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Report No: PAD2861

INTERNATIONAL DEVELOPMENT ASSOCIATION

PROJECT APPRAISAL DOCUMENT
ON A
PROPOSED CREDIT

IN THE AMOUNT OF US$20 MILLION

TO

SAINT LUCIA

FOR A

HEALTH SYSTEM STRENGTHENING PROJECT

August 14, 2018

Health, Nutrition & Population Global Practice
Latin America and Caribbean Region

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CURRENCY EQUIVALENTS

Exchange Rate Effective June 30, 2018

Currency Unit =	Eastern Caribbean Dollar (EC$)
EC$2.70 =	US$1.00
US$1.00 =	SDR 0.70

FISCAL YEAR
April 1 - March 31

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ABBREVIATIONS AND ACRONYMS

ACSC	Ambulatory or Primary Care Sensitive Conditions
CARICOM	Caribbean Community
CARPHA	Caribbean Regional Public Health Agency
CBA	Cost-benefit Analysis
DALY	Disability-Adjusted Life Years
DFIL	Disbursement and Financial Information Letter
EHS	Environmental Health and Safety
ESMF	Environmental and Social Management Framework
FMS	Financial Management Specialist
GDP	Gross Domestic Product
HRH	Human Resources for Health
HWMS	Health Care Waste Management System
IHR	International Health Regulations
IRR	Internal Rate of Return
M&E	Monitoring and Evaluation
MOF	Ministry of Finance
MOHW	Ministry of Health and Wellness
NCD	Noncommunicable Diseases
NGO	Non-governmental Organization
NHS	National Health Scheme
NIC	National Insurance Corporation
N-PCU	National-level Project Coordination Unit
NPV	Net Present Value
OKEU	Owen King-European Union
OOP	Out-of-pocket
PBF	Performance-based Financing
PHC	Primary Health Care
PIU	Project Implementation Unit
POM	Project Operations Manual
PPA	Project Preparation Advance
RPS	Regional Partnership Strategy
SDG	Sustainable Development Goals
SLUHIS	Saint Lucia Health Information System
TA	Technical Assistance
TAA	Total Available Amount
TOR	Terms of Reference
UHC	Universal Health Coverage
WBG	World Bank Group
WHO	World Health Organization
YLL	Years of Life Lived

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DATASHEET

BASIC INFORMATION

Country(ies)	Project Name	
St. Lucia	Health System Strengthening Project	
Project ID	**Financing Instrument**	**Environmental Assessment Category**
P166783	Investment Project Financing	B-Partial Assessment

Financing & Implementation Modalities

[ ] Multiphase Programmatic Approach (MPA)	[✓] Contingent Emergency Response Component (CERC)
[ ] Series of Projects (SOP)	[ ] Fragile State(s)
[ ] Disbursement-linked Indicators (DLIs)	[✓] Small State(s)
[ ] Financial Intermediaries (FI)	[ ] Fragile within a non-fragile Country
[ ] Project-Based Guarantee	[ ] Conflict
[ ] Deferred Drawdown	[ ] Responding to Natural or Man-made Disaster
[ ] Alternate Procurement Arrangements (APA)	

Expected Approval Date	Expected Closing Date
28-Sep-2018	31-Oct-2023

Bank/IFC Collaboration

No

Proposed Development Objective(s)

The development objective is to improve the accessibility, efficiency, and responsiveness of key health services.

Components

Component Name	Cost (US$, millions)

Component 1: Design and Implementation of an Essential Benefits Package	5.50
Component 2: Strengthening Service Delivery in Support of the Essential Benefits Package	13.00
Component 3: Institutional Capacity Building, Project Management and Coordination	1.50
Component 4: Contingent Emergency Response Component	0.00

Organizations

Borrower:	Ministry of Finance, Economic Growth, Job Creation, External Affairs and Public Service
Implementing Agency:	Ministry of Health and Wellness, Saint Lucia

PROJECT FINANCING DATA (US$, Millions)

SUMMARY

Total Project Cost	20.00
Total Financing	20.00
of which IBRD/IDA	20.00
Financing Gap	0.00

DETAILS

World Bank Group Financing

International Development Association (IDA)	20.00
IDA Credit	20.00

IDA Resources (in US$, Millions)

	Credit Amount	Grant Amount	Total Amount
National PBA	20.00	0.00	20.00
Total	**20.00**	**0.00**	**20.00**

Expected Disbursements (in US$, Millions)

WB Fiscal Year	2019	2020	2021	2022	2023	2024
Annual	0.61	2.00	5.00	6.39	5.00	1.00
Cumulative	0.61	2.61	7.61	14.00	19.00	20.00

INSTITUTIONAL DATA

Practice Area (Lead)

Health, Nutrition & Population

Contributing Practice Areas

Climate Change and Disaster Screening

This operation has been screened for short and long-term climate change and disaster risks

Gender Tag

Does the project plan to undertake any of the following?	
a. Analysis to identify Project-relevant gaps between males and females, especially in light of country gaps identified through SCD and CPF	Yes
b. Specific action(s) to address the gender gaps identified in (a) and/or to improve women or men's empowerment	Yes
c. Include Indicators in results framework to monitor outcomes from actions identified in (b)	Yes

SYSTEMATIC OPERATIONS RISK-RATING TOOL (SORT)

Risk Category	Rating
1. Political and Governance	Substantial
2. Macroeconomic	Substantial
3. Sector Strategies and Policies	Moderate
4. Technical Design of Project or Program	Substantial
5. Institutional Capacity for Implementation and Sustainability	High
6. Fiduciary	Substantial
7. Environment and Social	Substantial

8. Stakeholders	Moderate
9. Other	Moderate
10. Overall	Substantial

COMPLIANCE

Policy

Does the project depart from the CPF in content or in other significant respects?

[ ] Yes [✓] No

Does the project require any waivers of Bank policies?

[ ] Yes [✓] No

Safeguard Policies Triggered by the Project	Yes	No
Environmental Assessment OP/BP 4.01	✓	
Performance Standards for Private Sector Activities OP/BP 4.03		✓
Natural Habitats OP/BP 4.04		✓
Forests OP/BP 4.36		✓
Pest Management OP 4.09		✓
Physical Cultural Resources OP/BP 4.11		✓
Indigenous Peoples OP/BP 4.10		✓
Involuntary Resettlement OP/BP 4.12		✓
Safety of Dams OP/BP 4.37		✓
Projects on International Waterways OP/BP 7.50		✓
Projects in Disputed Areas OP/BP 7.60		✓

Legal Covenants

Sections and Description
None.

Conditions

Type	Description
Disbursement	Notwithstanding the provisions of Part A above, no withdrawal shall be made for payments made prior to the Signature Date, unless the following condition is met or fulfilled in a manner acceptable to the Association: Under Category (2) until and unless the Association has received adequate evidence that: (i) the first two Management Agreements have been signed; (i) the contract with the Independent Verification Agency has been signed; (iii) the first Verification Report has been completed; and (iv) the PBF Manual has been adopted; all in form and substance satisfactory to the Association and as further detailed in the POM. Financing Agreement: Paragraphs 1 and 2, Section III.B of Schedule 2.

Type	Description
Disbursement	Notwithstanding the provisions of Part A above, no withdrawal shall be made for payments made prior to the Signature Date, unless the following condition is met or fulfilled in a manner acceptable to the Association: Under Category (3), for Emergency Expenditures under Part 4 of the Project, unless and until the Association is satisfied, and has notified the Recipient of its satisfaction, that all of the following conditions have been met in respect of said activities: (i) the Recipient has determined that an Eligible Emergency has occurred, has furnished to the Association a request to include said activities in the CERC Part and an action plan in order to respond to said Eligible Emergency, and the Association has agreed with such determination, accepted said request and notified the Recipient thereof; (ii) the Recipient has prepared and disclosed all safeguards instruments required for said activities, and the Recipient has implemented any actions which are required to be taken under said instruments, all in accordance with the provisions of Section E of this Schedule; (iii) the Recipient's Coordinating Authority has adequate staff and resources, in accordance with the provisions of Section E of this Schedule, for the purposes of said activities; and (iv) the Recipient has adopted the CERC Manual in form, substance and manner acceptable to the Association and the provisions of the CERC Manual remain, or have been updated in accordance with the provisions of Section E of this Schedule so as to be appropriate for the inclusion and implementation of said activities under the CERC Part. Financing Agreement: Paragraph 3, Section III.B of Schedule 2.

