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THE COMMONWEALTH OF THE BAHAMAS

PROGRAMME TO SUPPORT THE HEALTH SYSTEM STRENGTHENING OF THE BAHAMAS

(BH-L1053)

LOAN PROPOSAL

This document was prepared by the project team consisting of: Ricardo Pérez-Cuevas, team leader (SPH/CJA); Luis Tejerina, Ian Mac Arthur, and Martha Guerra (SCL/SPH); Ana Paz; Natalie Bethel; (CCB/CBH); Nalda Morales (FMP/CBH); Sofia Greco (LEG/SGO); Heidi Fishpaw, Daniela Zuloaga (VPS/ESG); Maria Alejandra Escovar (CSD/RND); Carlos Alberto Henriquez (INE/INE); and Suzanne Duryea (SCL/GDI).

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ABBREVIATIONS	
DPH	Department of Public Health
EA	Executing Agency
EDGE	Excellence in Design for Greater Efficiencies
EHR-S	Electronic Health Record Solution
ESMR	Environmental and Social Management Report
ESMP	Environmental and Social Management Plan
ESS	Environmental and Social Strategy
HDI	Human Development Index
IDB	Inter-American Development Bank
IS4H	Information Systems for Health
GBV	Gender-Based violence
GDP	Gross Domestic Product
GOBH	Government of The Bahamas
LAC	Latin America and Caribbean
MOH	Ministry of Health
NHIA	National Health Insurance Authority
NCDS	Chronic Non-Communicable Diseases
PACI	Institutional Capacity Assessment Platform
PAHO	Pan American Health Organization
PCTI	Primary Care Transformation Initiative
PEU	Programme Execution Unit
PHA	Public Hospitals Authority
POM	Program Operation Manual
PMH	Princess Margaret Hospital
RMH	Rand Memorial Hospital
SPF	Safeguard Policy Filter
SRC	Sandilands Rehabilitation Centre
SSF	Safeguard Screening Form
WHO	World Health Organization

PROJECT SUMMARY
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<tr><td colspan="6">Special Contractual Clauses prior to the first disbursement: The Executing Agency (EA) will provide evidence to the satisfaction of the Bank of the fulfillment of two conditions: (i) the assignment of responsibilities for the execution of this Program to the project manager, procurement specialist and financial specialist that integrate the Project Executing Unit (PEU); and (ii) the approval and entry into force of an updated Project Operations Manual (POM). (¶3.5). For other conditions prior to first disbursement see Annex B of the Environmental and Social Management Report (ESMR).

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[a] Under the Flexible Financing Facility (document FN-655-1), the borrower has the option to request modifications to the amortization schedule, as well as currency, interest rate and commodity conversions. In considering such requests, the Bank will take into account operational and risk management considerations.

[b] Under the flexible repayment options of the Flexible Financing Facility (FFF), changes in the grace period are possible as long the Original Weighted Average Life (WAL) and the last payment date, as documented in the loan agreement, are not exceeded.

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

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

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

I. PROJECT DESCRIPTION AND RESULTS MONITORING

A. Background, problem addressed, and justification

1.1 **Country Profile.** The Bahamas is a high-income country scoring well on human development indicators. With a population of 393,244 inhabitants,[1] The Bahamas' gross national income per capita is US$33,460. The 2018 Human Development Index (HDI) classified the country within the very high human development category; it scored 0.805 and ranked 60th out of 189 countries.[2] In 2018, total health expenditures in The Bahamas were 6.2% of GDP, which were below the average of 7.9% recorded in Latin American and Caribbean states and the 12.4% spent by high-income countries.[3]

1.2 The COVID-19 pandemic and increasing fiscal constraints are testing the government's capacity for service delivery. Healthcare is universal and free at the point of service. From 2017 to 2019, the government's health expenditure as a percentage of total expenditure has seen a steady rise; from 12 percent to 14.2 percent. The Bahamas recorded widening fiscal deficits over the past two decades (from -1.5 percent of GDP FY2000/01- FY2009/ 10 to -3.3 percent of GDP FY2010/11FY2019/20) and a growing debt-to-GDP ratio (which increased at an average yearly rate of 5.4 percent between 2000 and 2019). Moreover, COVID-19 has further worsened economic and fiscal indicators. The economy is now expected to contract 16.2 percent in 2020 and the fiscal deficit is forecast to widen from 6.7 percent of the GDP in FY2019/20 to 9.5 percent of the GDP in FY2020/21. In an attempt to stabilize the economy and reduce debt levels, the government has cut into the FY2020/2021 budget, which saw an overall budget reduction of $113 million, and a health budget decrease of $26 million. With the COVID-19 pandemic still lingering however, the government has added a new line item in the budget as contingencies for the MOH of $21.3 million. This fiscal outturn will require stricter fiscal consolidation measures, post FY2021/22, to return to the government's fiscal targets.

1. Health status of the population

1.3 **Sociodemographic conditions.** The Bahamas is an archipelago of 700 islands, only of which are 30 inhabited; 85% of the population lives in New Providence and Grand Bahama, and the rest in the Family Islands. The country has a young population. The median age is 33 years, 9% are >65 years, and the life expectancy is 75.6 years (72.6 years for men, 78.6 for women). The annual population growth rate is 1.2, and the total fertility rate (children/woman) is 1.8, indicating a deceleration of population growth.[4]

1.4 **Chronic non-communicable diseases (NCDs) are among the top health needs of The Bahamas population.** NCDs are highly prevalent, one of every ten adults has diabetes, and four of every ten adults have hypertension. There is an NCD-related gender health gap since more women are obese (women 54.8%, men 31.8%), have hypertension (women 77.5%, men 66.2%) and have malignant tumors (women 66.2%, men 47.9%). The most common cancers are prostate, breast, colorectal and cervical cancer.[5] Additionally, NCDs are the leading causes of ambulatory and hospital care and cause 63% of disability-adjusted life

years.[6] Moreover, the top five leading causes of death (per 100,000 inhabitants) are ischemic heart disease (52.5), cerebrovascular disease (39.8), prostate cancer (31.9), breast cancer (28.8), and diabetes (27.1). The COVID-19 pandemic also had a high toll. In 2020 it caused 44.9 deaths per 100,000, ranking among the top five causes of death in the country.[7]

1.5 Appropriate preventive and curative care for NCDs in primary care facilities and hospital settings can reduce health costs [8],[9], and up to 25% of the mortality rates for these conditions.[10],[11] For example, more than 70% of breast cancer patients are diagnosed with late-stage cancer,[12] which in turn reduces treatment effectiveness and life expectancy and increases the costs of care; whereas early screening increases life expectancy and reduces the costs.[13] The total direct cost of diabetes and hypertension is $34.8 million per year, representing 17.6% of the country's public health expenditures.[14]

1.6 **Limited access to healthcare for victims of gender-based violence (GBV) is a challenge.** GBV is a pervasive problem; one in three women on average will experience domestic violence in their lives;[15] and among those women that suffered a violent incident that required medical attention, an intimate partner (14%) or a friend or acquaintance (17.8%) caused the injuries.[16] The Bahamas has taken significant strides to increase coordination and response to GBV. Some gains are the existing legislation concerning domestic violence and sexual offenses, national gender policies, programs, services, and protocols, and personnel trained to care for violence victims.[17] In 2013, the Ministerial Oversight Committee and the National Task Force started to oversee national strategic action plans to address GBV.[18] Nonetheless, human, and financial resources are still limited to address the number of persons needing assistance. Up to 22% of households report domestic violence [19] and the COVID-19 pandemic increased this problem by 11.3%.[20] Health care services face shortages in delivering emergency care to GBV victims that can meet their immediate healthcare needs and fulfill their long-term psychological, social, and supportive needs. Currently, there is scarce information regarding adherence to GBV protocols or skills, knowledge, and competencies of health providers.[21]

1.7 **The COVID-19 pandemic has been a severe public health emergency.** Currently, in The Bahamas, the COVID-19 pandemic might have a syndemic nature[1]. The overlap of high rates of NCDs and COVID-19 suggests a broader syndemic burden since comorbidities, such as NCDs, intersect with nutrition and other determinants of health. NCDs patients are at higher risk of severe COVID-19 related illness and death, and vice-versa, since COVID-19 leads to the neglect of NCDs.[22] The pandemic disrupted the continuity of preventive and curative services for NCDs patients, thus creating a medium-term threat. The disruption of NCDs treatment might increase the risks of acute complications, accelerate chronic complications, raise disability and premature mortality, and demand more healthcare services. Moreover, COVID-19 worsened GBV against women and children. Lockdowns, curfews, physical distancing left women isolated from their support networks and increased the barriers to access essential services.

[1] The term syndemic refers to two or more epidemics interacting synergistically and contributing, as a result of its interaction, to the clustering of the excess burden of disease in a location or population, more than just the sum of both.

1.8 The MOH reported the first COVID-19 case on March 15th, 2020, and The Bahamas' government (GOBH) declared the public health emergency on March 16th, 2020. The country flattened the curve from the pandemic´s onset until June 2020, when the authorities reopened the economy and international borders. Surges in travel-related cases and virus transmission among nationals and residents caused a spike in cases. The second wave lasted from July to November 2020. On June 8th, 2021, there were 12,024 accumulated cases reported, translating into 3,087 cases per 100,000 inhabitants, and the death count had reached 232 deaths representing a 2.3% case fatality rate. Though these figures are below the LAC average of 5,375 cases per 100,000 inhabitants and a 3.5% case fatality rate [7], they still represent a significant public health problem. Currently, an additional new risk to the Bahamas is the emergence of mutant COVID-19 strains, that are more contagious, for which the country lacks genomic sequency capacity for its identification and should submit samples to the WHO reference laboratory in Brazil.[23]

2. Health system challenges

1.9 **The Bahamas' health sector has significant strengths although it is siloed in different health institutions.** Its principal strengths are that the public healthcare sector is tax-financed, health services and healthcare are free for all, and all persons can receive services. The MOH is responsible for governance, stewardship, and regulations. Its Department of Public Health (DPH) exercises governance oversight for the Public Hospitals Authority (PHA) and the National Health Insurance Authority (NHIA), which are statutory bodies (Figure 1). The PHA and DPH cover 65%, and NHIA 22% of the population.[24] About 30% of the population has private insurance, which includes the 13% not covered by PHA and DPH and people who are also affiliated with the NHIA.[25] Additionally, the NHIA Board provides health benefits, such as prescription drugs and medical supplies for chronic diseases' patients through the National Prescription Drug Plan.[2]

1.10 DPH oversees the provision and management of primary healthcare services and the design and implementation of public health programs. It has several departments, including the public health information systems, maternal and child health, surveillance, school health services, Expanded Program of Immunizations, NCDs, and the hospital liaison. It has 74 clinics[3] that deliver public health services, curative care, and community services that include home visits to high-risk patients and follow-up care for patients at home through the District Nursing Services.

