowledge and habits of a mass communication campaign to prevent NCDs by comparing changes before and after the campaign's implementation.

RESULTS MATRIX

The objective of the Health Services Support Program is to prevent and control risk factors and NCDs among adults, and primary and secondary school students by strengthening the delivery of integrated primary care services; implementing behavior change programs and policies; improving health information management; ensuring adequate human resources for health; and enhancing health facilities investment management through the innovative application and use of information and communication technology (ICT) including hardware, software, people, data and network. Targets reflect 2012 and 2013 World Health Assembly resolutions adopted by WHO member states. To see an expanded version of this Results Matrix Annex, see optional link#7.

IMPACT INDICATORS	Unit	Baseline Value (2014)	Target Value (2019)	Means of verification
Mortality rate of six non-communicable diseases (ischemic heart disease, cerebrovascular disease, hypertensive diseases, cancers, diabetes, chronic respiratory illness)	#	740 (Male) 417 (Female) per 100,000 population	667 (Male) 375 (Female) per 100,000 population	PAHO/WHO Country Profile on NCDs; Annual Household Survey from Central Statistical Office
Prevalence of overweight/obesity among primary school age children (5-13 years)	%	23	21.85	TT NCDs Risk Factor Survey (Pan American STEPS)

OUTCOME INDICATORS	Unit	Baseline (2014)	Midterm (2017)	Midterm (2018)	Target (2019)	Source/Means of verification
Percentage of patients referred according to the 'Continuity of Care Referral Manual'	%	0	25	50	75	Primary Health Center reports as well as Hospital Statistical Reports
Number of health centers using new clinical protocols for screening, prevention, diagnosis, and management of risk factors and non-communicable diseases	#	0	85	90	97	Primary Health center reports
Number of health centers with functioning multidisciplinary teams	#	0	85	90	97	Health Center Staff Roster
Prevalence of physical inactivity among children in primary and secondary school	%	75	72	70	68	Pilot project evaluation survey
Percentage of children in primary and secondary school who consume one or more high-sugar beverage daily	%	70	67	65	63	Pilot project evaluation survey
Prevalence of adults consuming less than five servings of fruits and vegetables	%	M:92.8 F:89.3	M:92.3 F:88.8	M:91.5 F:88.2.	M90:8 F:87.3	TT NCDs Risk Factor Survey (Pan American STEPS)
Proportion of adults with untreated or uncontrolled raised blood pressure	%	M:25 F:16	M:24.5 F:15.5	M:24 F:15	M:23 F:14	TT NCDs Risk Factor Survey (Pan American STEPS)
Proportion of adults with diabetes having an annual foot exam to manage the diabetes	%	M:15 F:23	M:15.5 F:23.5	M:16 F:24	M:17 F:25	TT NCDs Risk Factor Survey (Pan American STEPS)
Proportion of adult females undergoing a pap smear test (once every 3 years)	%	51	52	54	56	NCDs Risk Factor Survey (Pan American STEPS)
Percentage of vacancies for physicians at the Regional	%	55	51	49	47	Regional Health Authority Annual Reports

PIU=Project Implementation Unit * CSO=Central Statistical Office * NCD=Non-communicable disease * M&E=Monitoring and Evaluation

OUTCOME INDICATORS	Unit	Baseline (2014)	Midterm (2017)	Midterm (2018)	Target (2019)	Source/Means of verification
Health Authorities						
Percentage of vacancies for nurses at the Regional Health Authorities	%	34	33	32	31	Regional Health Authority Annual Reports
Number of health centers utilizing Electronic Medical Records	#	0	60	80	97	Primary Health Center Reports
Percentage of health facility investment decisions made utilizing the 'Facility Asset Management Manual'	%	0	50	80	100	Facilities Asset Management Reports