I. STRATEGIC CONTEXT

A. Country Context

1. **Saint Lucia is an upper-middle income country which has been challenged by relatively low levels of economic growth and high unemployment since 2011.** The country has a population of 178,015, nearly 30 percent of which reside in Castries Quarter, where the capital (also called Castries) is located. The country is a mountainous island with a tropical, humid climate and ranks high on the United Nations Development Programme's (UNDP) Human Development Index (HDI). Gross National Income (GNI) per capita is US$8,440, life expectancy at birth is 75 years, and the Under-Five Mortality Rate is 12 per 1,000 live births; health outcomes are slightly better than the Caribbean small states average (World Development Indicators 2016). The country is politically stable, and the 2016 national elections resulted in a peaceful transition in political power.

2. **Following the 2008 financial crisis, the country has yet to regain pre-crisis growth levels, while unemployment remains high as does the share of the labor force who are informally employed.** Gross Domestic Product (GDP) growth rates have been below 2 percent since 2011 though this is expected to increase to almost 3 percent in 2018. Debt levels continue to remain high and were approximately 67 percent of GDP in 2017. Recent poverty estimates are not available, but a poverty assessment conducted in 2005 found that almost 29 percent of the population live in poverty. Unemployment rates are high at 21.2 percent in 2016 (World Development Indicators 2016). Among the employed, 57 percent earn less than EC$1,500 (US$555) per month while nearly half of the population is classified as not having decent work. There is a large share of employment in the informal sector, mainly in small and microbusinesses.[1]

3. **The economy has limited diversity and is heavily reliant on tourism.** An upward trend in tourist arrivals has been observed in Saint Lucia, with the tourism sector estimated to have contributed up to 40 percent of GDP and 47 percent of employment in 2016 through direct, indirect and induced contributions (World Travel and Tourism Council 2017). These figures are projected to increase going forward, reaching over 50 percent of GDP and 60 percent of jobs by 2027. However, these figures may be affected by the tourism industry's vulnerability to extreme weather events.

4. **Saint Lucia faces challenges in the form of natural disasters and climate change, which may have health implications.** Hurricanes are the most threatening natural hazard facing the country, posing significant destructive potential due to high wind speeds, heavy rains, and powerful storm surges that produce flooding. Saint Lucia was badly affected by Hurricane Tomas in 2010, which resulted in losses of up to 43 percent of GDP and caused fourteen deaths. The December 2013 severe rains and high winds caused floods due to a low-level trough *(region of low atmospheric pressure)* system resulting in economic losses, though to a lesser degree. Beyond concerns related to natural disasters, the country is prone to the adverse impacts of climate change. Climate change leads to rising temperatures, changes in rainfall patterns, and more and longer periods of extreme weather, with implications for water-borne and vector-borne diseases and food security.

B. Sectoral and Institutional Context

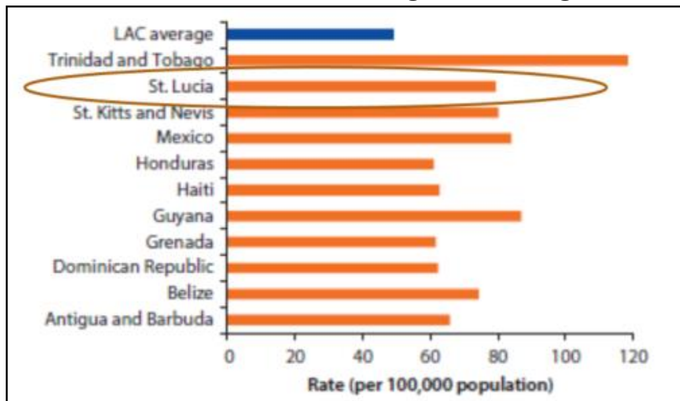
5. **Saint Lucia's health sector has recently been affected by new and emerging diseases, which have highlighted gaps in public health preparedness and response.** The country saw the first case of *Chikungunya* in 2014 and the first case of *Zika* in 2016. By the end of 2017, there were two cases of congenital microcephaly. Meanwhile, conditions such as dengue and leptospirosis remain endemic. An assessment on preparedness by the Caribbean Regional Public Health

[1] The Private Sector Baseline Survey (2009) estimated that about 40 percent of enterprises were considered informal.

Agency (CARPHA) following the West Africa Ebola outbreak in 2015 found mixed results for Saint Lucia, though in general the country scored above the regional average. Areas assessed included risk communication, preparedness, points of entry, transportation, health system, general infection prevention and control and laboratory services. A follow-up assessment the World Bank conducted in the wake of the country's 2017 *Zika* outbreak found that the same gaps in preparedness persisted two years later, and cited shortcomings in response and research. Therefore, while Saint Lucia performs well in some areas of preparedness and response, progress to address the remaining gaps has been slow.

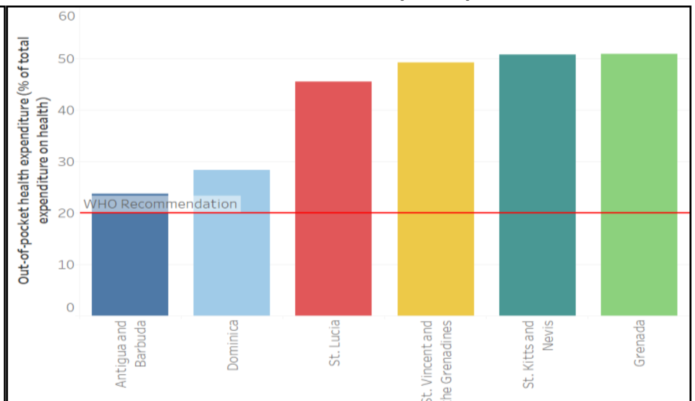
6. **Despite the increase in new and emerging diseases, noncommunicable diseases (NCDs) continue to be responsible for a growing burden of disease.** The population is equally distributed by gender and relatively young, with 26.2 percent comprised of youth and roughly 77 percent under 50 years of age (2012). Life expectancy has continued to increase in recent years, and reached 75 years in 2015, but has been coupled with an increase in NCDs. The prevalence of NCDs such as diabetes and heart disease have been increasing for several years, and remain a top priority for the government. Saint Lucia's mortality rate from diabetes, for example, is approximately 60 percent higher than the regional average (Figure 1). The majority of deaths (80 percent) are due to NCDs, which accounted for almost three quarters of the years of life lost (YLL) in Saint Lucia in 2012. In 2013, ischemic heart disease, cerebrovascular disease, and diabetes were the leading causes of mortality, resulting in 6.3 percent, 5.8 percent, and 7.15 percent, respectively, of total disability-adjusted life years (DALYs), together accounting for almost 20 percent of total DALYs (Global Burden of Disease study 2013). These conditions result in major productivity losses, while consuming a substantial share of the health budget. For example, the annual per capita cost of treatment for diabetes in 2011 was US$794, nearly 50 percent more than per capita health spending of that year. Analysis of claims data from the National Insurance Corporation (NIC), of which 70 percent of the employed are active members, shows that since 2009, the share of claimants paid for sickness benefits has increased, as has the average amount of sickness benefits paid. This implies a substantial productivity loss in the economy due to illness.