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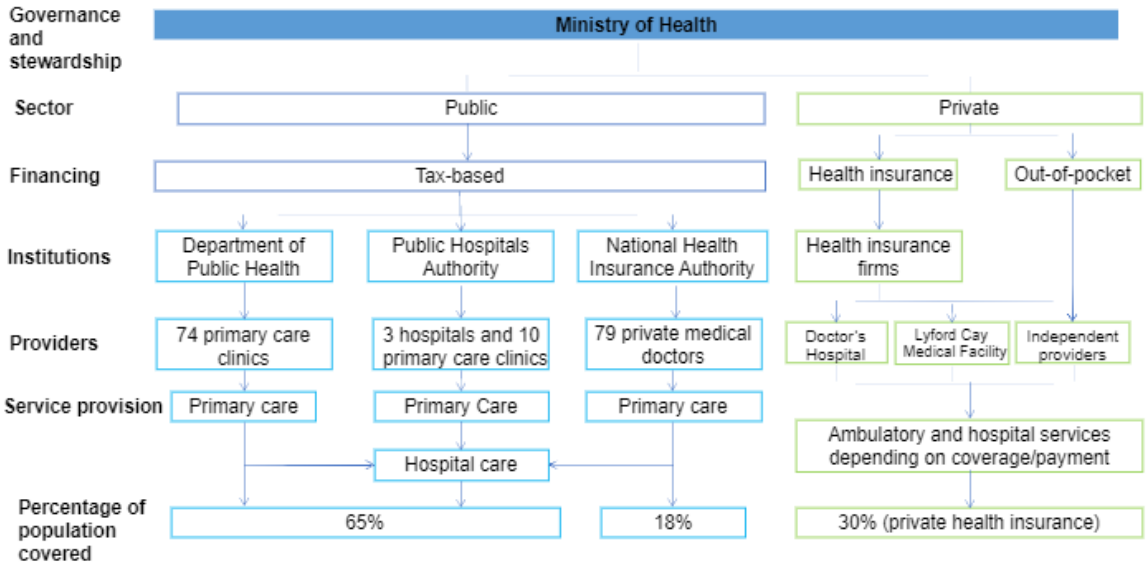
[2] The National Insurance Board provides benefits relating to sickness, maternity, funeral, retirement, invalidity, survivorship, unemployment, injury, disablement, and death.

[3] The DPH classifies its facilities in three levels: Level I facility provides advanced healthcare services that include basic hospital care. The level II facility provides intermediate primary healthcare services comprising outpatient care, emergency care, laboratory, and pharmacy. The level III facility offers essential services such as treatment for common illnesses, outpatient curative care, maternal and childcare, and immunizations.

Figure 1. The Bahamas Healthcare System



1.11 The PHA manages the nation's three public hospitals: the Princess Margaret Hospital (PMH) with 400 beds; the Rand Memorial Hospital (RMH), which has 85 beds and a network of ten primary care clinics; and the Sandilands Rehabilitation Centre (SRC), which provides psychiatric, geriatric and substance abuse treatment. PHA is the only public provider of secondary and tertiary care for patients referred from the DPH, PHA clinics, and the NHIA. The PHA also oversees the National Emergency Medical Services and the Supplies Management Agency.

1.12 The NHIA, is financed with public funding. It operates a public-private model with a network of 108 physicians who deliver primary care services through a risk-based explicit package of standard health benefits. Affiliation with NHIA is voluntary; patients do not have to pay at the point of service. NHIA provides primary care physician visits, specific laboratory tests, diagnostic imaging, and breast, cervical, colorectal, and prostate cancer screening. NHIA has facilities in five islands that cover people living in 17 islands, and it has seven clinical laboratories.

1.13 The private sector delivers services through health insurance and out-of-pocket payments. The country has two private hospitals in New Providence, the Doctors Hospital and the Lyford Cay Medical Facility, and the Okyanos Stem Cell Therapy Centre in Grand Bahama. There are also individual private providers.

1.14 On average, the country has 19.3 medical doctors and 31.3 nurses/midwives per 10,000 people, which is above the WHO recommendation of 44.5 human resources (medical doctors, nurses, and midwives) per 10,000 people.[26], [27] However, there are limitations to their distribution due to the archipelago's geographic characteristics, which reduce public services' capacity to meet the population's demands.

1.15 **Health spending is allocated mainly for hospital care, and primary care needs further investment.** For the fiscal year 2019-2020, the public sector health

budget was $328M, which was allocated as follows: the PHA received $209M (63.8%), MOH (other) $18.3M, (5.7%), the National Prescription Drug Program $17.4M (5.4%), and primary care $83.3M (25%). The primary care amount was distributed among the DPH $40.2M, NHIA $28.6M, and PHA-primary care $14.4M. For the FY 2019-2020, primary care represented about 25% of the public sector health budget, and by 2024-2025 without integration of PHA-primary care, DPH and NHIA, this percentage will increase to 31%.

1.16 **The public healthcare sector faces challenges in providing high-quality and efficient primary care services.** The first challenge is the fragmentation of the health system, which causes inefficiencies in service delivery. The MOH DPH, PHA and NHIA models coexist in parallel and have different organizational characteristics and supply capabilities. As a result, the implementation of national policies, programs, and healthcare is fragmented,[28] obstructing coordination of services. Second, the patients have multiple pathways to receive healthcare such as the NHIA, DPH, and PHA, resulting in services duplication, limited cost control, inequitable access, and resource allocation inefficiencies.[29] Therefore, current care models only partially fulfill primary care's essential attributes resulting in uncertain quality, and lack of integration, coordination, and continuity of services. Third, the NHIA's projections indicate that running two public primary care systems will cause an increase in costs due to the expanded enrollment of NHI without integration with the public clinics. The projected expansion comprises to increase from the current 87,000 to 113,000 affiliates in 2021, although recently, NHIA paused enrollment until further notice. Between 2019 and 2025, the costs of the parallel primary care systems will increase from US$83 to $127M, whereas integrating these services could reduce the amount to US$117M in the same period.[30]

1.17 The primary healthcare infrastructure is aged, lacks proper maintenance, is vulnerable to natural hazards, and requires improvements. Most health facilities are aging, were built in the 1980s, and have experienced disasters from natural hazards. According to the Inform Risk Indicators, The Bahamas is highly exposed to tropical cyclones and droughts. In the Caribbean region, between 1980 and 2007, 98% of disasters related to natural hazards were caused by recurrent meteorological, hydrological, and climate-related events. The events were mainly tropical cyclones (strong winds and storm surges), floods, droughts, and extreme temperatures, which are all expected to worsen with climate change. The impacts of extreme weather events on the health sector of The Bahamas include total damage estimated in US$37.7 Million from Hurricane Dorian in 2019 and US$1.6 million from Hurricane Joaquin in 2015. After Hurricane Matthew in 2016, Andros, Berry Islands, Grand Bahama, and New Providence were the most affected islands and disruption of health services lasted three days. In 2019, Hurricane Dorian hit the islands of Abaco and Grand Bahama and severely affected the infrastructure, equipment, medical supplies, and electrical and water supply. Besides the toll on human lives, the storm caused severe structural damages to primary healthcare facilities,[31] reducing their capacity to provide health care during and after the crisis.[32] The storm's consequences underscored the health infrastructure's vulnerability to natural hazards and prompted a focus on climate resilience as a priority for healthcare infrastructure planning (OEL#3). The clinics are scattered along the archipelago, which poses logistical and organizational challenges for appropriate maintenance and delivery of medications

and supplies. Many clinics are aging and degrading due to an inadequate maintenance program, making them less resilient to disasters and climate conditions. The population increase exceeds the clinics' capacity, which is becoming insufficient to satisfy demand and signals the need to retrofit and expand them. Moreover, the COVID-19 public emergency and the hurricanes' number and characteristics of the victims underscore the importance of designing adaptable clinics to respond to a public affected by public health disasters.

1.18 **The COVID-19 pandemic disrupted essential health services delivery in primary care clinics.** The PHA and DPH struggled to balance the pandemic's response while simultaneously providing essential health services. The MOH prioritized the resources for the pandemic but widened the existing shortages in the distribution and availability of health care personnel, infrastructure, and medical equipment.[33] It reorganized ambulatory services and transformed primary care clinics for COVID-19 patients and implemented telemedicine services. Still, patients with chronic conditions and those requiring elective hospital care experienced access barriers. In July 2020, PMH temporarily suspended elective admissions and surgeries, except for emergency surgeries, C-sections, oncology, and vascular services.