OUTPUTS		Unit	Base	Y1	Y2	Y3	Y4	Y5	End	Source
Component 1 - Implementation of NCDs Prevention and Control Plan										
1.1	Policies developed and presented to Cabinet (1) Primary and Secondary school nutrition and physical activity; 2) National food and nutrition policy with dietary guidelines; 3) physical activity; 4) harmful alcohol use and 5) policy to provide routine screening and treatment for Non-communicable diseases within the primary care system	# of policies	0		1	2	2		5	Cabinet Note
1.2	Change Management and Institutional Strengthening Plan implemented	# of plans	0				1		1	Cabinet Note
1.3	'Healthy schools TT' pilot project designed	# of pilot projects	0	1					1	Healthy School Pilot Progress Reports
1.4	'Healthy schools TT' pilot project implemented in 100 schools	# of pilot project	0		1				1	Healthy School Pilot Progress Reports
1.5	'Healthy schools TT' pilot project evaluated in 200 schools	# of pilot project	0	1		1			2	Healthy School Pilot Evaluation Survey
1.6	'Green' Durable Outdoor Gyms provided to pre-pimary, primary and secondary schools	# of gyms	0		150	420	449	200	1219	Healthy School Pilot Progress Reports
1.7	All Schools provided with equipment to implement 'Healthy Schools TT' project	# of schools	0		150	420	449	200	1219	Healthy School Pilot Progress Reports
1.8	All Schools covered by Research and Implementation teams (Health educator, Coordinator, Research assistants, Statistician) for 'Healthy School TT' implementation	# of schools	0		150	420	449	200	1219	Healthy School Pilot Progress Reports
1.9	Pre-Primary, Primary and Secondary Schools provided with education and communication material packages (for	# of schools	0		150	420	449	200	1219	Healthy School Pilot Progress Reports

OUTPUTS		Unit	Base	Y1	Y2	Y3	Y4	Y5	End	Source
	students, parents, teachers)									
1.10	Pre-Primary, Primary and Secondary Schools that have implemented 'Healthy Schools TT'	# schools	0		150	420	449	200	1219	Healthy School Pilot Progress Reports
1.11	Comprehensive, life course, gender-sensitive Behavior Change Communication (BCC) campaign to address risk factors and Non-communicable diseases designed	# of campaigns	0		1				1	BCC Design Report
1.12	Comprehensive, life course, gender sensitive Behavior Change Communication (BCC) campaign to address risk factors and Non-communicable diseases implemented	# of campaigns	0			1			1	BCC Campaign Progress Reports
1.13	Comprehensive, life course, gender sensitive Behavior Change Communication (BCC) campaign to address risk factors and Non-communicable diseases evaluated	# of campaigns	0	1		1			2	BCC Campaign Evaluation Survey
1.14	Research study conducted on accessibility and usage of primary care and NCD services	# of studies	0	1					1	MOH Technical Team Reports
1.15	Research study on gender-based determinants of NCDs, risk factors, health seeking, screening patterns, and uptake of services by males and females	# of studies	0	1					1	MOH Technical Team Reports
1.16	Protocols with associated training modules for standardized screening and management of risk factors and non-communicable diseases developed	# of protocols	0	6					6	MOH Technical Team Reports
1.17	Health centers with Primary care teams trained in new protocols for screening and management of risk factors and NCD services	# of health centers	0		20	30	35	12	97	Primary Health Center Reports
1.18	Health facilities with staff trained in gender sensitivity	# of health facilities	0			40	40	33	113	Primary Health Center Reports and Hospital Reports
1.19	Guidelines established for configuration of multidisciplinary primary care teams	# of guidelines	0	1					1	Primary Health Center Reports and Hospital Reports;
1.20	Health centers with functioning multidisciplinary teams	# of health centers	0		80	85	90	97	97	Primary Health Center Reports
1.21	'Continuity of Care Referral Manual' with associated training module developed	# of manuals	0	1					1	Primary Health Center Reports
1.22	Health centers with Primary care teams	# of health centers	0		80	85	90	97	97	Primary Health Center Reports