Figure 1. Age-standardized Mortality Rates from Diabetes, Selected Countries and Regional Average



Source: Estimates based on WHO 2008 data on the Global Burden of Disease. Note: LAC = Latin America and the Caribbean

Figure 2. Out of Pocket (OOP) Health Expenditures in Selected Caribbean Countries (2014)



Source: World Development Indicators

7. **Total and public sector expenditures on health as a share of GDP (6.7 and 3.6 percent, respectively) in Saint Lucia are comparable to regional averages (2014), but public sector expenditure in health is still below the 5 percent threshold recommended by the World Health Organization (WHO) (Table 1).** The Ministry of Health and Wellness (MOHW) and the NIC provide the main revenue streams for the operation of public health services. The 2017 MOHW budget was EC$110 million (US$41 million), representing the majority of financing for the sector. Although NIC's focus

is the provision of disability insurance and pensions (pensions made up 63.4 percent of total benefits paid in 2013), the NIC pays an annual flat amount to the MOHW to cover hospital services provided to its members at Victoria and St. Jude Hospitals.[2] The NIC covers 50,000 formal sector workers (or about half the estimated labor force), collecting a 10-percent payroll tax on salaries (5 percent from employers, 5 percent from employees), up to EC$5,000 (US$1,851) per month.

8. **Compared to regional averages, Saint Lucia stands out as having a large share of total health expenditures coming from Out of Pocket (OOP) payments.** Saint Lucia's OOP payments are at almost 46 percent, nearly two and a half times higher than the WHO recommended target of less than 20 percent (Figure 2; Table 1). These high levels of OOP expenditures are of concern, as they are regressive, result in a lack of financial protection, and may serve as a barrier to accessing health care services, particularly among the lower income quintiles, who are also more likely to be affected by risk factors leading to poor health. While those with NCDs spend an average of 36 percent of their household expenditure annually on health care, this figure varies widely by income level - the poor spend close to 50 percent of their per capita expenditure and the rich spend less than 20 percent (2006). Less than ten percent of the population has private health insurance, which is concentrated among the higher income quintiles (MOHW 2014). Those who do not have health insurance or who have exhausted their insurance coverage rely on the Medical Fund, which has an annual budget of EC$800,000 (US$296,296) and is limited at EC$10,000 (US$3,703) per person.[3] Coverage options for different segments of the population are described in Annex 5 in greater detail.

Table 1. Key Health Expenditure Data for Saint Lucia and Regional Comparators[4]

	Saint Lucia		Caribbean Small States		Latin America & the Caribbean	
	1995	2014	1995	2014	1995	2014
Health expenditure, total (% of GDP)	**6.1**	**6.7**	5.3	6.2	6.3	7.2
Health expenditure, public (% of GDP)	**3.0**	**3.6**	2.8	3.3	3.0	3.7
Public sector expenditure in health (% of total)	**50.0**	**53.6**	53.4	53.4	47.4	51.2
Out-of-pocket health expenditure (% of total)	**49.1**	**45.6**	30.9	32.1	39.6	31.7

9. **Health care services are delivered by the public and private sectors as well as several non-governmental organizations (NGOs).** Within the public sector, health care in Saint Lucia is delivered through 34 health centers, two polyclinics, two district hospitals and one general hospital (Victoria Hospital); the general hospital is expected to be decommissioned and converted to a polyclinic. There is also a parastatal polyclinic and a parastatal hospital, with the Owen King European Union Hospital expected to be statutorized[5] shortly. The public sector is estimated to provide a third of primary care services and about 93 percent of hospital services. Incentive structures are also limited in the public sector as these facilities do not keep the revenues collected from private insurance companies, and thus have little incentive to pursue collection or report performance. In contrast, St. Jude Hospital, which has been statutorized, receives a government subsidy but has financial autonomy. Within the private sector, the exact number of providers for primary care is presently unknown (it was 77 in 2011), but there are five polyclinics and one general hospital (Tapion Hospital). The private sector focuses on primary care services, diagnostic tests and pharmaceuticals, with limited involvement in hospital services, though the specific quantum of services delivered is difficult to estimate. Meanwhile, NGOs provide health services that tend to be focused on certain conditions or target groups, though these services cover relatively few

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[2] The NIC transferred about EC $5.5 million (US$2 million), or about 8 percent of total benefits, to the MOHW in 2013. Victoria Hospital and St. Jude Hospital were the two public hospitals in Saint Lucia at that time.

[3] Once resources from the Medical Fund are exhausted, or in cases of catastrophic or overseas expenditures, applications are made on a case-by-case basis (requiring Chief Medical Officer and Cabinet approval) for medical expenses covered through the General Budget.

[4] The World Bank. (n.d.). *Indicators*. Retrieved from The World Bank: http://data.worldbank.org/indicator?tab=all

[5] Statutorization refers to a government agency, in this case the hospital, being allowed to be managed independently on a commercial basis and with its own Board.

patients. For example, the World Pediatric Project delivers almost all services for children free of charge (costs are covered by the NGO).

10. **Despite the many actors providing health services, it is estimated that there is an unmet need of at least 30 percent in primary care services and 23 percent in secondary and tertiary care services (MOHW 2017)**. Further, while Saint Lucia exceeds the minimum targets for human resources in health (HRH) density, there is a lack of specialists and an aging nursing workforce. In addition, health facilities are inadequately equipped to cope with the growing burden of NCDs. Challenges are also seen in primary care services, which serve as the first point of contact with the health system, which are often not equipped to deal with NCDs as seen in Table 2, forcing patients to rely on higher (and costlier) levels of care, such as hospitals. This is inefficient, and reduces access to services. Moreover, low productivity presents a further challenge to improving service delivery at the primary care level as health facilities are paid on a historical basis which can lead to providers seeing fewer patients.

Table 2. Availability of diabetic medicines, basic technologies and procedures in the public health sector

Medicines in primary care facilities		Basic technologies in primary care facilities	
Insulin	●	Blood glucose measurement	●
Metformin	●	Oral glucose tolerance test	○
Sulphonylurea	●	HbA1c test	○
Procedures		Dilated fundus examination	○
Retinal photocoagulation	○	Foot vibration perception by tuning fork	●
Renal replacement therapy by dialysis	○	Foot vascular status by Doppler	○
Renal replacement therapy by transplantation	○	Urine strips for glucose and ketone measurement	●

Source: World Health Organization. Diabetes Country Profile – St. Lucia. 2016.
Note: Darkened circles represent availability; empty circles indicate unavailability.

11. **Against a sectoral backdrop of limited fiscal space, a double burden of disease, emerging new diseases, and a service delivery system unable to meet population needs, there has been a new push for health sector reform in the country.** As part of this push, the government is looking to roll out an essential package of health services through a new unit (National Health Insurance Unit within the MOHW) formed for this purpose. This unit will also seek to develop and implement a national health financing mechanism to fund the delivery of these services, while improving the efficiency and sustainability of current financing and identifying new sources of revenue for the sector. The reform effort prioritizes strengthening primary health care (PHC) by introducing financial incentives to enhance service delivery, improve health infrastructure to ensure provision of necessary services, and strengthening preparedness and response for public health emergencies through improvements in care integration**.**

12. **A draft essential benefits package has been developed by the MOHW, with delivery of the full package estimated at approximately EC$69 million (US$25.5 million), 62 percent more than the current MOHW budget (EC$110 million, US$40 million),[6] further highlighting the need to identify less costly ways of delivering health care and to explore additional financing options for delivering necessary services.** The proposed essential benefits package has been determined based on the cost of services provided at the existing general hospital (Victoria Hospital), which may differ from the fee schedule set by the OKEU Hospital going forward. These costs will need to be taken into consideration in the rollout of the essential benefits package, to ensure that public hospitals are able to deliver the secondary/tertiary care services as guaranteed through the essential benefits package. At this time, the predominant model under consideration for financing the essential benefits package is one whereby revenue generation is shifted to the employed,

[6] Of the current MOHW budget of EC$110 million, only EC$10 million of costs are recovered.

with the Government responsible for premiums for the unemployed and the poor, and where health funds are privately managed in order to improve efficiency. Other options actively being considered, which will be further assessed for financing the essential benefits package include sin taxes, increasing the NIC contributions for health, and increasing the Value Added Tax.[7]

13. **The government also seeks to improve the efficiency and fiscal sustainability of service delivery, a major part of which involves improving the integration of primary care services and scaling-up NCD prevention efforts.** In support of these efforts, the National NCD Commission was reestablished in 2017 with the agenda of accelerated NCD action to achieve the 2025 global NCD targets and the health-related targets within the 2030 Sustainable Development Goals. Eighty percent of cancers, diabetes and heart diseases are preventable, with prevention efforts found to be very cost-effective.[8] NCDs currently represent the major cause of morbidity and premature mortality in Saint Lucia, with a grim outlook for the future given the high prevalence of risk factors for NCDs. For example, while the prevalence of diabetes is currently 14.6 percent, close to 60 percent of the population are overweight, more than 40 percent are inactive and almost 30 percent are obese.[9] Real-time data is problematic to obtain, making it difficult to identify those at risk and to make evidence-based recommendations, as well as to inform strategic purchasing and health technology assessments. The lack of data also makes it challenging to respond to public health emergencies when they occur. Nonetheless, extensive efforts are underway to improve Saint Lucia's Health Information System (SLUHIS), as described in Annex 4.