1.19 **The public health sector has been responding to the challenges of the COVID-19 pandemic with support from multiple stakeholders, including IDB.** Before the pandemic's onset, the MOH formulated the COVID-19 Preparedness and Response Plan [34] in keeping with WHO recommendations [35] to reduce the disease's spread and provide accessible and high-quality care to COVID-19 patients. The MOH sponsors ongoing public information activities promoting preventive measures and offering education and guidance to the public on access to COVID-19 care.[36] Moreover, the MOH reinforced primary care clinics and hospitals for COVID-19 patients. Access to the COVID-19 vaccine became a top priority. The country signed on to receive the COVID-19 vaccine for 22% of the people through the Covax Facility, and with PAHO's support, developed the National COVID-19 Vaccination Plan.[37] The IDB is supporting the country's efforts to tackle the pandemic. On December 9th, 2020, the Board of Directors approved loan 5179/OC-BH for US$20 million to strengthen public health response, support vaccines' procurement, implement the National COVID-19 Vaccination Plan, and accelerate the introduction of digital health information technology. In June 2021, the loan reached eligibility, and within the upcoming weeks, the Government will request the first disbursement. On March 10th, 2021, The Bahamas received a donation of 20,000 Astra Zeneca COVID-19 vaccines from India's Government.[38] The MOH began the vaccine rollout on March 17, 2021, in New Providence and Grand Bahama. On March 30th, the country received 33,600 doses of COVID-19 vaccines through the Covax facility. The COVAX forecast for the first semester of 2021 is to deliver 100,800 doses; on May 28, the country had received 67.200 doses.[39] On June 4th, 2021, the MOH had administered 55,037 doses and there were 8,659 people (2.2% of the population) fully vaccinated. [7],[40]

3. Main health policies to strengthen health services

1.20 **The public healthcare sector has ongoing initiatives to strengthen primary care services and reduce fragmentation**. The National Health Services

Strategic Plan 2010-2020 established the strengthening of primary care services as a key strategy to reach universal health coverage and reduce the burden of NCDs and their associated costs.[41] In keeping with this Strategic Plan, the MOH's objectives are to provide accessible, continuous, and coordinated care to improve health outcomes. The GOBH is promoting actions to overcome fragmentation. For example, one proposal consists in establishing a single standard primary health benefit package for the population, merging the PHA, DPH and NHIA under a harmonized primary care model and the entire primary healthcare sector utilizing a common electronic health record (EHR). In October 2020, the NHIA launched the National Health Insurance Primary Care Transformation Initiative (PCTI) to achieve universal health coverage; PCTI considers that primary care services are the foundations to achieve it. The PCTI has four elements: (i) Integrating the public primary healthcare system; (ii) establishing a minimum standard of coverage for all Bahamians that comprise preventive and curative care, health education, diagnostic imaging, screening programs for cancer, and laboratory tests; (iii) implementing pragmatic reforms to private insurance establishing that individuals who have private insurance will no longer be eligible to enroll in the NHIA and that private insurers should mirror the NHIA's standard health benefits; and (iv) providing every eligible Bahamian with a single record, which creates the possibility to extend the current NHI's EHR.[42] Subsequently, besides expecting to increase enrollment, NHIA, expects to provide coverage and medical care for catastrophic conditions, such as chronic kidney failure and cancer.

1.21 The MOH has been working towards the modernization of its health information system to reduce the public healthcare sector's fragmentation. There has been an asymmetric development of the health information system within public healthcare sector institutions. The NHIA has a primary care electronic health record system (EHR-S) that serves 43,000 people and enables them to access their health information through a digital patient portal. By contrast, the MOH is about to begin a transition from a paper-based to a digital-based health information system. Currently, data management in healthcare facilities is predominantly paper-based with manual data entry and reporting. Standardized recording and reporting forms and policies to fulfil public health functions support the MOH's health system. However, the MOH has already started to modernize its health information system. Since 2018, the MOH and the PAHO/WHO have collaborated on strengthening the National Information Systems for Health (IS4H) initiative through a country-led process. In 2019, the PAHO/WHO conducted a Rapid Assessment of IS4H,[43] [44], to set the initial recommendations and delineate a high-level roadmap for improvement. Then, in 2020, the PAHO/WHO and the MOH performed a full IS4H Maturity Model Assessment that pointed out the progress of The Bahamas towards implementing best practices with individual stakeholders, organizations, and units, and recommended to the MOH to establish formal standards, policies, and procedures within organizations. The IS4H Maturity Model Assessment Report allowed development of the National IS4H Plan of Action, which this loan will fund. The focus is on bolstering primary care clinics' ability to improve the quality and continuity of care and collect quality data to support clinical, managerial, and policy decision-making. Through this effort, the MOH aims to strengthen its capacity to collect, integrate, and analyze health data from other national stakeholders to support effective decision-making and ensure interoperability among national health care providers toward the vision of "one person, one record" in health. As mentioned

earlier, IDB supports developing the health information system from investment loan 5179/OC-BH. These efforts synergize with the IS4H action plan.

1.22 **Rationale.** The project will address three main challenges described above: (i) public system fragmentation and dissimilar quality of care; (ii) inadequate condition of primary health facilities and medical equipment; and (iii) development of the health information system for clinical, managerial use of information.

1.23 To respond to the first challenge of public system fragmentation and dissimilar quality of care, the Program will introduce improvements in health personnel competencies [45], organization of the services, and quality improvement activities [46],[47]. It will also modernize the processes of care [48] and the managerial capabilities to administer the medical facilities and create health networks. The Program also will implement a person-[4] and community-centered model of care [49] for NCDs patients, and it will improve the competencies to care for GBV patients. Finally, it will implement quality improvement mechanisms to standardize the healthcare quality for NCD patients. These interventions will enable the functional integration of the public primary care system, thus PHA, DPH and NHIA would deliver homogeneous health services. Primary care interventions to improve NCDs care are the most efficient way to reduce hospital admissions and premature mortality.[50],[51]

1.24 To address the second challenge the Program will build or retrofit nine (9) primary healthcare clinics with climate-resilient and energy-efficient infrastructure to withstand storms and floods. Also, the clinics will receive new furniture and medical equipment for the provision of higher quality healthcare.

1.25 To respond to the third challenge the Program will support the modernization of the health information system in congruence with the IS4H initiative. IS4H actions include the cybersecurity and data governance frameworks, along with the development and implementation of the norms and regulations.[52] The Program will also introduce the electronic health record and digital technology in fifty-four (54) clinics, which represent 72% of existing primary care clinics of the DPH. An IS4H implementation team will develop and implement these activities.

1.26 **Bank experience and lessons learned.** The Bank approved in December 2020 its first operation 5179/OC-BH (Program to Support the Health Sector to Contain and Control Coronavirus and to Mitigate its Effects on Service Provision) in The Bahamas, which reached eligibility for disbursement in June 2021. Among the early lessons, the Bank confirmed the need to establish a strong capacity for project management within the MOH. To address this challenge, a PEU was established for project management within the MOH and coordinate with other government stakeholders (Component 4). The design of this health program will benefit from lessons learned from the Bank's health portfolio, for components 1 and 2, this program will benefit from lessons learned of the operations to integrate

[4] Person-centered care is the foundation for safe, high-quality healthcare. It is care that is respectful of and responsive to the individual patient's preferences, needs, and values. It involves seeking out and understanding what is essential to the person, fostering trust, establishing mutual respect, and sharing decisions and plan care. Critical dimensions of person-centered care include respect, emotional support, physical comfort, information and communication, continuity and transition, care coordination, involvement of care takers and family, and access to care.

primary healthcare service delivery, through the integration of health networks and improvement of the processes of care, strengthen infrastructure in primary care clinics, and improve the model and quality of care for NCD's patients in El Salvador, (2347/OC-ES), Guatemala (4792/OC-GU), and Jamaica (4668/OC-JA) and (ATN/OC-17804-JA). Moreover, for component 3, it will benefit from experiences in the design of telemedicine services adapted to the pandemic in Honduras and Argentina (4518/BL-HO, 4449/BL-HO, 3815/BL-HO) and strategic investments in tools to improve the design and implementation of electronic health records (ATN/OC-16717-RG) and (ATN/OC-17825-RG).

1.27 **Coordination with other multilateral and/or donor agencies and partners.** PAHO/WHO supports the MOH by providing technical assistance, supplies, and equipment to expand its health services and modernize the health information system. During the COVID-19 pandemic, PAHO contributed with technical support, supplies, and equipment for epidemiological surveillance, laboratory capacity, contact tracing, and case management. PAHO has been the purchasing agent for the COVID-19 vaccine and provides technical advice for the country's COVID-19 strategic vaccination plan. The Multilateral Investment Guarantee Agency (MIGA) of the World Bank Group is expected to approve in 2021 a guarantee loan to support the PHA to: (i) expand service capacity; and (ii) enhance the diagnostic capabilities and modalities of care provided by the PMH and SRC. The proposed works include new planned construction, expansion, and renovation of existing facilities; also, renovation of the new infectious disease unit, reforming access to urgent care and emergency care services at PMH, and renovating priority wards at PMH and SRC. The IDB has been in regular communication with PAHO, with whom all digital health interventions for loan 5179/OC-BH and the current loan are being coordinated. In addition, the IDB has been in communication with MIGA to articulate both institutions' efforts to strengthen both hospital services and primary care services. The convergence of efforts to reinforce public health actions, not only to respond to the pandemic but also to strengthen public health, primary care, and hospital services, will support the MOH's efforts to improve access and reach universal coverage.

1.28 **Strategic alignment.** This program is consistent with the Second Update to the Institutional Strategy (AB-3190-2) and is strategically aligned with the development challenges of Social Inclusion and Equality by improving the delivery of healthcare services and by improving coverage, access, and quality of health care. The program is also aligned with the cross-cutting themes of (i) Gender equality since it will implement innovations in health care for domestic violence victims as described in subcomponent 1.2, an action consistent with the Gender Action Plan for Operations 2020-2021 (GN-25319), and with (ii) Climate change by strengthening the resilience of clinics to natural hazards and climate change. Additionally, the program is aligned to the Corporate Results Framework 2020-2023 (GN-2727-12) through the indicators on beneficiaries receiving health services and on beneficiaries of enhanced disaster and climate change resilient facilities. According to the Joint Multilateral Development Bank (MDB) approach to climate finance tracking, 44.47% of the total IDB funding for this program is directed toward climate change mitigation and adaptation activities. Thus, it contributes to the IDBG's climate finance goal of 30% of approvals by the year 2021 (OEL#2). The program is consistent with the Health Sector Framework Document (GN-2735-9) lines of action that address fiscal and financial

sustainability. It contributes to reducing the health sector fragmentation Also, it addresses the line of action that improves the organization and quality of healthcare service delivery and supports health care services integration by enhancing the coordination between primary and secondary care levels and accelerating the introduction of digital health. The program is also aligned with the Country Strategy's strategic objective to strengthen institutional capacity for the digital government (GN-2920-1) and with the cross-cutting issues of: (i) data, since it will improve the collection, dissemination, and availability of data in the health sector; and (ii) gender, because it reinforces the capacity to provide health care to domestic violence victims. The program is included in the 2021 Operational Program Report (GN-3034).

B. Objective, components, and cost

1.29 **Objectives.** The main objective is to support the strengthening of The Bahamas health system to meet the population's health needs. The specific objectives are to: (i) integrate primary and secondary care services that the DPH, PHA and NHIA deliver; (ii) improve access, coverage, and quality of community and ambulatory services through a person and community centered model of care; and (iii) increase the efficiency of health services.