OUTPUTS		Unit	Base	Y1	Y2	Y3	Y4	Y5	End	Source
	trained in new 'Continuity of Care Referral Procedures'									
1.23	Patient self-management and education material booklets developed and printed	# of booklets	0		500.000				500.000	MOH Technical Team Reports
2.1	Staff recruitment package for nurses, physicians and allied health professionals designed	# of packages	0			1			1	Cabinet Note
2.2	Staff recruitment package implemented	# of packages	0			1			1	Cabinet Note
2.3	Human Resource for Health employment web portal and job database functional	# of web portals	0		1				1	e-HIMS report;
2.4	Staff retention Plan designed	# of plans	0			1			1	Cabinet Note
2.5	Staff retention Plan implemented	# of plans	0			1			1	Cabinet Note
2.6	Change Management and Communication Plan designed	# of plans	0			1			1	Cabinet Note
2.7	Change Management and Communication Plan implemented	# of plans	0			1			1	Cabinet Note
2.8	Counterpart Change Management Implementation Team established	# of teams	0		1				1	Cabinet Note
2.9	Governance Roadmap for Human Resources for Health Plan Implementation	# of roadmaps				1				Cabinet Note
2.10	Physicians enrolled in post graduate metabolic disease management	# of physicians	0			3	3	4	10	MOH Human Resources Reports
2.11	Nurses and Allied Professional Staff who receive continued education (14 month post graduate)	# of staff	0			30	50	50	130	MOH Human Resources Reports;
2.12	'Caring for the Caregivers' Staff Wellness Project pilot designed	# of studies	0		1				1	Caring for Care Givers Reports
2.13	Health centers in North west Regional health authority implementing Care for care givers staff wellness project	# of pilots	0		3				3	Primary Health Center Reports;
2.14	Evaluation carried out in the three health centers in North west Regional health authority that implemented Care for care givers staff wellness project	# of evaluations	0	1		1			2	Caring For Care Givers Evaluation Survey
Component 3 – e-Health Information Management System										
3.1	Electronic Health Records Policy developed and presented to Cabinet	# of policies	0	1					1	Cabinet Note

OUTPUTS		Unit	Base	Y1	Y2	Y3	Y4	Y5	End	Source
3.2	e-Health Information Management System Solution architecture (electronic medical records for patient registration; scheduling/appointments; admission, discharge & transfer; pharmacy; emergency; surgical theatre) developed and presented to Cabinet	# of systems	0		1				1	Cabinet Note
3.3	Policy paper on e-Health Information Management System Governance Structure developed and presented to Cabinet	# of policy papers	0	1					1	Cabinet Note
3.4	e-Health Information Management System implemented-5 Regional Health Authorities	# of systems	0			2		3	5	e-HIMS Management reports
3.5	IT Specialist Staff hired	# of staff				14			14	MOH Technical Team Reports
3.6	Approved Change Management Plan	# of plans	0		1				1	Cabinet Note
3.7	User training programs delivered at 5 Regional Health Authorities	# of training programs				5			5	Annual Regional Health Authority Reports;
Component 4 - Health Facilities Investment Management										
4.1	Facilities Asset Management System implemented at Ministry of Health	# of systems	0		1				1	Facilities Asset Management Reports
4.2	Guidelines for Standard Operating Procedures (SOPs) for health facilities planning, design, construction and maintenance completed	# of guidelines	0		4				4	Facilities Asset Management Reports
4.3	Routine Maintenance Management System (RMMS)designed and implemented	# of systems	0				1		1	Facilities Asset Management Reports
4.4	Policy paper on Public Private Partnership Health Sector governance structure developed and presented to Cabinet	# of policy papers	0		1				1	Cabinet Note
4.5	Public Private Partnership contract templates and lease arrangements developed	# of templates	0			4			4	Project Management Unit Reports
4.6	PPP Training program delivered to Project Management Unit	# of training programs			1					Project Management Unit Reports
4.7	Project Management Unit Staff hired	# of staff				7			7	Project Management Unit Reports