C. Relevance to Higher Level Objectives

14. **The Project is in line with the World Bank's twin goals of eliminating extreme poverty and boosting shared prosperity.** Within the health sector, the World Bank's strategy to achieve the twin goals is through assisting countries to accelerate progress toward the achievement of UHC as noted in the Priority Directions for the Health, Nutrition and Population Global Practice 2016-2020. The Saint Lucia Health System Strengthening Project is linked to two main areas under this broader goal, namely financing protection (establishing systems for fair, efficient and sustainable financing) and service coverage (ensuring equitable access to affordable, quality health services). UHC also represents an essential part of the Sustainable Development Goals (SDGs), and is included as a target in SDG 3 (SDG 3.8), namely "achieve universal health coverage, including financial risk protection, access to quality essential health care services, and access to safe, effective, quality, and affordable essential medicines and vaccines for all."

15. **The Project is also consistent with the 2018 Performance Learning Review[10] of the Regional Partnership Strategy of the Organisation of the Eastern Caribbean States (2015-2019), discussed by the Board of Executive Directors on November 13, 2014, which strengthens the strategic focus on macro-fiscal issues and deepens engagement to support resilience, including human capital resilience.** Activities conducted under the Project directly contribute to achieving results under the PLR Outcome 5 – Improved Human Capital Results through Higher Quality Standards for Education and Health – by supporting investments in public primary care facilities to properly equip them to improve their NCD management capabilities. At the country level, the National Health Strategic Plan 2006-2011 continues to drive the

[7] Implementation of all the various measures is expected to yield EC$99.5 million. The complete list of options considered are as follows: (i) tax on processed foods (EC$17.3 million); (ii) alcohol tax adjustment (EC$4.3 million); (iii) tobacco tax (EC$2.7 million); (iv) increased excise tax on vehicles under 1800 cc (EC$11 million); (v) increased NIC contribution (compliance and raise in capped salary level) (EC$22 million); (vi) private health insurance (EC$10 million); (vii) allocation of 1.5 percent of VAT (EC$32.1 million).
[8] See Cecchini, Michele, et al. "Tackling of unhealthy diets, physical inactivity, and obesity: health effects and cost-effectiveness." The Lancet 376.9754 (2010): 1775-1784 for a review of the cost-effectiveness of various measures.
[9] World Health Organization. Diabetes Country Profile – St. Lucia. 2016.
[10] Performance and Learning Review (PLR) of the Regional Partnership Strategy (RPS) for the Organisation of the Eastern Caribbean States (OECS), Report No. 118511-LAC, May 1, 2018.

health agenda, and highlights several key priorities relevant to the activities proposed under this Project. These include responding to the growing problem of chronic NCDs, and the implementation of a UHC strategy to facilitate access to a basic package of health care services in a financially sustainable manner.

II. PROJECT DESCRIPTION

A. Project Development Objective

PDO Statement

The development objective is to improve the accessibility, efficiency, and responsiveness of key health services.

PDO Level Indicators

16. The following key results will be monitored throughout the Project:

a) Number of people registered under the National Health Scheme (reported separately for women) (Accessibility)
b) Percent of diabetic/hypertensive patients > 18 years at public primary care facilities managed according to national protocols (reported separately for women) (Efficiency)
c) Compliance with 2005 International Health Regulations (IHR) by maintaining a trained Rapid Response Team (RRT) to respond to events that may constitute a public health emergency (Responsiveness)

B. Project Components

17. **The Government has requested World Bank financing for a Project to support its strategy for achieving UHC.** The Project will strengthen Saint Lucia's health system, focusing on the establishment of an essential benefits package, strengthening institutional readiness and performance particularly at the primary care level, and improving public health emergency preparedness and response. An essential benefits package has been drafted (see Annex 5), and will be refined and rolled out using a phased approach. Following the deployment of similar programs in other countries in the region, it would begin with a minimum, essential benefits package which fits within the government's fiscal space, with benefits added over time as efficiency gains are made and administrative systems (and revenue collection) improve. To support the services delivered through the essential benefits package, the Project will also strengthen service delivery, with a focus at the primary care level. A detailed description of the Components and activities to be supported under the Project is provided in Annex 3.

Component 1. Design and Implementation of an Essential Benefits Package (US$5.5 million)

18. Component 1 focuses on the demand side and includes the review of the design and implementation of the benefits package, including administration, purchasing and contracting arrangements, regulations surrounding the scheme, and potential sources of additional revenue for expanding health service coverage. The Project will finance the analytics to support the Government in its design of the package and the roll-out of information technology and systems platforms in support of the implementation of the package. Public funds will finance the provision of the package. Activities described under Subcomponent 1.1 will be undertaken in parallel. A summary of the proposed benefits package is provided in Annex 5.

19. **Subcomponent 1.1. Review of the Essential Benefits Package (US$1 million).** This subcomponent would support the review of the essential benefits package. Proposed activities under this subcomponent, which will be undertaken in parallel, include reviews of: (i) public sector expenditure in health, (ii) current insurance payment systems and coverage, (iii) evaluation of coverage options for those outside of the formal sector, and (iv) in-depth assessment of the proposed benefits package. Supporting activities such as the development of Standard Operating Procedures (SOPs)/clinical

procedures, investments in the national health information system (HIS) and development of legislation will also be conducted.

20. **Subcomponent 1.2. Implementation of the Essential Benefits Package (US$4.5 million).** Findings from the previous subcomponent will support direct actions to roll out the implementation of the benefits package. Activities supported under this component include investments in IT systems and infrastructure for administration of the benefits package, establishment of purchaser provider agreements, review of and support to requisite audits, communications campaigns and training activities.

Component 2. Strengthening Service Delivery in Support of the Essential Benefits Package (US$13 million)

21. **Subcomponent 2.1. Improving Service Delivery through Performance-Based Financing (PBF) (US$4 million).** This subcomponent proposes to include a PBF scheme focused on diabetes and hypertension to improve the efficiency of health expenditure by providing bonuses based on performance. PBF for health has been implemented in several countries to achieve health outcomes by linking incentives with results. Commonly referred to as pay for performance or performance-based incentives, programs reward the suppliers of health services, healthcare providers or facilities, upon achieving certain results such as immunizing a percentage of the population or increasing the number of preventative screenings in an area. In the case of Saint Lucia, the proposed PBF scheme will focus on strengthening NCD management at the primary care level. Activities to be financed include the revised design of the PBF scheme, health facility outreach, and PBF bonus payments based on performance.

22. **Subcomponent 2.2. Strengthening the Supply of Health Care Services (US$4.5 million).** This subcomponent focuses on the supply-side and would involve strengthening the integration of primary care systems to enhance the role of primary care facilities and encourage their use as the first point of contact for health services, particularly NCDs. This component would finance goods, minor refurbishments, consultancy services, trainings/workshops, and operational costs in support of key investments/activities. Activities conducted under this subcomponent include a survey of institutional readiness of health facilities, improvement of health facilities, and development of a health facility network. Supporting activities such as radio systems for communication with health facilities are also envisioned.