1.30 **Component 1: Improvement of the Delivery of Healthcare Model (US$8 million).** This component will finance the activities to: (i) reorganize the provision of primary and hospital care; (ii) implement a person and community-centered model of care, which also will include specific actions to provide health services for GBV victims; and (iii) standardize the quality of care that the DPH, PHA and NHIA provide.

1.31 **Subcomponent 1.1.** This subcomponent will finance the reorganization of the DPH and PHA's provision of primary care and hospital care to NCDs' patients by: (i) designing and renewing evidence-based clinical protocols and care pathways; (ii) implementing training courses through digital technology to update health personnel; (iii) improving preventive and curative care processes to provide coordinated and continuous care through introducing clinical decision support tools, and promoting the creation of interprofessional care teams; and (iv) implementing healthcare management systems to ensure that health personnel, healthcare supplies and health information are administered properly.

1.32 **Subcomponent 1.2.** This subcomponent will finance: (i) the design and implementation of a person- and community-centered care model to enhance the community's involvement in health promotion, prevention, and self-care[5]; (ii) the strengthening of health services for victims of GBV by modernizing care pathways and enhancing tele-mental health services; and (iii) the training of health personnel to recognize, competently screen, or query suspected cases and comprehensively respond to GBV through the development of protocols.

[5] The implementation of a person- and community-centered model of care comprises (i) training and education activities to build the capacity of all staff, (ii) procedures and organizational changes to engaging users for effective partnership in their healthcare, and (iii) collection and reporting of patient care experience data through surveys or other feedback mechanisms.

1.33 **Subcomponent 1.3.** This subcomponent will finance activities to standardize and increase the quality of care that DPH, PHA and NHIA provide to NCD's patients through: (i) the design of quality-of-care indicators for NCDs; and (ii) the implementation of homogeneous mechanisms to improve and evaluate the quality of care through the use evidence-based guidelines and health data stored in the electronic health record.

1.34 **Component 2: Enhancement of the Capacity for Provision of Primary Care (US$20 million).** This component will improve the infrastructure to provide primary care services in seven (7) islands. The MOH prioritized nine primary care clinics[6] that will be built or retrofitted and equipped with new furniture and medical equipment.

1.35 **Subcomponent 2.1.** This subcomponent will finance the construction and retrofitting of nine primary care clinics in seven islands. The physical works required for the infrastructure improvement will fulfill three attributes: a. resiliency to disaster and climate change risks mostly related to storms, i.e., flooding and strong winds. b. sustainability and energy-efficient design to comply with the EDGE "green building" certification, and c. sound design to care for and contain the spread of transmissible diseases, such as COVID-19, and handle other infectious disease outbreaks that might occur. This subcomponent will also finance the furniture needed for the clinics, as well as the EDGE certification for the clinics and a maintenance plan that will enhance all three attributes of the infrastructure.

1.36 **Subcomponent 2.2.** This subcomponent will finance the upgrading of medical equipment which includes essential medical devices, such as stethoscopes and sphygmomanometers; equipment for diagnoses such as ultrasound, electrocardiogram, portable X-ray machines; also, equipment for laboratory tests, and emergency care such as defibrillators; and equipment for dental services and preventive care. It also will finance the procurement of six ambulances.

1.37 **Component 3: Modernization of the Health Information System (US$10 million).** This component will finance the digitalization of the health information and management system of the DPH MOH.

1.38 **Subcomponent 3.1.** This subcomponent will finance the IS4H implementation team and an implementation plan for the EHR that will address the integration of existing and new applications and equipment, such as laboratory, pharmacy, and diagnostic imaging applications into the new EHR system and the Health Information Exchange that will be implemented in 54 clinics of the DPH.[7]

1.39 **Subcomponent 3.2.** This subcomponent will finance the activities needed to implement a Health Information Exchange, the development of a cybersecurity framework and a data governance framework. It will also document and modernize

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[6] The MOH based the selection criteria on: (i) the current infrastructure conditions, prioritizing the ones with worst conditions due to aging or damages caused by Hurricane Dorian; (ii) needs to increase care capacity and therefore infrastructure expansion; and (iii) the needs to increase the level of care provided, moving to a more complex facility setup.

[7] The MOH based its selection criteria according to the roadmap of the IS4H that considers the potential benefit in terms of the coverage of population of these clinics, the feasibility of the connectivity and the implementation of the EHR given the geographical conditions of the country.

the flow and use of information for managerial, clinical, and public health functions following IS4H management and governance principles.

1.40 **Subcomponent 3.3.** This subcomponent will finance the activities to develop and implement norms and regulations, change management, digital technology procurement (connectivity equipment and laptops, tablets, etc.), deployment of electronic health records, and telemedicine in alignment with IS4H digital technology standards in 54 primary care clinics.

1.41 **Subcomponent 3.4.** This subcomponent will finance a Functional Assessment of the health system to identify essential IS4H functions that must be performed in The Bahamas. The assessment will provide the basis for an updated organizational structure, and functional roles. The component will also fund a human resource development strategy and a knowledge management roadmap for the country.

1.42 **Administration and Other Costs (US$2 million).** This component will finance the activities to strengthen the MOH's institutional project management, and fiduciary, and procurement capabilities for project implementation. It will support the Program Executing Unit's (PEU) consultants, and specialized technical services, independent auditing, and studies to underpin the implementation of the Program and its impact evaluation, and the implementation of the ESMP.

C. Key results indicators

1.43 The key results indicators will track progress in reducing the mortality rates for cardiovascular conditions, diabetes, and cancer, increasing the proportion of patients with diabetes and hypertension that are under control and reducing avoidable hospitalizations. These indicators will measure the combined effect of the improvement in access and quality of care after implementing healthcare workers' training programs, modernizing clinical protocols and care processes by introducing a person- and community-center care model, and investing in infrastructure, medical technology, and digital health information systems, such as the introduction of the electronic health record and telemedicine services.

1.44 **Beneficiaries.** Enhancing the capacity to provide primary healthcare through reinforcing the medical facilities and providing new medical equipment, will facilitate access and improved services to approximately 60,000 people living in nine Family Islands. The improvements in the delivery of the model of primary healthcare and hospital services and introducing digital health information systems in 57 clinics will improve access and the quality of healthcare, which will directly benefit at least 157,000 persons (40%) of The Bahamas population.

1.45 **Economic viability.** The economic rationale for the proposed actions is based on the averted human capital loss and the public health budget savings. Improvements to the delivery of care model (Component 1) will facilitate attaining efficiency gains in the public health system, particularly regarding primary care. Building five new clinics as part of enhancing the capacity for the provision of primary care (Component 2) will seek to improve the population's health averting the loss of human capital. Finally, introducing the digital health information system (Component 3) will help to improve healthcare processes (e.g., service access,

diagnosis, and treatment), resulting in public health budget savings. Based on the foregoing, a cost-benefit analysis was carried out, estimating a net present value (NPV) of US$55 million and a benefit to cost ratio of 1.29 in the base scenario, which considers a discount rate of 3%, suggesting that the proposed actions are economically beneficial. Additionally, a sensitivity analysis was conducted by varying the cost and effectiveness of the interventions.

II. Financing Structure and Main Risks

A. Financing instruments

2.1 This Program is structured as a specific investment loan for a total amount of US$40 million and will be financed with resources from the Bank's Ordinary Capital. This instrument is considered to be appropriate due to its fixed scope, logical interdependence of the components and its physical and technical individuality. The disbursement period will be five years. Table 2.1 lays out the budget by component. The disbursement period (Table 2.2) was determined based on initial estimates of the procurement plan and the pluriannual execution plan.

Table 2.1. Summary of Program costs (in US$)

Components	Total	%
Component 1. Improvement of the Delivery of Healthcare Model	**8,000,000**	**20.0**
Subcomponent 1.1 Reorganization of primary and hospital care	2,900,000	7.3
Subcomponent 1.2. Implementation of a person and community-centered care model	2,500,000	6.2
Subcomponent 1.3. Standardization of the quality of care	2,600,000	6.5
Component 2. Enhancement of the Capacity for Provision of Primary Care	**20,000,000**	**50.0**
Subcomponent 2.1. Strengthening of the physical infrastructure	17,995,000	45.0
Subcomponent 2.2. Upgrading of medical equipment.	2,005,000	5.0
Component 3. Modernization of the Health Information System	**10,000,000**	**25.0**
Subcomponent 3.1. Integration of digital health information initiatives	1,376,000	3.4
Subcomponent 3.2 Modernization of the flow of information	1,467,000	3.7
Subcomponent 3.3 Implementation of IS4H	7,057,000	17.6
Subcomponent 3.4. Training needs and recruitment requirements	100,000	0.3
Administration and other costs	**2,000,000**	**5.0**
Project auditing	180,000	0.5
Project executing unit	1,520,000	3.8
Impact evaluation	300,000	0.7
Total	**40,000,000**	**100.0**

Table 2.2 Disbursement schedule US$

Source	Year 1	Year 2	Year 3	Year 4	Year 5	Total
IDB	4,980,000	9,030,000	23,667,000	1,371,500	951,500	40,000,000
%	12.45	22.58	59.17	3.43	2.38	100.00

B. Environmental and social risks

2.2 Based on the provisions of Operational Policy OP-703, this program has been classified as Category "B" since the environmental and social impacts of this operation are expected to be minor to moderate. The main impacts are related to upgrading of existing clinics and the construction of new clinics and include

potential minor pollution and impacts on natural habitat where clinics will be built. In addition, given the COVID-19 pandemic, there will be more health risks to workers and communities, associated with the transmission of the virus, than would normally be the case. A consultation process about the operation and the Environmental and Social Assessment (ESA) were prepared by the Ministry of Health with the support of the IDB and carried out on April 27, 2021 virtually and documented in a Consultation Report. Both the Consultation Report and the final ESA and the Environmental and Social Management Plan (ESMP) were disclosed on May 25, 2021. The consultation process was meaningful and inclusive of vulnerable actors, and commensurate with the magnitude of impacts and risks, which are small to moderate. The main comments of participants were to ask if additional health services or personnel would be offered at their local clinic as a result of the operation, the timing of the project construction activities, and the difficulty to arrive to health facilities due to flooding or narrow roads. The final ESA and ESMP include a description of the MOH's protocols for management and disposal of medical wasted and measures to avoid degradation of natural habitat. The disaster risk has been classified as High because hospitals are critical infrastructure, and the country is vulnerable to hurricanes, sea level rise and flooding. In this context, investment to upgrade the infrastructure will consider disaster risk and climate change adaptation and mitigation actions to increase the resilience and reduce the vulnerability of health facilities exposed to extreme weather events. As part of the preparation of this program, the team has developed a Disaster Risk Narrative (part of the Climate Change Annex OEL#2) and an Infrastructure Technical Annex that describes the measures to increase resilience, and improve energy and water efficiency, along with a climate-resilient design aligned with the EDGE certification. A Disaster Risk Assessment (DRA) and detailed Disaster Risk Management Plan (DRMP) will be prepared for the Program. Also, design measures for disaster resiliency will be included in the upgraded and new clinics to be financed.