FIDUCIARY ARRANGEMENTS

Country : Trinidad and Tobago
Project : Health Services Support Program (HSSP) TT-L1039
Executing Agency: Ministry of Health (MOH)
Prepared by : Shirley Gayle, Fiduciary Procurement Specialist and Gregory Dunbar, Fiduciary Financial Management Specialist

I. EXECUTIVE SUMMARY

1.1 Since 2005, the GORTT has been making steady strides towards improving the transparency, efficiency and cost-effectiveness of Public Financial Management (FPM) framework within which public money is managed. Cabinet has agreed to multi-annual planning horizons and on the annual budget ceilings, however politically agreed ceilings have not yet been reflected in any issue of the annual Call Circular that heralds the start of the formal Budget Cycle. A Single Treasury Account (TSA), which includes development financing, is maintained but only for Central Government. The bank accounts of State-owned Entities (SOE) and wholly-owned corporations are outside of this net, which impairs effective cash and debt management. The process for accounting and reporting continues to be manual and heavily paper-based, which negatively impacts efficiencies, accuracy and timeliness of reporting for decision-making. However, the Bank is currently preparing an investment loan (TT-L1042) with the GORTT for the implementation of an Integrated Financial Management System The Office of the Auditor General for Trinidad and Tobago has been improving its capabilities, tools and techniques to deliver its mandate with institutional strengthening provided via TT-T1024. Other oversight arms, such as the Public Accounts Committee (PAC) of Parliament, are seriously under resourced, which accounts for a significant backlog in the reviews of both audited and unaudited accounts of public entities. The procurement framework is being overhauled with drafting of new legislation which is now before Parliament for approval. The new legislation proposes a decentralized procurement system overseen by a Regulator.

1.2 Despite the short-comings of the PFM framework, the budget, treasury and external audit sub-systems have been cleared by the Bank for use during execution and supervision of Bank-financed operations. The area of accounting and reporting is usually augmented by the use of an off-the-shelf accounting software.

1.3 The Bank's methodology for Project Risk Assessment (GRP) was utilized to identify the program's risks and to determine the corresponding risk response. The Institutional Capacity Assessment System (ICAS or SECI) methodology was used to evaluate the fiduciary capacity of the Executing Agency (EA).The MoH's capacity to execute the proposed program suggests a risk level of medium with respect to overall financial management and procurement management, the areas of internal control; financial planning and budgeting; accounting and financial reporting systems. It is anticipated that after implementation of certain risk responses, the risk will be further reduced.

II. EXECUTING AGENCY'S FIDUCIARY CONTEXT

2.1 The MoH is established within the public sector architecture with a clear mandate. It has prior experience in executing an IDB project with the previous 937/OC-TT (TT0024) "Health Sector Reform Program", which ended in 2010, some 7 years after the original expiry date. The role of the PIU and the execution arrangements including the procurement of the *e*-HIMS will be outlined in the Operations Manual (OM) to document pertinent policies and procedures, roles and responsibilities related to fiduciary and technical operations at the MoH and within the PIU. It is important that this manual sets out the reporting relations among PIU's staff and between the PIU's staff, the Technical Team and Permanent Secretary (PS), the Project Inter-Ministerial Implementation Steering Committee as well as between the MoH and the NCDs Technical Advisory Committee. Some aspects of the execution arrangements have been documented in the OM for the PROPEF (TT-L1035), which will be updated for this program. As a government ministry, the financial management arrangements for the MoH are governed by the Exchequer and Audit Act and the Financial Regulations made thereunder; the Financial Instructions, 1965, the Financial Regulations (Stores) and Circulars issued by the Minister with responsibility for Finance.

2.2 The procurement function in the MoH is carried out by the Organization and General Administration Unit (O&GA). O&GA procures recurrent goods and services such as stationery, office equipment and vehicles. There is a Project Management Unit that administers the Ministry's major infrastructure program. These purchases are guided by the Central Tenders Board Act 1961 as well as the thresholds granted to Permanent Secretaries by Cabinet. The PS has authority to approve procurements up to TT$1M. Procurements above this up to $2M are approved through the Ministerial Tenders Committee and above TT$2M through the CTB. The PS has delegated authority by way of purchasing thresholds to the Heads of satellite units (Vertical Services and Special Programs). . The Ministry does not have an internal Procedures Manual for procurement however Circulars 5 and 6 issued by the PS in 2012 give instructions for the procurement of goods and services including the monetary thresholds and the limits for department Heads. This capacity will be augmented with the hiring of staff to meet the needs of the PIU.