23. **Subcomponent 2.3. Public Health Emergency Preparedness and Response (US$4.5 million).** As part of efforts to strengthen the health system and address the growing threat posed by climate change, this Project also addresses weaknesses in public health emergency preparedness and response. Activities under this subcomponent include strengthening of surveillance and information systems, laboratory capacity, and preparedness for public health emergencies. Under the Project, the National Health Care Waste Management Plan will be updated to include measures for how to manage equipment distribution and installation in the case of a disease outbreak.

Component 3: Institutional Capacity Building, Project Management and Coordination (US$1.5 million)

24. This Component would cover project implementation efforts, including project management, fiduciary tasks and monitoring and evaluation (M&E) associated with supervision of the Project. This Project will be managed by a stand-alone Project Implementation Unit (PIU) housed within the MOHW, whose duties will include oversight of refurbishment activities as well as compliance with safeguards and local permit requirements during refurbishment/rehabilitation, and implementation of the Health Care Waste Management System (HWMS) during operation. The Project also secured a Project Preparation Advance (PPA) to allow selected Project activities to begin during the preparation process. The PPA phase is envisioned to be completed by the time the Legal Agreement for the Project is signed. Activities to be financed by the PPA will be implemented with oversight from the existing national-level Project Coordination Unit (N-PCU), and will consist solely of consultancies and hiring of staff for the PIU within MOHW. As such, support is envisioned for

financial management and procurement functions, in addition to the development of a HWMS in accordance with the Terms of Reference in the Environmental and Social Management Framework (ESMF).

Component 4. Contingent Emergency Response Component (CERC) (US$0 million).
25. This Component will provide funding following an eligible emergency.[11] The Component will include conditions for the use of funds, and will only be triggered when certain actions, as agreed by the Government and the Bank are met. These actions include the following: (i) the country experiences an eligible emergency; and (ii) presents a sound and actionable country-level response plan. This component provides a platform for country-level discussions on the importance and need for country-level readiness to respond to disease outbreaks, including vector-borne diseases. Once triggered, the component will be guided by Investment Project Financing (IPF) Policy, Paragraph 12, which enables rapid reallocation of funds between Project components following an emergency. Together with the operational and fiduciary arrangements that underpin its implementation, the component provides a conduit for additional emergency funds into the Project. The Pest Management Policy (OP 4.09) has not been triggered. Support for emergency response or outbreaks will not include pesticide use for vector control, but rather technical, logistic, training, and planning activities. Any minor quantities of pesticides would be addressed by specific measures and procedures in the ESMF for storage, handling and application of pesticides.

C. Project Beneficiaries

26. **Project beneficiaries consist of the entire 178,015 resident population of Saint Lucia given the public goods nature of improved public health emergency preparedness and response**. All individuals covered by the essential benefits package will also directly benefit from the Project. It is estimated that 50 percent of Project beneficiaries are women**.**

D. Results Chain

27. **The Results Chain highlighting the link between Project activities and achievement of the PDO is illustrated in Annex 3.** Investments made under the Project complement each other to result in an overall strengthening of the health system. The achievement of project outcomes over the course of the Project will be monitored using the Results Framework, as described in Sections III.B (Results Monitoring and Evaluation Arrangements) and VI (Results Framework and Monitoring).

E. Rationale for Bank Involvement and Role of Partners

28. **The health sector has received external support focused on capital investments or technical assistance instead of broader sector reform.** Following the closing of the Bank-financed Saint Lucia HIV/AIDS Prevention and Control Project (US$7.9 million) in 2010, the Bank has not had further investments in Saint Lucia. Most recently, the Bank's investments in the health sector have been through the Disaster Vulnerability Reduction Project (P127226) where several health facilities were rehabilitated. Investments by other agencies have been limited to capital investments or targeted toward specific areas within the health system. For example, the European Union funded the construction of the new OKEU Hospital [which at EC$167 million (US$62 million) was the largest infrastructure project undertaken by the EU in the Eastern Caribbean at the time], and the Pan-American Health Organization (PAHO) is providing financing to upgrade

[11] An eligible emergency means the imminent or actual occurrence of a natural or man-made crisis or disaster, which, in the opinion of the Bank, has the capacity to cause major adverse economic, health and/or social impacts in the Recipient's population.

selected health facilities to improve their climate and disaster resilience. Socieux+, an EU technical assistance (TA) facility on social protection, labor and employment, will provide three months of TA to MOHW focused on assessing the health financing context in the country and formulating possible policy options. In addition, they will be providing training for MOHW staff on policy design for health reform. These activities were expected to be completed in the first half of 2018, and will contribute to the evidence and knowledge base available for the implementation of the essential benefits package.

29. **Regional agencies have provided TA emphasizing the achievement of UHC, addressing NCDs, and improving public health preparedness and response, though these efforts have generally not been focused at the country level.** Under the Caribbean Community (CARICOM), the development of a regional health insurance scheme was explored several years ago, though these efforts did not come to fruition due to the lack of a country-specific focus. Meanwhile, CARPHA, the lead technical body in the region which brings together five former key public health regional agencies to provide a coordinated public health platform across the region, has been involved in addressing NCDs and infectious diseases. CARPHA conducts surveillance and research as well as a range of health promotion and prevention activities and serves as a regional Reference Laboratory. In addition to CARPHA, the Pan American Health Organization and the United States Center for Disease Control and Prevention also maintain an active presence in the region. In Saint Lucia specifically, engagement has been limited to TA or disaster preparedness and recovery. Thus, there is a need for deeper and more comprehensive support as it pertains to the achievement of UHC, which is the focus of the Project.

F. Lessons Learned and Reflected in the Project Design

30. **The Project design considers lessons learned from the Bank's operations and international experience:**

a) **The recent Independent Evaluation Group Cluster Country Program Evaluation on Small States provides several useful lessons (2016).** The IEG review suggests sustained engagement around a limited set of objectives, which are reflected in the focused approach undertaken by the Project. The review also notes the importance of proper sequencing of activities, which led the Borrower to secure a PPA to ensure adequate time for implementation and appropriate sequencing. The need to provide adequate support to implementation of investments was also noted, resulting in the establishment of the PIU within the MOHW.

b) **A "business as usual" approach to UHC cannot be taken in a small island state setting as in Saint Lucia.** The small island context is characterized by a shortage of health workers and its inability to tap into economies of scale due to its small population size. Furthermore, the epidemiological profile of small islands has been burdened by NCDs more so than any other region or country group, as seen in East Asia and the Pacific Region as well. As a first step to UHC, an essential benefits package tailored to the country context, which considers the opportunity cost of off-island health services while ensuring delivery of NCD preventive services, is essential.

c) **Lessons on global PBF experiences demonstrate it supports a country in its path toward UHC.** PBF approaches, especially on the supply side, can improve the alignment between resources and health priorities by creating incentives for health facility managers and health workers to expand the coverage of essential public health interventions and improve their quality by linking facility payments to service delivery and quality indicators.

d) **The tight fiscal space and communications are key consideration in the development of the essential benefits package.** A phased approach beginning with a minimum, essential benefits package that fits within the government's fiscal space with benefits added over time is necessary. A well-designed and implemented

communications strategy is needed to ensure that the goals, achievements, and experiences of the reform are shared effectively to create awareness and build concrete understanding of the process and benefits of the reform.

III. IMPLEMENTATION ARRANGEMENTS

A. Institutional and Implementation Arrangements

31. **The Project has put in place a two-phase approach to allow for immediate PPA implementation, proper capacity building and knowledge transfer, and close technical supervision of Project implementation.** The Project will be implemented by the N-PCU at the outset, and by the MOHW PIU for the remaining period of implementation. This two-phase approach allows for transfer of capacity from the N-PCU to the new MOHW PIU and takes advantage of the existing N-PCU to kickstart implementation under the PPA. The first phase will engage the existing N-PCU to manage project implementation during an interim period to align with the implementation period of the PPA. The PPA phase is envisioned to be completed by the time the Project's Legal Agreement is signed. The second phase will transition the project management function from the N-PCU to the MOHW PIU for the remaining life of the project.