C. Fiduciary risk

2.3 If an institutional structure designed to create direct accountability of the PEU towards the MOH is not put in place within the MOH to prioritize activities and prepare the technical requirements, there will be delays in hiring the consultants and purchasing goods and services timely, which will delay the execution for at least six months (medium high). To mitigate this risk, it is necessary to develop a plan that includes actions to facilitate interaction with the MOH, prepare the technical requirements, TOR for the procurement activities, and train the PEU procurement staff on IDB's procurement policies.

2.4 If the approvals of the different steps of the procurement processes need to be taken by the high-level authorities, delays can occur and affect the projects' schedule for at least three months (medium high). To mitigate this risk, it will be necessary to review the procurement process timelines with the project's stakeholders to identify the steps that can be approved at a lower level and estimate the different steps' duration considering the time needed to coordinate between departments.

2.5 If the Integrated Financial Management Information System (IFMIS) does not provide timely the financial statements, disbursement requests and other reports

due to MOH’s lack of experience executing IDB operations, there will be delays to accomplishing the audit requirements for at least two months (medium high). To mitigate this risk, it is needed to strength the capacity of the existing 5179/OC-BH's PEU, hiring a Financial Officer, providing training in IDB financial policies and procedures, and the use of a commercial accounting system (Quickbook or similar).

D. Other risks and key issues

2.6 Seven development risks were identified, including its corresponding mitigation measures. If the MOH does not improve its capacity to execute the Program, given its scarce experience to manage public investment projects from multilateral organizations, there will be delays in the procurement and financial processes during the first year. These circumstances will slow down the disbursements and undermine the accomplishment of the project’s component planned activities (medium-high). To mitigate this risk there will be implemented actions to strengthen the existing Project Executing Unit to manage the project and bridge the MOH’s knowledge gaps in project scheduling, human resources, risk management, communication, and stakeholder management.

2.7 If there is a low perception of ownership within the MOH authorities and technical staff regarding the Program goals, this situation will delay the project's components' decision-making and procurement processes. Consequently, the MOH will slow down for at least six months to accomplish outputs planned for the first year of execution (medium-high). To mitigate this risk, there will be a continuous dialogue using effective communication strategies among IDB and the MOH’s technical teams to inform and promote the ownership of the project and through the implementation of robust supervision plans agreed with the MOH.

2.8 Hurricanes and their associated hazards (intense winds and floods) can happen in the intervention area. In that case, these natural events could negatively impact the health facilities' construction works, causing a delay in the execution of Component 2 for at least three months. These events can also impact the facilities during operation, causing damages to the clinics and/or interruption of critical services (medium-high). To mitigate this risk, a Disaster Risk Management Plan will be prepared.

2.9 If the flow of information is not fluid in the first six months of execution and there is no coordination between the MOH, PEU, and IDB, the project will yield low-quality products key to Component 1. In that case, this situation will cause to extend the execution of Component 1 to more than six months (medium-high). To mitigate this risk, a comprehensive communication plan, a plan of action and a supervision plan to coordinate all relevant stakeholders, will be developed and implemented.

2.10 If the PEU activities' strategic planning does not consider the slow process of human resources contracting within the Government of The Bahamas, the consultants' on-boarding will be paused. This situation will delay the consultants' products and the execution of the Programme for up to three months (medium-high). To mitigate this risk, the PEU will develop a governance structure for effective implementation of signatures for approval.

2.11 If the MOH does not begin implementing current IS4H guided investments in 2022, the electronic medical record implementation will be delayed, causing to extend the project execution by 12 months (medium-high). To mitigate this risk, a Program execution plan with inputs from multiple stakeholders and all involved parties, to ensure it reflects a realistic timeline, will be developed.

2.12 If the MOH does not develop the telehealth services included in the IS4H actions, the expansion of these services will be delayed, extending for more than 12 months to execute Component 3 (medium-high). To mitigate this risk, a Program execution plan with inputs from multiple stakeholders and all involved parties, to ensure it reflects a realistic timeline, will be developed.

2.13 **Sustainability.** This program's investments represent significant progress of the Bahamas' health system to reach its strategic plan for universal health coverage. Therefore, the MOH has taken provisions to guarantee their sustainability. The GOBH intends to strengthen healthcare fiscal sustainability through investing in primary healthcare services, which are the most efficient way to provide healthcare. Investments in digital health information systems also include the strengthening of human resources and implementation of a maintenance plan to guarantee the continuity of the services. Also, for the new and retrofitted infrastructure, the program contemplates the EDGE green building certification for all nine clinics. Among the design criteria to be considered achieving this certification, we can mention the following aspects: (i) solar protection elements to decrease direct solar radiation and wall and roof insulation, double glassed windows, and natural ventilation to reduce the need for AC systems and their subsequent energy demand; (ii) to increase the natural lighting in the buildings and the use of LED lamps to decrease the energy demand for lightening; (iii) the implementation of photovoltaic backup systems in specific clinics; (iv) the implementation of water-saving strategies, such as faucet aerators, doubled flushed toilets and waterless (or dry) urinals, water-efficient washing machines, as well as rainwater catchment and storage, and the use of native vegetation to reduce the need for water usage to maintain gardens; (v) the use of energy-saving equipment such as efficient AC units, fridges; (vi) the use of vegetation to provide shade and naturally cool down the buildings and external areas of the clinics; (vii) permeable paving outside the building to enable the infiltration of storm-water runoff; and (viii) the program supports developing and implementing a maintenance plan to inform users and train maintenance teams on the best sustainable practices to keep the buildings functioning under the best possible conditions.

III. IMPLEMENTATION AND MANAGEMENT PLAN

A. Summary of implementation arrangements

3.1 **Execution and administration.** The MOH will be the EA, which already established a PEU responsible for the loan 5179/OC-BH administration. The said PEU will also administer this program, which will finance it from 2023 onwards. The PEU’s responsibilities include planning, budgeting, accounting, procurement, social and environmental safeguards, monitoring, and reporting program

implementation progress. The PEU staff[8] will be reinforced with a financial assistant. Also, the PEU will contract specialized external consultancies, individuals, and firms to prepare the plans to retrofit existing clinics, build the new ones, supervise construction, and define the technical specifications and procurement for new medical equipment and digital health information system. The MOH's technical, procurement, and fiduciary team will work closely with the PEU staff to benefit from knowledge transfer and capacity building.

3.2 Specific responsibilities of the PEU comprise all activities for program execution, including: (i) serving as project liaison with the Bank; (ii) preparing, submitting, and implementing the Annual Operating Plans (AOP) and financial plans; (iii) drawing up budgets and disbursement requests; (iv) preparing and updating the Pluriannual Execution Plan (PEP), AOP, Procurement Plan (PP), Risk Matrix (RM), and the Project Monitoring Report (PMR); (v) financial administration of the Program according to accepted accounting principles and presenting audited financial statements; (vi) carrying our procurement processes that result in the timely acquisition of high-quality products and that comply with both the policies of the Bank and those of the GOBH; (vii) ensuring the consistent alignment of Program activities with expected results as well as periodic data collection to enable the monitoring of the indicators included in the RM; and (viii) presenting semi-annual progress reports.

3.3 The Project Steering Committee will be in charge of the coordination mechanisms to facilitate the program's implementation among the DPH, NHIA, and PHA. Representatives from the MOH, DPH, NHIA, PHA and MOF will integrate the Project Steering Committee. This Committee has among its specific responsibilities the provision of the required inter-institutional coordination and collaboration and the general oversight of the program to ensure coherence and coordination in project implementation among the different stakeholders. The PEU will operationalize these actions through the accomplishment of its specific responsibilities. The updated project operating manual will describe the responsibilities of the Project Steering Committee and the PEU.

3.4 **Program Operating Manual (POM).** The existing POM of the loan 5179/OC-BH will be updated to establish the policies, procedures, rules, and detailed responsibilities of the PEU during program execution, which will set forth standards and guidelines for the EA regarding all areas of program execution, including programming, execution and financial plan, fiduciary arrangements, monitoring, and reporting, among others. The POM will describe the roles and means of coordination between the MOH and the MOF regarding assigning budget space, accompanying program implementation, follow up activities, and processing the required adjustments to activities and goal.

3.5 **Special contractual conditions prior the first disbursement of the program resources. The EA will provide evidence to the satisfaction of the Bank of the fulfillment of two conditions: (i) the assignment of the responsibilities for the execution of this program to the programme manager, procurement**

[8] The PEU is composed by the Project Manager, financial officer, procurement officer, financial assistant, procurement assistant, civil engineer, monitoring and evaluation expert, administrator, communication officer, coordinator of Component 1 and Component 2.

specialist and financial specialist that integrate the PEU, necessary to assure the EA is in a position to execute the operation once disbursement occurs**; and (ii) the approval and entry into force of an updated POM,** which details the guiding principles for execution and coordination of activities.

3.6 **Retroactive financing.** The Bank may retroactively finance eligible expenditures made by the borrower prior to the loan approval date up to an amount of US$8 million (20% of the Loan Amount) provided that requirements substantially similar to those established in the loan agreement were met. These expenses may include consultant services, purchasing of medical equipment, supplies, health infrastructure and digital equipment and must have been incurred on or after the approval date of the Project Profile (March 8, 2021), and no expenditures incurred more than 18 months prior to the Loan approval date should be included.