III. FIDUCIARY RISK EVALUATION AND MITIGATION ACTIONS

3.1 The Project Team, in consultation with MoH and other stakeholders, has identified the major risks that are likely to affect the proposed Program. The parties have also jointly developed a preliminary Risk Mitigation Matrix which outlines the risk responses to be taken. The main mitigation measures for fiduciary arrangements will include: definition and establishment of the functions, roles and responsibilities of the major entities for the execution of the program, before eligibility date; formal and informal training processes for the fiduciary officers, the development of the project planning documents, PEP, AOP, PP and FP and the deployment of an accounting system, acquired and installed under TT-L1035 to supplement recording and reporting, will also be addressed before the initiation of the program. The MoH will document and formalize all these arrangements,

including key processes such as budget, payment/disbursement and procurement, in the Program's Operation Manual (OM), which will be an update to the OM developed under TT-L1035. Other measures to respond to the boarder project risk are incorporated as institutional strengthening activities throughout the four components and outlined in the initial Risk Matrix for the Program. The Bank will provide fiduciary support and supervision on these institutional arrangements while providing continual training and advice as needed on Bank's policies, procedures and practices. The level of the fiduciary risk will be monitored during execution through a supervision plan designed for such purpose and through the annual financial audit exercise.

3.2 A joint Matrix review will be undertaken annually, and any necessary additional mitigating actions will be adopted. The overall financial management risk rating of the EA is Medium for all execution areas. The implementation of the mitigation actions indicated below can reduce the risk level too low for the execution of the Project.

Risks Identified	Mitigating Measures
Medium Risk- Lack of clear assignment of roles and r responsibilities and poor coordination between the entities involved, impairing project execution.	Operations Manual to be developed, incorporating an Organizational Chart with defined and elaborated roles and responsibilities of the MoH, the Project Inter-Ministerial Steering Committee, MoH Counterpart Change Management Implementation Team, the NCDs Technical Advisory Committee, Technical Team, PIU and coordination with other key functionaries involved in execution for operations and financial management, reporting, risk management and performance monitoring and supervision.
Medium Risk-Accounting and reporting system needs.	An accounting system that will integrate and facilitate the financial reporting and budgeting under the project, according to source of funding and categories of investments (at a minimum) will be implemented for the project.
Medium-High Risk-Errors and delays in procurement processes due to unfamiliarity with IDB policies. Disbursements and financial management and reporting procedures.	Training on Bank's financial management and procurement procedures will be provided to the project team of the Ministry. Recruitment of experienced procurement specialist to support PIU.
Medium-High Risk-Lack of project management skills.	Training in project management will be conducted to support the execution of the project.

IV. ASPECTS TO BE CONSIDERED IN THE SPECIAL CONDITIONS OF CONTRACT

4.1 In order to move forward the contract negotiations by the project team, the following Fiduciary Arrangements should be considered in the special conditions to complement the conditions appearing the Bank's General Conditions to sovereign guaranteed investment operations:

A. Special Conditions Precedent to First Disbursement includes:

(i) Evidence that the Borrower, through MoH, has hired a Technical Director, Program Coordinator, Procurement and Finance Officers pursuant to professional profiles satisfactory to the Bank; and,

(ii) Evidence that MoH has approved, with the prior non-objection of the Bank, an Operations Manual (OM) for the project, including inter alia administrative, procurement, financial management (budgeting, cash management,

payment/disbursement, accounting and reporting) policies, procedures, execution arrangements including *e*-HIMS and other internal control requirements to define overall project management for the project.