32. **During the first phase, aligning with the PPA, the N-PCU will manage the project implementation based out of the N-PCU.** The N-PCU has the existing structure (office and human) in place and the experience and capacity based on its long-standing role in managing the implementation of Bank-financed projects. The N-PCU has an overall manager who will provide oversight and guidance to the project management duties and will make available the time of a Financial Management Specialist and Procurement Specialist to support the implementation of activities under the PPA. The N-PCU will also manage the PPA activities which include the hiring of a Project Manager, Financial Management Specialist (FMS), and Procurement Specialist for the Project. This would allow the N-PCU to provide oversight and guidance to these newly contracted staff and "on-the-job" training during PPA implementation, which in addition to the training to be provided by the Bank, will ensure these staff have the capacity to take on project management functions under phase 2. This would also provide time for the MOHW PIU to acquire and put in place a project accounting system, document fiduciary procedures in the Operations Manual and prepare terms of reference for the annual external audit.

33. **During the second phase, the management and implementation of the Project will be transitioned to the MOHW PIU based out of the MOHW.** The three positions contracted under phase 1 will move over to the MOHW-PIU by the time the Legal Agreement for the Project is signed. A Project Manager will lead the day-to-day implementation and report to the MOHW Permanent Secretary on Project interventions in MOHW priority and strategic areas, on the coordination of efforts with other partners, and for technical coordination of activities financed under the Project. The MOHW PIU team will include the following positions: (i) Project Manager, (ii) Monitoring and Evaluation Specialist, (iii) FMS, (iv) Procurement Specialist, and (v) PBF Project Coordinator. Further details on implementation arrangements are provided in Annex 1.

B. Results Monitoring and Evaluation Arrangements

34. **A results framework together with monitoring arrangements have been developed to monitor progress, and is described in Section VI in greater detail.** PDO level indicators and intermediate indicators will be monitored by the MOHW. Some indicators will be under the purview of specific units or systems within the MOHW as specified in the monitoring arrangements. The PDO level indicator on responsiveness will be reported to WHO which is a benefit to the project since the data is required to be annually reported to WHO, it will also be made available to the Project. Several indicators rely on protocols that have not yet adequately implemented, while in other instances they rely on

improvements in HIS systems or on reporting from newly-established institutions such as the National Insurance Unit. Data will be collected as these protocols are developed and systems are established, and will be the responsibility of the M&E Officer within the MOHW PIU as described in Section IIIA on Institutional and Implementation Arrangements.

C. Sustainability

35. **The Government of Saint Lucia is committed to the Project, which contributes to the achievement of UHC, an area of importance in the National Health Strategic Plan 2006-2011 (which continues to be valid).** Health has been identified as a high developmental priority under the Government, and discussions focused on the Project have been underway for a considerable time. The government is increasingly moving toward a performance-based approach to budgeting, which strongly aligns with the PBF approach adopted through the Project to strengthen service delivery at the PHC level. In working towards a sustainable service delivery model for the health system, the essential benefits package will be reviewed and modified to respond to available fiscal space and population needs, with periodic update mechanisms defined. Such periodic update mechanisms will allow the benefits package to evolve and incorporate new, potentially cost-saving technologies. Activities conducted under the Project such as (i) establishing and/or strengthening institutions and mechanisms to collect adequate revenues, (ii) pooling risks and managing revenues equitably and efficiently, (iii) carrying out strategic purchasing of services and conducting health technology assessments, and (iv) ensuring adequate monitoring and auditing of service delivery and outcomes, will further contribute to improving the sustainability of the health system over time. While no decision has been made on the provision of PBF payments following the completion of the Project, these funds are limited and the discontinuation of the Project as source of funding will be taken into consideration in the review of the financing of the essential benefits package following Project completion.

IV. PROJECT APPRAISAL SUMMARY

A. Technical, Economic and Financial Analysis

36. **The Project is relevant and consistent with the aim of improving the accessibility, efficiency, and responsiveness of health services provided by Saint Lucia's National Health System.** The Project will use a simple design consisting of two technical components, which reduces fragmentation and increases flexibility. The Project will support efforts that directly address the sustainability of an essential package of health services in line with Saint Lucia's epidemiological profile, as well as systemic elements related to the integration of care at the primary care level which is an enabling factor for the provision of health services in a more efficient manner. The introduction of PBF represents a first step towards helping to shift the focus from an inputs-based approach to a results approach. A results focus will contribute to improved efficiency and several health system pillars such as governance, quality of health service delivery and health financing (strategic purchasing). The Project components are complementary and the budget for each component and subcomponent is reasonable and balanced.

37. **The Project is expected to yield the following measurable economic benefits.** These benefits consist of (i) gains in productive life by decreasing the number of disability-adjusted years from reduced mortality rates and morbidity from both communicable and NCD-related conditions, particularly diabetes and circulatory conditions, which represent the second highest disease burden (11 percent of total DALYs in 2016), and (ii) cost savings from reduced hospitalizations (admissions and readmissions) caused by conditions susceptible to ambulatory care. Additional benefits (not measured) can be also be surmised from interventions aimed at strengthening public health emergency preparedness and response, but these benefits are not included in the analysis.

38. **The cost-benefit analysis produces a positive result of the Project in every scenario considered.** The Net Present Value (NPV), expressed as the difference between benefits and costs of the interventions, is positive (US$15-117 million, with sensitivity analysis and the estimated internal rate of return (IRR) ranging between 26.6 and 91.3 percent, assuming conservative scenarios for gains derived from reduced loss of years of life due to disability or death. These are further described in Annex 2. The Project is expected to be cost-effective due to the relatively low investment required (US$20 million), the resulting high expected reduction in DALYs (due to the sensitivity of the proposed interventions) and high attributed monetary value of the interventions (equivalent to a year of GDP per capita), as suggested by the literature.

39. **A substantial share of health services in Saint Lucia are delivered through the MOHW.** The rationale for public provision lies in the positive long-term effects of improved utilization and quality of health services. There is evidence that links investments in health with economic growth, especially in low- and middle-income countries. Improving utilization and quality of essential health services is critical for building human capital and is necessary to achieve inclusive and sustainable development.

40. **The World Bank's value-added includes the provision of technical guidance on the design and implementation of the essential benefits package and the PBF model; discussion and systematization of procedures for integrating health care services at the primary level of care; implementing South-South exchanges on topics to enable the health sector to benefit from international experiences; and opening the dialogue for lines of PBF based on results and outcomes.** In addition, the World Bank will continue to provide support for the policy dialogue across the health sector.

B. Fiduciary

a) Financial Management

41. **A FM assessment[12] was conducted as part of the appraisal mission.** The overall conclusion of this assessment was that the Project's FM arrangements (accounting staff and systems, internal control produces, and Project external auditors) are not yet in place at the MOHW PIU.

42. **The Borrower should therefore take appropriate actions to ensure the proposed FM action plan is implemented satisfactorily within the established deadlines.** In the interim, a one phased approach will be put in place to allow the N-PCU to provide FM support to the Project during the PPA implementation period. Based on the assessment, gaps in FM arrangements in place at the MOHW were noted. The FM arrangements would become acceptable to the Bank subsequent to the resolution of the following during implementation of the PPA.

Action	Responsible Entity
1. Employ additional FM staff.	MOHW
2. Project operating manual including FM project manual.	MOHW
3. Acquire and implement project accounting system that facilitates the recording, control and reporting of project transactions for the provision of required financial reports	MOHW
4. Provide the Project's financial management staff with formal training in FM and disbursements.	World Bank
5. Provide the Project's financial management staff with hands-on training in FM and disbursements.	National PCU/ MOHW
6. Prepare Terms of Reference (TOR) for the Office of the Director of Audit	MOHW

[12] The assessment was conducted in accordance with OP/BP 10.00 and in line with specific Bank Guidelines Manual for World Bank-Financed Investment Operations (document issued by Operations Policy and country Services OPCFM on March 1, 2010) to assess the adequacy of financial management arrangements in place at the MOHW's PIU.