3.7 **Procurement.** The proposed program will be carried out in accordance with the Policies for the Procurement of Works and Goods Financed by the IDB (GN-2349-15) and the Policies for the Selection and Contracting of Consultants Financed by the IDB (GN-2350-15), and with the provisions established in the loan contract and these procurement fiduciary arrangements.

3.8 **Disbursements and financial management.** The disbursement period for the loan resources is five years. The Bank will provide an advance of funds according to program liquidity needs substantiated by its current and anticipated commitments for a period of not less than 90 days and not more than 180 days. The PEU will control the utilization of the advance of funds and limit expenditure to planned and eligible activities, and it will maintain records of financial transaction in accordance with Bank fiduciary policies. When 80% of the advance of funds has been spent, the PEU may submit a justification of expenditures for review by the Bank and request a new disbursement.

3.9 **Audit.** Throughout the loan disbursement period, the EA will submit to the Bank, the project's Annual Audited Financial Statements (AFS) within 120 days after the close of the fiscal year and within the Original Disbursement Period or any extension thereof, and a Final Audited Financial Statement of the program within one hundred twenty (120) days following the date of the last disbursement date of the Program. As agreed with the Bank, the Borrower and the EA will select and External Independent Auditor, eligible to the Bank. The audit's scope and related considerations will be governed by the Financial Management Guidelines (OP-273-12) and the Guide for Financial Reports and Management of External Audit. Audit costs will be financed with project resources. The fiscal year will be from July 1st to June 30th of each year.

B. Summary of arrangements for monitoring results

3.10 The EA will be responsible for implementing the Monitoring and Evaluation plan (REL#2) and referring mainly to the results and outputs indicators of the Results Matrix.

3.11 The Monitoring of the program will employ the following standard Bank instruments: (i) PEP and AOP; (ii) PP; (iii) Results Matrix; (iv) PMR; and (v) audited financial statements. Semi-annual progress reports will be presented by the EA,

through the PEU, within thirty (30) days after the end of the corresponding semester and should include a description of the physical and financial execution of activities in the corresponding period as well as the relevant issues relating to implementation, risks, mitigation measures and environmental and social safeguards.

3.12 **Evaluation.** An evaluation will measure the impacts of the loan on avoidable hospitalizations using the model of differences in differences, which compares treatment units with units not treated with data from before and after the implementation.

Development Effectiveness Matrix		
Summary	BH-L1053	
I. Corporate and Country Priorities		
Section 1. IDB Group Strategic Priorities and CRF Indicators		
Development Challenges & Cross-cutting Issues	-Social Inclusion and Equality -Gender Equality and Diversity -Climate Change	
CRF Level 2 Indicators: IDB Group Contributions to Development Results	-Beneficiaries receiving health services (#) -Beneficiaries of enhanced disaster and climate change resilience (#) -Agencies with strengthened digital technology and managerial capacity (#)	
2. Country Development Objectives		
Country Strategy Results Matrix	GN-2920-1	Strengthen institutional capacity for digital government
Country Program Results Matrix	GN-3034	The intervention is included in the 2021 Operaraional Program.
Relevance of this project to country development challenges (If not aligned to country strategy or country program)		
II. Development Outcomes - Evaluability		Evaluable
3. Evidence-based Assessment & Solution		9.8
3.1 Program Diagnosis		2.5
3.2 Proposed Interventions or Solutions		3.5
3.3 Results Matrix Quality		3.8
4. Ex ante Economic Analysis		10.0
4.1 Program has an ERR/NPV, or key outcomes identified for CEA		1.5
4.2 Identified and Quantified Benefits and Costs		3.0
4.3 Reasonable Assumptions		2.5
4.4 Sensitivity Analysis		2.0
4.5 Consistency with results matrix		1.0
5. Monitoring and Evaluation		6.0
5.1 Monitoring Mechanisms		4.0
5.2 Evaluation Plan		6.0
III. Risks & Mitigation Monitoring Matrix		
Overall risks rate = magnitude of risks*likelihood		Medium High
Environmental & social risk classification		B
IV. IDB´s Role - Additionality		
The project relies on the use of country systems		
Fiduciary (VPC/FMP Criteria)	Yes	Financial Management: Budget, Treasury, External Control. Procurement: Information System.
Non-Fiduciary		
The IDB's involvement promotes additional improvements of the intended beneficiaries and/or public sector entity in the following dimensions:		
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		

The proposal presents a program for $40,000,000 to be financed by an investment loan. The general objective of the program is to support the strengthening of the Bahamas Health System to meet the population's health needs. The specific objectives are to: 1) integrate primary and secondary care services that the DPH, PHA, and NHIA deliver; 2) implement a person and community-centered model of care; and 3) increase the efficiency of the health services.
The proposal presents a diagnosis of the problem, as well as a review of international evidence. The proposed solutions are an appropriate response to the problems identified in the proposal and its contributing factors. The results matrix is consistent with the vertical logic of the project, presenting adequate indicators at the level of outcomes and impacts. The outcome indicators are appropriately defined to measure the achievements of the project's specific objective.
The economic evaluation considers the averted human capital loss and the savings in the public health budget. The cost-benefit analysis estimated a net present value of US$55 million and a cost to benefit ratio of 1.29, with a 3% discount rate.
The overall evaluation proposed will assess the impact of the loan on improving primary care services' performance and implementing the electronic health record. The evaluation will focus on measuring whether the primary care services can provide continuous and coordinated high quality care to patients with non-communicable diseases. A differences-in-differences methodology will be used to estimate the impact of the program.

RESULTS MATRIX

Project Objective	The specific objectives for this operation will be: (i) integrate primary and secondary care services that DPH, PHA and NHIA deliver; (ii) improve access, coverage, and quality of community and ambulatory through a person and community centered model of care; and (iii) increase the efficiency of health services. The achievement of these objectives will contribute to the general objective: To support the health needs of the population.

General Development Objective

Indicators	Unit of measurement	Baseline value	Baseline year	Expected year for achievement	Target	Means of verification	Comments
General development objective: To support the strengthening of The Bahamas health system to meet the population health needs							
Mortality rate of cardiovascular disease	Mortality rate per 100,000	To be defined by the MOH[1]	2019	2025	20% relative reduction	Health statistics. Health Information and Research Unit MOH	ICD-10 I0-I25 Age-standardized mortality rates will be estimated for sex and age group intervals of ten years in the population 30>years. Pro-gender: gender tracking. Up to 20-25% relative reduction in the mortality from CVDs is feasible with primary and secondary care interventions.[2] OPS/WHO reported that in The Bahamas, the cardiovascular disease mortality rate per 100,0000 is 92.1 for men and 53.7 for women.[3]

1 The MOH's Department of Health Information and Research Unit will provide the baseline values.
2 Dugani S. et al. Ischemic heart disease: cost-effective acute management and secondary prevention.Prabhakaran, D. et al., 2017. Cardiovascular, Respiratory, and Related Disorders. DCP3, Volume 5. Washington, DC: World Bank (WB). doi:10.1596/978-1-4648-0518-9.
3 PAHO/WHO Core health indicators 2019. Health Trends in the Americas.

Indicators	Unit of measurement	Baseline value	Baseline year	Expected year for achievement	Target	Means of verification	Comments
Percentage of hypertensive patients with blood pressure-controlled	Percentage	To be defined by the MOH[1]	2021	2025	10% increase above baseline value	Electronic and paper clinical registries of primary care and hospital settings	Primary care interventions to improve hypertension treatment increase up to 10% the proportion of hypertensive patients with blood pressure controlled.[4] Numerator: number of patients who have blood pressure controlled (<65 years BP target <130/80 mm Hg. >65 years <140/90 mm Hg).[5] Denominator: number of hypertensive patients that assisted to medical visits for hypertension control in primary care clinics The Bahamas PAHO/WHO STEPS NCDs Risk Factor Survey reported 19.8% of patients with blood pressure controlled.[6]
Percentage of diabetes patients with blood glucose controlled	Percentage	61.5%[7]	2021	2025	5% increase above baseline value	Electronic and paper clinical registries of primary care and hospital settings	Primary care interventions increase up to 5% the proportion of DM patients with controlled blood glucose. Numerator: number of DM patients with blood glucose controlled (Hemoglobin A1C ≤ 7). Denominator: number of DM patients that assisted to medical visits for diabetes control in primary care clinics
Ambulatory care sensitive hospitalizations	Rate	To be defined by the MOH	2021	2025	15.0	Hospital discharges records/ Health statistics. Health Information and Research Unit MOH	For more details, please see the impact evaluation in the Monitoring and Evaluation plan (REL#2).

4 Egan B. et al. Improving hypertension control in primary care with the measure, accurately, act rapidly and partner with patients protocols. Hypertension 2018; 72:1320-1327.
5 Unger T. et al., 2020 International Society of Hypertension Global Hypertension Practice Guidelines. Hypertension 2020; 75(6). 1334-1357.
6 PAHO/WHO STEPS Noncommunicable Disease Risk Factor Survey. Data Book for the Bahamas 2019.
7 PAHO. Institutional Response to Diabetes and its Complications. An evaluation of the quality of diabetes care. DPC/NC/DIA/66/1.3/273-04.

Specific Development Objectives

Indicators	Unit of measurement	Baseline value	Baseline year	Year 1	Year 2	Year 3	Year 4	Year 5	End of Project	Means of verification	Comments
Specific development objective 1: to integrate primary and secondary care services that DPH, PHA, NHIA deliver											
Compliance rate with referrals guidelines for NCDs between primary and secondary/ tertiary care levels	%	25%[8]	2020	30%	40%	50%	60%	70%	70%	Electronic and paper clinical registries at primary care and hospital settings	The indicator evaluates the proportion of NCDs patients referred appropriately to secondary care services. Numerator: number of patients referred appropriately to secondary care services. Denominator: total number of NCDs patients requiring referral.[9] The indicator measures the quality of care and the reduction in the healthcare services fragmentation. For more details see the Monitoring and Evaluation Plan (REL#2).
Percentage of primary health care personnel (medical doctors and nurses) trained in HEARTS protocol	%	0	2020	10%	15%	20%	25%	40%	40%	MoH and PHA HR Training records; NHIA Physicians provider profile	HEARTS is an institutionalized training program for cardiovascular disease management in primary health care clinics that includes hypertension, diabetes, and dyslipidemia.[10] The indicator evaluates the proportion of health personnel that received the HEARTS. Numerator: number of health personnel that received the HEARTS. Denominator: the total number of health personnel planned to receive the HEARTS.