A. Exchange rate

For purposes of justification of expenses to the Bank (including reimbursements), where the project expenses have been incurred in local currency, the equivalent amount to be reported in the project currency, shall be determined using the effective exchange rate on the payment date, without regard to the source of the financing used.

B. Financial reports and audit financial statements

The MoH will be required to submit annual audited financial statements of the program within 120 days following the closing of each fiscal year. The last of these audited financial statements shall be presented by MoH no later than 120 days following the date stipulated for the final disbursement of the Financing. The financial statement audits will be conducted in accordance with the Bank's policies, and will be carried out by a firm of independent public accountants acceptable to the Bank or the Auditor General for Trinidad and Tobago, where such appointment has been accepted.

V. REQUIREMENTS AND AGREEMENTS FOR EXECUTION OF PROCUREMENT

5.1 The procurement fiduciary arrangements establish the conditions applicable to all procurement execution activities in the project. **Procurement Execution: Staff:** The PIU in the MoH shall be staffed with a Procurement Specialist, experienced in procurement within central government... **Procurement of Works Goods and Non-Consulting Services:** Procurement under the project will be governed by the policies contained in GN2349-9 Policies for the Procurement of Goods and Works. The Procurement Plan indicates the procedures to be used for the contracting of works, goods, and services generated under the project. The processes subject to National Competitive Bidding (NCB) may be executed through the use of National Bidding Documents satisfactory to the Bank. Where these are not available, the Bank's Standard Bidding Documents will be used. Review of technical specifications during the preparation of the selection process, is the responsibility of the project sector specialist. **Procurement of Information Technology (IT) Systems**: Procurement of The HIMS and any other IT systems will be done in keeping with the policies referenced above. The Bank's information technology Specialist will provide technical review and advice as necessary. **Selection and Contracting of Consultants**: Procurement of Consulting services will be conducted in accordance with GN2350-9 Policies for the Selection and Contracting of Consultants. The Procurement Plan indicates the procedure to be used for the contracting of consulting services. Review of Terms of Reference for the selection of consulting services is the responsibility of the project sector specialist. **Selection of Individual Consultants:** Individual Consultants will be selected in accordance with the policy for Selection of Consultants referenced above and may be done by 3CV selection or open advertisement depending on cost. **Recurrent Expenses:** The project will finance recurrent expenses including: salaries/stipends of project staff. **Sole Source Selection:** may be permitted with appropriate justification according to the Bank's policies and with the Bank's non-objection. **Training:** The detailed procurement

plan indicates the consultancy services to which training and workshops are applicable. As per GN-2350-9 if the assignment includes an important component for training or transfer of knowledge to Borrower staff or national consultants, the TOR shall indicate the objectives, nature, scope, and goals of the training Project, including details on trainers and trainees, skills to be transferred, time frame, and monitoring and evaluation arrangements. The cost for the training Project shall be included in the consultant's contract and in the budget for the assignment.

5.2 **Procurement Plan and supervision (PP):** *(See attached link in POD)*

A. Procurement Supervision

5.3 The procurement plan of the project covering the duration of project execution is attached. It indicates the procedures to be used for the procurement of goods, the contracting of works or services, and the method of selecting consultants, for each contract or group of contracts. It also indicates cases requiring prequalification; the estimated cost of each contract or group of contracts; the requirement for prior or post review modality by the Bank. Ex ante supervision will be maintained for high value procurements. Once the PIU staff are in place and orientated, the supervision arrangements will be revisited with the Team Leader and the modality determined for other activities. Where ex post is applied, reviews will be performed at least once per year but may be done more frequently if the volume of procurement activities under the ex post review modality warrants. The ex post review process will include at least one physical inspection visit.

5.4 The procurement plan will be updated annually or as necessary, as required by the Bank.

B. Records and Files

5.5 The PIU shall maintain the files and records of the project. All records and files will be maintained by the Executing Agencies, according to accepted best practices, and be kept for up to three (3) years beyond the end of the operation's execution period.