43. **The project Financial Management Specialist (FMS), supervised by the Financial Analyst from the MOHW's Accounts Department and reporting to the Project Manager, will have overall responsibility for project FM matters.** These responsibilities are namely: (a) planning, (b) budgeting, (c) accounting, (d) internal control, (e) funds flow, (f) financial reporting, and (g) auditing arrangements. The appointment of the Project FMS should be completed within the PPA period. The Project funds, expenditures, and resources will be accounted for using a computerized accounting software and the basis of accounting will be Financial Reporting under Cash Basis or Modified Cash Basis. Disbursements of IDA funds will be done on report-basis (quarterly interim unaudited financial reports) and specific arrangements for PBF as described in the Disbursement and Financial Information Letter (DFIL). The Project will make use of advances and direct payment methods for disbursements. Special commitments and reimbursement methods will also be available for the Project.

44. **The MOHW PIU will provide quarterly interim unaudited financial reports (IUFRs) and annual audited financial reports.** IUFRs will be due to the World Bank within 45 days of the end of each calendar quarter. The Project financial statements will be audited annually and the audit report will be submitted to the World Bank no later than six months after the end of each financial year.

45. **Finally, Subcomponent 2.1 proposes to include PBF** focused on diabetes and hypertension. For the output-based portion of the PBF, the unit cost and the verification modalities will be specified in the PBF Operational Manual (OM). For the result-based portion of the PBF, the list of eligible expenditures, the results' targets and the verification modalities will be confirmed during the implementation of the PPA and documented in the PBF OM. Once the MOHW-PIU previously mentioned items are defined, the WB FMS and disbursement officer will review acceptability for disbursement.

b) Procurement

46. **Procurement procedures.** The Borrowers will carry out procurement under the Project in accordance with the World Bank's "Procurement Regulations for IPF Borrowers" (Procurement Regulations) dated July 2016 and revised in November 2017 under the "New Procurement Framework (NPF), and the "Guidelines on Preventing and Combating Fraud and Corruption in Projects Financed by IBRD Loans and IDA Credits and Grants", dated July 1, 2016, and other provisions stipulated in the Financing Agreements. Further, the 'Guidelines on Preventing and Combating Fraud and Corruption in Projects Financed by IBRD Loans and IDA Credits and Grants', dated October 15, 2006, and revised in January 2011, will apply.

47. **Procurement arrangements.** Under both phases of project management, the PIUs will include procurement responsibilities. The N-PCU will designate a procurement specialist to support the project procurement functions during the PPA period. Under the PPA, a procurement specialist will be hired based at the MOHW PIU to then take over the project procurement functions.

48. **PPSD Summary.** A simplified Project Procurement Strategy for Development (PPSD) was developed for the Project which defines the applicable procurement arrangements, appropriate selection methods, including market approach, and type of review to be conducted by the World Bank. It is foreseen that most Project activities will be carried out through national or international competition.

49. **Procurement Plan.** A procurement plan for the first 18 months of the Project has been developed and agreed upon. The Project will be executed in accordance with the World Bank Procurement Regulations and the provisions

stipulated in the Procurement Plan and the OM.

50. **Procurement capacity.** While the MOHW has limited exposure to Bank procurement procedures, the N-PCU has long-standing experience and capacity in having managed the procurement activities under other World Bank-funded projects. The capacity assessment of the MOHW PIU will be conducted on June 18, 2018 to assess the quality and capacity of the PIU to handle procurement activities under this Project. Specific procedures for the Project will be detailed in the operation manual of the project, which will be developed under the PPA. The N-PCU procurement specialist will transfer knowledge to the MOHW-PIU selected procurement officer.

C. Safeguards

a) Environmental Safeguards

51. **The Project is considered as environmental risk Category B, given that the Project is not likely to result in significant negative, irreversible and/or large-scale impacts on human populations and/or the environment.** The Environment and Social risk rating is considered Moderate under the Project, though it is rated Substantial to account for the vulnerability of Saint Lucia to natural hazards such as hurricanes. The sole safeguard policy triggered is OP/BP 4.01 (Environmental Assessment). An ESMF was prepared given that location of works is unknown at this time. The ESMF has screening protocols to ensure impacts are minimized, and references the World Bank Group Environmental Health and Safety (WBG EHS) Guidelines and the sector guidance WBG EHS Guidelines for Health Care Facilities.

52. **The Project would include improvements and refurbishments of up to 34 selected primary health facilities including equipment inventory, procedures provided, and infrastructure, based on a survey to be conducted during implementation.** Refurbishment works may take place at existing facilities anywhere on the island of Saint Lucia. In addition, a national health care waste management plan will be updated for activities that include minor refurbishments and the proper disposal of medical equipment. The type of refurbishments envisioned could include minimal infrastructure adjustments such as establishing partitions in existing structures, improving lighting, and painting. The magnitude of such refurbishments is minor as potential adverse environmental impacts due to these interventions potentially involving dry-wall installation, installation of new lighting fixtures, and properly disposing of unused paint. It is also possible that additions, expansions, or annexes might also be rehabilitated or constructed. Under the Project, the national health care waste management will be updated for activities that include the minor refurbishments and the proper disposal of medical equipment. This may involve improvements to wastewater disposal systems and/or medical waste storage facilities.

53. **The potential negative impacts can be grouped into two categories: those associated with typical small civil works during refurbishment, and those associated with medical waste management during operation.** The former are minor and short-term, and are addressed within the ESMF by the provision of a generic Environmental and Social Management Plan (ESMP) with Best Management Practices (BMPs) and standard contract clauses for small civil works, and a pre-design screening to identify any special conditions requiring additional mitigation measures. The latter are addressed by provision of TOR to develop a Health Care Waste Management System (HWMS) during the early stages of implementation.

54. **The MOHW PIU will provide oversight for the refurbishing projects as well as on compliance with safeguards and local permit requirements during refurbishment/rehabilitation, and implementation of the HWMS.** The development of the HWMS will include capacity-building through occupational health and safety training, including exposure to diseases, medical waste and the use of certain equipment with radiation, in accordance with the

Terms of Reference in the ESMF.

55. **The ESMF was disclosed on the MOHW website on June 7, 2018, along with an invitation to provide input and feedback via the email address or telephone numbers provided.** In addition, emails and links to the draft document were provided to key stakeholders to solicit input. The ESMF will be updated to include the comments from the public consultation, and the final version will be posted on the websites of the MOHW and WBG. The ESMF includes a grievance redress/feedback mechanism to be established to ensure citizens have a forum to raise concerns/complaints and/or provide feedback on services delivered or from which they may have been excluded.

56. **The Project is expected to have limited climate co-benefits at 4 percent, due to climate adaptation activities under Subcomponent 2.3 which focuses on public health emergency preparedness and response.** This Subcomponent addresses vulnerability to climate change due to events such as rising temperatures and more and longer periods of extreme weather, which have important implications for water-borne and vector-borne diseases. In addition, the Project is expected to develop a Health Care Waste Management Plan under Subcomponent 2.2, which is expected to improve the management and treatment of medical waste, thereby yielding climate mitigation benefits.

b) Social Safeguards

57. **OP 4.12 is not triggered for this Project** as Project financed activities are focused on technical analysis and improving the integration of health services already offered by the existing health care system and will not require any land acquisition or cause any negative impacts on livelihoods.