8 Schneiders, J. et al. Quality indicators in type 2 diabetes patient care: analysis per care-complexity level. Diabetol Metab Syndr 11, 34 (2019). https://doi.org/10.1186/s13098-019-0428-8.
9 Vargas I, et al. Understanding communication breakdown in the outpatient referral process in Latin America: a cross-sectional study on the use of clinical correspondence in public healthcare networks of six countries. Health Policy Plan. 2018;33(4):494-504. doi:10.1093/heapol/czy016.
10 PAHO/WHO. Hearts in the Americas. https://www.paho.org/en/hearts-americas.

Indicators	Unit of measurement	Baseline value	Baseline year	Year 1	Year 2	Year 3	Year 4	Year 5	End of Project	Means of verification	Comments
Specific development objective 2: To improve access, coverage, and quality of community, ambulatory, and hospital services through a person and community centered model of care											
Coverage of screening for renal complications in diabetes patients	Percentage	65%	2020	65%	70%	75%	75%	80%	80%	EHR/paper records data analysis	The indicator measures the progress of the renal complications screening for diabetes patients. Numerator: total number of diabetes patients screened for renal complications Denominator: total number of diabetes patients that should have been screened for renal complications.
% of personnel trained that is certified to provide care according to protocol to gender-based violence victims	Percentage	Value to be confirmed by the MOH	2021	30%	40%	50%	60%	80%	80%	Project implementation audits	Pro-gender: gender tracking. Training personnel for gender-based violence is part of the actions to strengthen primary health care. Numerator: total number of health personnel certified after being trained to provide care to gender-based violence victims Denominator: total number of health personnel in primary care centers
% of victims of domestic violence receiving tele-health counseling services	Percentage	Value to be confirmed by the MOH	2021	20%	30%	40%	50%	70%	70%	EHR/paper records data analysis	Health care services for victims of domestic violence require promoting users' help-seeking behavior and respond through risk assessment, screening, and referral to counseling and other services. Numerator: number of victims of domestic violence receiving telehealth/in-person consulting services Denominator: number of suspected victims of domestic violence who were offered telehealth/in person consulting services. Pro-gender: gender tracking.
% of victims of domestic violence receiving in-person counseling services	Percentage	Value to be confirmed by the MOH	2021	20%	30%	40%	50%	70%	70%	EHR/paper records data analysis	

Indicators	Unit of measurement	Baseline value	Baseline year	Year 1	Year 2	Year 3	Year 4	Year 5	End of Project	Means of verification	Comments
Number of male beneficiaries of new and retrofitted clinics with enhanced resilience to natural hazards and climate change	Number	23,603	2021	23,886	24,173	24,463	24,757	25,054	25,054	Project implementation audits	All clinics include enhanced resiliency. All beneficiaries for the nine clinics are considered. The estimation of the beneficiaries is done as part of the economic analysis of the operation. The beneficiaries are counted once the clinics are finished and in operation. The estimates consider that the population growth of The Bahamas is 1.2 per year.
Number of female beneficiaries of new and retrofitted clinics with enhanced resilience to natural hazards and climate change	Number	22,845	2021	23,119	23,397	23,677	23,961	24,249	24,249	Project implementation audits	
Specific development objective 3: To increase health services efficiency											
Electronic Medical Record Information System implemented in Primary Health Care Clinics operated by the Department of Public Health	Percentage	0	2021	0%	50%	70%	80%	100%	100	Use and satisfaction of EHR-S Satisfaction survey	

Indicators	Unit of measurement	Baseline value	Baseline year	Year 1	Year 2	Year 3	Year 4	Year 5	End of Project	Means of verification	Comments
Data from primary health care clinics available in a central repository accessible by the Ministry of Health to support the calculation of key indicators	Percentage	0	2021	0%	0%	50%	70%	80%	100	Report from central repository system with names of clinics providing information	Numerator: number of clinics that can report production data automatically to a centralized repository in the MOH. Denominator The 54 clinics that will be part of the project. The report from the MOH should identify each clinic that contributes information and the date for the information contributed.
Number of partner agencies with information systems that are connected and/or integrated with health information exchange	Number	0	2021	1	3	4	5	6	6	Annual IS4H report	Ministry of Education, Ministry of Social Services and Urban Development, Department of Meteorology, Department of Environmental Health Services, National Insurance Board, Department of Statistics/or replacement agency.

Outputs

Indicators	Unit of measurement	Baseline value	Baseline year	Year 1	Year 2	Year 3	Year 4	Year 5	End of Project	Means of verification	Comments
Component 1: Improvement of the Delivery of Healthcare Model											
1.1 Number of clinical protocols and pathways updated and distributed	Number	0	2021	5	5	5	0	0	15	Project implementation audits Handbook on the management of health Conditions in Primary Care settings[11]	Clinical protocols for primary care services and hospital services updated for prevention, screening, diagnosis, and treatment for NCDs
1.2 Number of NCDs processes of care updated and implemented	Number	0	2021	5	5	5	0	0	15	Project implementation audit Handbook on the management of health Conditions in Primary Care settings[12]	For more details see the Monitoring and Evaluation Plan (REL#2).
1.3 Number of in-service trainings programs for healthcare workers and allied health personnel implemented[13]	Number	0	2021	2	2	2	2	1	9	Training logs	For more details see (REL#2).

11 The handbook is a guide to care for patients in primary care clinics and the community that covers the skills and knowledge required by any health provider who deliver primary and community care.
12 Idem.
13 Allied health services comprise patient care assistants, x-ray technician dental assistants, SLP specialists and technicians, community health nursing, Foundation Programme for physicians, and renal nursing.

Indicators	Unit of measurement	Baseline value	Baseline year	Year 1	Year 2	Year 3	Year 4	Year 5	End of Project	Means of verification	Comments
1.4 Number of potential health networks contacted and asked to integrate a health network with a community-centered model of care	Number	1	2021		1	1	1	0	3	Project implementation audits	
1.5 Number of health networks with tele-mental health services for victims of domestic violence implemented	Number	0	2021	1	1	1	0	0	3	Project implementation audits	
1.6 Primary care clinics with services for victims of domestic violence implemented	Number	0	2021	1	3	5	0	0	5	Project implementation audits	
1.7 Compendium of quality-of-care indicators for NCDs developed and implemented	Number	0	2021	1	2	3	5	8	8	Project implementation audits	The quality of care and quality assurance system indicators will comprise diabetes, hypertension, cervical, breast, colorectal, prostate cancer, myocardial infarction, and cardiovascular conditions.
1.8 Quality assurance system for chronic non communicable disease implemented	Number	0	2021	1	0	0	0	0	1	Project implementation audits	

Indicators	Unit of measurement	Baseline value	Baseline year	Year 1	Year 2	Year 3	Year 4	Year 5	End of Project	Means of verification	Comments
Component 2: Enhancement of the Capacity for Provision of Primary Care											
2.1 Number of existing primary care clinics with infrastructure upgrades completed and EDGE certification	Number	4	2021	0	0	0	0	4	4	Project implementation audits	EDGE is a green building certification system created by the IFC, a member of the World Bank group, that focuses on making buildings more resource efficient.[14] This certification will make clinics incorporate energy and water efficiency measures and climate resilient design.
2.2 Number of new primary care clinics constructed with EDGE certification	Number	0	2021	0	0	0	0	5	5	Project implementation audits	
2.3 Number of new and retrofitted clinics with new furniture supplied	Number	0	2021	0	0	0	4	5	9	Project implementation audits	
2.4 Number of primary care clinics with new medical equipment supplied	Number	0	2021	0	1	3	6	9	9	Project implementation audits	
2.5 Maintenance plan for infrastructure and equipment implemented	Number	0	2021	0	0	0	0	1	1	Project implementation audits	The maintenance plan will enhance resiliency to disaster and climate change risks, and sustainability and energy-efficient operation. It is expected to be implemented at the end of the project.

[14] EDGE enables design teams and project owners to assess the most cost-effective ways to incorporate energy efficiency and water saving options into their buildings. It offers a certification process that quantifies the impact of the measures adopted and estimates savings and profits Certification is initiated at the early design stage, when details of the project are entered into the EDGE software and green options are selected. The project must reach the EDGE standard of a 20% improvement in energy, water, and materials as measured against local construction practice. When achieved, the project is registered for certification.

Indicators	Unit of measurement	Baseline value	Baseline year	Year 1	Year 2	Year 3	Year 4	Year 5	End of Project	Means of verification	Comments
Component 3: Modernization of the Health Information System											
3.1 IS4H implementation team established	Number	0	2021	0	1	0	0	0	1	Contracts of key personnel signed	
3.2 Connectivity in primary care clinics	Clinics	0	2021	0	54	54	54	54	54	Use and satisfaction of EHR-S Satisfaction survey	Connectivity means that the healthcare center has all the hardware and services needed to access the internet and send and receive health records from other institutions. The indicator reflects the number of healthcare centers that had connectivity during the year.
3.3 Clinics equipped with end user devices	Clinics	0	2021	0	54	0	0	0	54	Use and satisfaction of EHR-S Satisfaction survey	
3.4 Health Information Exchange Platform implemented	Number	0	2021	0	0	1	0	0	1	Usage report from platform	
3.5 Business Intelligence Platform implemented	Number	0	2021	0	0	1	0	0	1	Dashboard sample from platform	
3.6 EHR Solution implemented	Number	0	2021	0	24	12	12	6	54	Report from EHR-S from each of the clinics	
3.7 Cybersecurity technical framework implemented	Number	0	2021	0	0	0	1	0	1	Cybersecurity document approved	

Indicators	Unit of measurement	Baseline value	Baseline year	Year 1	Year 2	Year 3	Year 4	Year 5	End of Project	Means of verification	Comments
3.8 Cybersecurity and health information privacy policies related to the use of the EMR system in primary care clinics operated by the Department of Public Health approved	Number	0	2020	0	1	0	0	1	1	Policy document approved	The policy document should include a structure similar to that of the NIST framework making the necessary adaptations to make it relevant for the country and the health sector. The functions of the framework for example include identify, protect, detect, respond, recover.
3.9 Health information protection program implemented	Number	0	2021	0	1	0	0	0	1	Health information protection program	
3.10 National IS4H Strategic Plan approved	Number	0	2021	0	1	0	0	0	1	Document National IS4H Strategic Plan	

Country: Bahamas **Division:** SPH **Operation No.:** BH-L1053 **Year:** 2021

Fiduciary Agreements and Requirements

Executing Agency (EA): Ministry of Health

Project Name: Support for the Health System Strengthening of The Bahamas for Health Risks

I. Fiduciary Context of Executing Agency

1. Use of country system in the project (Any system or subsystem that is subsequently approved may be applicable to the operation, in accordance with the terms of the Bank's validation).