5.6 Country Thresholds for Procurement (in US$'000s) [1] www.iadb.org/procurement.

Works			**Goods**			**Consulting Services**
International Competitive Bidding	National Competitive Bidding	Shopping/ Price Comparison	International Competitive Bidding	National Competitive Bidding	Shopping/ Price Comparison	Short Lists Solely by Nationals/ NCB
≥3,000	250 – 3,000	<250	≥250	50 - 250	Goods <50	<200

VI. SPECIFIC FIDUCIARY ARRANGEMENTS FOR FINANCIAL MANAGEMENT

A. Programming and Budget

6.1 In keeping with to Section 3, subsection (5) of National Development (Inter-American Development Bank) Loans Act Chapter 71.07 it is a requirement for the Ministry of Planning and Sustainable Development (MPSD) to lay before Parliament a proposal for to incorporate in the Appropriation's Bill any new development financing. The MPSD, as

Focal Point for multilateral lending will liaise with the MoH to facilitate the assignment of a Budget Line in the annual Budget Cycle of the GoRTT for this operation to open the way for drawdowns under the proposed loan once ratified. The PIU will liaise with the MoH to ensure its liquidity needs are sent forward as part of the Ministry's annual submission to the annual budget process.

6.2 The Borrower will commit to allocate, for each fiscal year of Program execution, adequate fiscal space to guarantee the unfettered execution of the Program; as determined by the project's operative instruments such as the Annual Operating Plan, the Financial Plan and the Procurement Plan.

B. Accounting and Financial Information Systems

6.3 Program accounting will be completed under the cash basis, in accordance with International Financial Reporting Standards (IFRS) or its equivalent and the Audit and Exchequer Act and (related) Financial Regulations of GoRTT. Given the paper-based system that is used by Central Government and its inherent limitations, the accounting system will be augmented by the use of off-the-shelf accounting software previously acquired under TT-L1035. The accounting software will record and classify all financial transactions by component, provide information related to: planned vs. actual financial execution and generate: Statements of Cash Flows; Cumulative Investments; and list of Commitments.

C. Treasury: Disbursements and flow of Funds

6.4 The EA will establish, exclusively for the Program, a separate bank account, denominated in US Dollars, at the Central Bank of Trinidad and Tobago for the management of the Project resources. The 18-month financial plan (included in the first AOP) will serve as the basis for the disbursement of funds to the EA to cover the Project's needs (per year: 2 minimum; 4 maximum) and for the purpose to keep the Bank's projections. The main disbursement methodology will be the Advance of Funds, based on the liquidity needs of the project. Other disbursement methodologies that will be used on a smaller scale are the Reimbursements (to Borrower or Executing Agency), Direct Payment to Supplier and Reimbursement against a Letter of Credit. Disbursements will be reviewed within the ex post modality, except for Requests for Direct Payment to Suppliers and Reimbursements (to Borrower or Executing Agency).

D. Internal Control and Internal Audit

6.5 The management of the Program, at both the level of the MoH and the PIU, will assume the responsibility for designing and implementing a sound system of internal control for the Program. Given the limited presence of codified policies and procedures, the agreed system of internal controls will be documented in the OM and will provide reasonable assurance that: (i) the project funds are used for their intended purpose; (ii) project assets are properly safeguarded as outlined in the Financial Regulations (Stores); (iii) project transactions, decisions and activities are properly authorized, documented, recorded and supported; and (iv) project transactions are executed in accordance with the established policies, practices and procedures delineated in the legal agreements. In addition, proper segregation of duties, approval authority levels for signature of contracts, commitment of funds, reception of

goods and services and payment to suppliers and beneficiaries should be arranged adequately and completely captured in the accounting system and records of the Program.