☒ Budget	☐ Reports	☐ Information System	☐ Partial NCB
☒ Treasury	☐ Internal audit	☐ Shopping	☐ Advanced NCB
☐ Accounting	☒ External Control	☐ Individual Consultants	☐ Others

2. Fiduciary execution mechanism

☒	Particularities of the fiduciary execution	The fiduciary execution will be under the Project Executing Unit for the 5179/OC-BH Program to support the health sector to contain and control Coronavirus and mitigate its effect in service provision.

3. Fiduciary Capacity

Fiduciary Capacity of the EA	The MOH will be the Executing Agency, which already established a PEU responsible for the loan 5179/OC-BH administration. The said PEU will also administer this program, which will finance it from 2023 onwards. As the Ministry has no recent experience working with IDB projects, it will be necessary to work closely with their technical, procurement, and fiduciary team to benefit from knowledge transfer and capacity building.

4. Fiduciary risks and risk response

Area(s)	Risk	Risk level	Risk response
Financial	If the Integrated Financial Management Information System (IFMIS) doesn't provide the Financial Statements, Disbursements Requests and other reports due to the MOH lack of experience executing IDB operations, there will be delays in accomplish with audit requirements or at least two months.	Medium high	Hire a Financial Assistant to strength the capacity of the existing PEU of BH-L1055 operation, and the use of a commercial auditing software (QuickBooks or similar)
Procurement	If an institutional structure designed to create direct accountability of the PEU towards the MOH is not put in place within the MOH to prioritize activities and prepare the technical requirements, there will be delays in hiring the consultants and purchasing goods and services timely, which will delay the execution for at least six months.	Medium high	Develop a plan with PEU that includes actions to facilitate interaction with the MOH, prepare the technical requirements, TOR for the procurement activities, and train the PEU procurement staff on IDB's procurement policies.

Area(s)	Risk	Risk level	Risk response
Procurement	If the approvals of the different steps of the procurement processes need to be taken by the high-level authorities, delays can occur and affect the projects' schedule for at least three months.	Medium high	Review the procurement process timelines with the project's stakeholders to identify the steps that can be approved at a lower level and estimate the different steps' duration considering the time needed to coordinate between departments.

5. Policies and Guides applicable to operation: Procurement for the proposed program will be carried out in accordance with the Policies for the Procurement of Works and Goods Financed by the IDB (GN-2349-15) and the Policies for the Selection and Contracting of Consultants Financed by the IDB (GN-2350-15), and with the provisions established in the loan contract and these procurement fiduciary arrangements.

The financial management will be conducted in accordance with the Operational Guideline OP-273-12.

6. Exceptions to Policies and Rules: None.

II. Aspects to be considered in the Special Provisions of the Contract

Pre-first disbursement conditions; NA
Exchange Rate: To determine the equivalence of an Eligible Expenditure incurred in the Local currency, the exchange rate in force on the date of payment of the expenditure in the Local Currency of the Borrower's country in accordance with the General Conditions of the loan, article 4.10 b(ii).
Type of Audit: Throughout the loan disbursement period, the EA will submit to the Bank the project's annual Audited Financial Statements within 120 days after the close of the fiscal year and within the Original Disbursement Period or any extension thereof, and a Final Audited Financial statement of the Program within one hundred twenty (120) days following the date of the last disbursement date of the program. The audit will be conducted by a Bank-eligible External Independent Auditor, the audit's scope and related considerations will be governed by the Financial Management Guidelines (OP-273-12) and the Guide for Financial Reports and Management of External Audit. Audit costs will be financed with project resources. The fiscal year will be from July 1st to June 30th of each year.

III. Agreements and Requirements for Procurement Execution

☒	Bidding Documents	For procurement of Works, Goods and Services Different of Consulting executed in accordance with the Procurement Policies (document GN-2349-15), subject to ICB, the Bank's Standard Bidding Documents (SBDs) or those agreed between EA and the Bank will be used for the particular procurement. Likewise, the selection and contracting of Consulting Services will be carried out in accordance with the Consultant Selection Policies (document GN-2350-15) and the Standard Request for Proposals (SRP) issued by the Bank or agreed between the EA and the Bank will be used for the particular selection. The revision of the technical specifications, as well as the terms of reference of the procurements during the preparation of selection processes, is the responsibility of the sectorial specialist of the project. This technical review can be ex-ante and is independent of the procurement review method.
	Advanced Contracting	The Bank may retroactively finance from the resources of the loan, up to the sum of US$8 million (20% of the proposed loan amount), eligible expenses incurred by

<table>
<tr><td></td><td>Retroactive financing</td><td>the Borrower prior to the date of approval of the loan. These expenses may include consultant services, purchasing of medical equipment, supplies, health infrastructure and digital equipment provided that requirements shall be in accordance with those set out in the loan contract. Such expenses must have been incurred from the Project Profile Approval date (March 8, 2021), but under no circumstances will expenses incurred more than 18 months before the loan approval date be included. (See GN-2349-15, GN-2350-15 Policy on Retroactive Financing and Advance Contracting.</td></tr>
<tr><td>☒</td><td>Procurement supervision</td><td>The supervision method will be ex ante.
Procurement plan:
http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=EZSHARE-1042447432-13
<table>
<tr><td>Works</td><td>Goods/Services</td><td>Consulting Services</td></tr>
<tr><td>[14,980,000]</td><td>[9,769,000]</td><td>[10,275,000] Firms
[4,976,000] Singles</td></tr>
</table></td></tr>
<tr><td>☒</td><td>Records and Archives</td><td>The MOH will maintain and keep all records and electronic files of the Project for up to three years.

beyond the operation's execution period, according to best practices.</td></tr>
</table>

Main Acquisitions

Description of the procurement	Selection Method	New Procedures/ Tools	Estimated Date	Estimated Amount 000'US$
Goods				
Medical equipment for PHC	International competitive bidding		01-February-2024	1,455,000
Works				
Construction of new PHC clinics	International competitive bidding		01-May-2023	12,120,000
Non-consulting services				
Phase 2 Expand and maintain EMR	International competitive bidding		15-January-2023	1,710,000
Acquire EHR solution Phase 1	International competitive bidding		01-September-2021	1,562,500
Consulting Firms				
Quality assurance system for NCDS	Quality and Cost Based Selection		01-June-2022	1,900,000
In-service trainings programs for healthcare workers	Quality and Cost Based Selection		15-January-2022	1,600,000
Health networks with person and community centered model	Quality and Cost Based Selection		01-March-2022	1,500,000
Individuals				

To access, [procurement plan click here]

Procedures	Justification of Use

IV. Agreements and Requirements for Financial Management

☒	Programming and Budget	The Budget Increase Act – Budget Reformulations and Financial Management and Audit Bill (2010 and 2013 amendment) define the Public Financial Management of the country. During its budget call of each year, the MOF Budget Department sends out its circular, including the required forms to be completed. The Borrower has committed to allocating adequate budgetary space to guarantee the program execution. The fiscal year is inter-annual, going from July 1st to June 30th.
☒	Treasury and Disbursement Management	**Preferential Disbursement Method:** Advance of Funds. **Disbursement Mechanism:** Electronic using Online- Disbursement's IDB **System. Bank Account:** To establish a Special Account at the Central Bank of The Bahamas, denominated in US Dollars. The Review of Disbursements will be ex-post. Considering possible delays and bureaucratic procedures to collect supporting documents and processing payments, the minimum level of justification to request a new advance of funds will be 70% of the total accumulated balance pending justification. **Exchange Rate:** To determine the equivalence of an Eligible Expenditure incurred in the Local currency, the exchange rate in force on the date of payment of the expenditure in the Local Currency of the Borrower's country. **Type of Audit:** Annual Audited Financial Statements within 120 days after the closing of each fiscal year. The Audit will be conducted, preferably by a Bank-eligible independent audit firm. The Audit's scope and related considerations are the Financial Management. Guidelines (OP-273-12) and the Guide for Financial Reports and Management of External Audit. The Audit will finance with project resources. **Fiscal Year:** July 1st to June 30th of each year. Financial **Plan Period:** Six months.
☒	Accounting, information systems and reporting	The Integrated Financial Management Information System (IFMIS) does not provide reports for external organisms' projects financed. To comply with IDB requirements of internal control and records, the project should maintain auxiliary records and systems (e.g., QuickBooks or similar). Accounting Method and **Currency:** Cash basis. The specific accounting norms will be IFRS.
☒	Project Financial Supervision	Financial, Accounting and Institutional Inspection visits or meetings will be performed to: (i) Review of the Reconciliation and supporting documentation for disbursements; (ii) Compliance with financial and procurement procedures; (iii) Review of compliance with the lending criteria; (iv) Follow up on audit findings and recommendations; and (v) Review the financial progress, planning and disbursement projections.

DOCUMENT OF THE INTER-AMERICAN DEVELOPMENT BANK

PROPOSED RESOLUTION DE-__/21

Bahamas. Loan ____/OC-BH to The Commonwealth of The Bahamas
Programme to Support the Health System Strengthening
of The Bahamas

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 Commonwealth of The Bahamas, as borrower, for the purpose of granting it a financing to cooperate in the execution of the Programme to Support the Health System Strengthening of The Bahamas. Such financing will be for the amount of up to US$40,000,000 from the resources of the Bank's Ordinary Capital, and will be subject to the Financial Terms and Conditions and the Special Contractual Conditions of the Project Summary of the Loan Proposal.

(Adopted on ___ _____ 2021)

LEG/SGO/CCB/EZSHARE-2030403020-4453
BH-L1053