E. External Control and Reporting

6.6 As an eligible entity to audit Bank-financed operations, the Auditor General for Trinidad and Tobago will be included as an option, along with independent private audit firms, for the conduct of the Financial Audits of the Program. Audits will be performed in accordance with Bank's Guidelines for Financial Reports and External Audit and the International Standards on Auditing (ISA) or the equivalent. The EA, through the PIU, will be responsible for contracting of an external auditor eligible to the Bank to perform the Program audit as follows: (i) an annual financial audit of the Program to be submitted within 120 days of the end of fiscal year; (ii) a quarterly review of expenditures included in disbursement requests to be submitted within 20 days of following the end of each calendar quarter; and (iii) one final financial audit of the Program to be submitted within 120 days after the date of last disbursement.

F. Financial Supervision Plan

6.7 Financial Supervision will be informed by the initial and subsequently assessed risk of the Program and the MoH. Financial, Accounting and Institutional Inspection visits will be conducted at least once per year to ascertain the proper functioning of the accounting systems, and the adequacy of the internal control system and follow up the fiduciary risk initially assessed.

G. Execution Mechanism

6.8 The Borrower has designated the MoH as Executing Agency, with broad oversight responsibility for all matters related to the Program, and with direct responsibility for the administration of loan financing and the procurement processes. The execution structure will involve several tiers including a Project Inter-Ministerial Steering Committee, the Program Technical Team, the National Advisory Committee on NCDs, the MOH Counterpart Change Management Implementation Team and a PIU. The MoH will hire the staff of the PIU using loan resources., The PIU will be responsible for the overall administration of resources and for coordinating and executing the activities of the Program.

6.9 **The PIU** will be comprised of five (5) professionals including a Technical Director, Program Coordinator, Procurement Officer, Finance Officer, and Administrative Assistant. The Director of Finance of the MoH will provide technical supervision of the work of the Finance Officer. Specific responsibilities of the PIU will include: (i) preparation, implementation and coordination of the Annual Operating Plans (AOPs);(ii) preparation of budgets, project accounting, including disbursements and reimbursement of Project funds; (iii) preparation of the Program's Procurement Plan, (iv) coordination of the preparation of technical reports, progress and financial reports; (v) monitoring of the progress of Program activities and analysis of variances of actual results against plans; (vi) hiring the external audit and ensuring that the approved recommendations are implemented; (vii) facilitation of external evaluations of the Program and ensuring, in collaboration with the participating entities, that the approved recommendations are implemented; and (viii) serving as a liaison for the Program with

the Bank. For the execution of the e-HIMS Component, the MoH, through the PIU, will hire the services of a Subject Matter Firm (SMF) that will act as technical advisor to the MoH in articulating the requirements of the system and providing industry expertise. The MoH will outline, in the OM, the specific arrangements to address the procurement, supervision and implementation of the e-HIMS. **The Program Technical Team**, established under TT-L1035 and chaired by the Deputy Permanent Secretary, will transition to TT-L1039 to provide technical support, monitor overall performance of the operation and facilitate the work of the PIU. The Program will also be supported by a **Project Inter-Ministerial Steering Committee (PIMSC)**, chaired by the Ministry of Health. The PIMSC will comprise the Ministries of Education, Public Administration and Finance and other relevant Ministries. The PIMSC will provide strategic and policy guidance. **MoH Counterpart Change Management Implementation Team** will function as a peer implementation team working with consultants hired under the Program to facilitate knowledge transfer. The loan will provide partial financing for these full time staff positions on a decreasing basis given that GORTT has committed to funding these positions and any other required technical staff. Comprising members from Government Ministries and the national community, the **NCDs Technical Advisory Committee** is an existing body that will provide strategic oversight, monitor progress and broker involvement of all key stakeholders.

DOCUMENT OF THE INTER-AMERICAN DEVELOPMENT BANK

PROPOSED RESOLUTION DE-___/14

Trinidad and Tobago. Loan _____/OC-TT to the Republic of Trinidad and Tobago
Health Services Support Program

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 Republic of Trinidad and Tobago, as Borrower, for the purpose of granting it a financing to cooperate in the execution of a health services support program. Such financing will be for an amount of up to US$110,000,000 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 _____ 2014)

TT-L1039
LEG/SGO/IDBDOCS#39055361-14