58. **The Project will support citizen engagement mechanisms that will collect patient feedback on their perception of quality of health services and patient satisfaction.** Under the country's Continuous Quality Improvement (CQI) strategy, approved in 2018, a citizen engagement mechanism has been developed, yet not implemented. A focus group discussion was held with key MOHW stakeholders to discuss and identify potential citizen engagement mechanisms. Those identified included suggestion boxes and exit polls at the health facility-level and defining clear communication channels through which beneficiaries can direct feedback to respective Boards. Moreover, under subcomponent 2.1, performance based financing, a sample of patients from the health facilities will be interviewed periodically to collect perceptions regarding main services offered at each level of care. Two citizen engagement indicators are included in the Project Results Framework to reflect the citizen engagement actions that will be supported under the Project which relate to the percentage of PHC facilities that have implemented exit surveys with service users in a one-year period and presenting results to the MOHW and the percentage of PHC facilities participating in the PBF scheme that have developed an action plan(s) based on the results of quarterly satisfaction surveys.

59. **The Project has a strong gender dimension by supporting actions related to NCDs and ensuring *Zika* monitoring at the primary care level.** NCD-related preventive services will be incorporated into the essential benefits package to ensure women, who are at higher risk for NCDs due to high rates of overweight/obesity, have access to needed preventive NCD services addressing diabetes and hypertension. A greater number of women relative to men currently access health services which may be partly explained by prenatal care. The Project will ensure that women are equally represented among those registered for the National Health Scheme, the PBF scheme, and accessing health services. Where relevant, selected indicators in the Results Framework will be reported separately for women. In addition, the Project will work to integrate care at the primary care level to ensure early monitoring services, particularly *Zika*, are targeting women for early detection and response.

c) Other Safeguards

Not applicable.

d) Grievance Redress Mechanisms

Communities and individuals who believe that they are adversely affected by a World Bank (WB) supported project may submit complaints to existing Project-level grievance redress mechanisms or the WB's Grievance Redress Service (GRS). The GRS ensures that complaints received are promptly reviewed in order to address Project-related concerns. Project affected communities and individuals may submit their complaint to the WB's independent Inspection Panel which determines whether harm occurred, or could occur, as a result of WB non-compliance with its policies and procedures. Complaints may be submitted at any time after concerns have been brought directly to the World Bank's attention, and Bank Management has been given an opportunity to respond. For information on how to submit complaints to the World Bank's corporate Grievance Redress Service (GRS), please visit http://www.worldbank.org/en/projects-operations/products-and-services/grievance-redress-service. For information on how to submit complaints to the World Bank Inspection Panel, please visit www.inspectionpanel.org.

In addition, MOHW will develop a Grievance Redress Mechanism to register, track, address and resolve any complaints or related issues associated with the Project. All complaints or related issues can be sent to the designated email account for the Project and by telephone, as posted on the work site, to the attention of the Project Coordinator. Reported issues should include a name, date and contact information with a detailed description of the case. All reported cases will be logged by the PIU and directed to the Project Coordinator's attention who will be responsible to assign or escalate the case to the appropriate personnel. There will be a normal response time of 7 days for each case, however high-level cases may require up to 14 or more days for a response. The Project Coordinator for high-level cases will direct the matter to the attention of the Director to which the PIU will report and further to the WBG representatives where necessary. The PIU will maintain a Data Base to log all complaints and to track each from date received to date resolved and highlight how each case was resolved.

V. KEY RISKS

60. **The overall risk rating for the Project is categorized as Substantial**. According to the Systematic Operations Risk-rating Tool, the Project would face one high risk, five substantial risks, and three moderate risks.

61. **Political/Governance Risks.** The political/governance risks are substantial considering the transitions in political power from incumbent parties to new political parties calling for change in Saint Lucia (2016) which represent a sensitive political environment. In addition, experience from other country contexts suggests that the implementation of an essential benefits package and reforms to service delivery and financing often face pushback from the medical establishment as they are concerned about issues such as a potential loss of revenue, and increased accountability. This risk will be mitigated through consultations with the medical establishment and by ensuring appropriate communication surrounding the proposed benefits package. In addition, a stakeholder workshop focused on the development of the essential benefits package is planned as a further risk mitigation measure.

62. **Macroeconomic Risks.** The macroeconomic risks are considered substantial given the high debt levels and heavy reliance of the economy on the tourism sector. This sector is particularly vulnerable to external shocks that may occur, such as economic shocks in source countries, natural disasters and pandemics. High debt levels may limit the fiscal space available to address shocks that occur. The Project will mitigate risks associated with pandemics through a subcomponent that aims to improve preparedness and response to public health emergencies. In addition, the proposed

essential benefits package will be rolled out in several phases to ensure fit within the available fiscal space, with expansion of benefits conducted as additional fiscal space becomes available (for example, through revenue collection, efficiency gains, improved tax administration, and increased tax rates or bases). A phased approach would also allow alignment between the essential benefits package and developments at the national level, such as the complete opening of the OKEU Hospital, thereby ensuring these developments are taken into consideration.

63. **Technical Design Risks.** The technical design of the Project is rated as a substantial risk considering the complexities of conducting activities in parallel, including activities that require very specialized expertise (such as actuarial science) which may be challenging to find in a small country context. Mitigation measures include clear sequencing of activities and sourcing of international consultants to work in tandem with local consultants in areas where local expertise may be lacking.

64. **Institutional Capacity Risks.** The institutional capacity risks are considered high due to the limited experience of the newly established PIU at the Ministry of Health and Wellness (MOHW) in implementing World Bank-financed projects. To mitigate this risk, temporary mentoring and support from the N-PCU would be provided to the MOHW-PIU, in addition to hiring dedicated staff, and providing close supervision from the World Bank.

65. **Fiduciary Risks.** The overall fiduciary risk is assessed as substantial. This is due to (i) limited institutional fiduciary experience of the MOHW in Bank-funded projects; (ii) absence of dedicated fiduciary staff within the Implementing Agency, and the need to set up a new PIU. To mitigate this risk, the appropriate fiduciary professionals with the capacity to manage the Project will be engaged by the PIU.

66. **Environmental and Social Risks.** The Environment and Social risk rating is considered Moderate under the Project, though it is rated Substantial to account for the vulnerability of Saint Lucia to natural hazards such as hurricanes. Certain investments made through the Project are expected to contribute to the reduction of health consequences of natural hazards, such as the development of radio systems for communication with health facilities and the establishment of emergency operations centers for public health emergencies. In addition, Component 2.3 of the Project which focuses on public health emergency preparedness and response, will also help mitigate some of the potential health consequences of a disaster, such as a disease outbreak. Lastly, while the Project is expected to have low to moderate environmental impacts, a breakout of disease could pose significant environmental and social risks for the Project. To this end, the Project includes activities such as updating of national health care waste management plans, as well as mitigation measures in the Environmental and Social Management Framework.

VI. RESULTS FRAMEWORK AND MONITORING

Results Framework
COUNTRY: St. Lucia
Saint Lucia Health System Strengthening Project

Project Development Objectives(s)

The development objective is to improve the accessibility, efficiency, and responsiveness of key health services.

Project Development Objective Indicators

Indicator Name	DLI	Baseline	Intermediate Targets				End Target
		2019	1	2	3	4	2024
Accessibility							
Number of people registered under the National Health Scheme (Number)		0.00	20,000.00	40,000.00	60,000.00	80,000.00	100,000.00
Number of people registered under the National Health Scheme (women) (Number)		0.00	10,000.00	20,000.00	30,000.00	40,000.00	50,000.00
Efficiency							
Percent of diabetic patients > 18 years at public primary health facilities managed according to national protocols (Percentage)		0.00	10.00	20.00	40.00	50.00	60.00

Indicator Name	DLI	Baseline	Intermediate Targets				End Target
		2019	1	2	3	4	2024
Percent of diabetic patients > 18 years at public primary health facilities managed according to national protocols (women) (Percentage)		0.00	10.00	20.00	40.00	50.00	60.00
Percent of hypertensive patients > 18 years at public primary health facilities managed according to national protocols (Percentage)		0.00	10.00	20.00	40.00	50.00	60.00
Percent of hypertensive patients > 18 years at public primary health facilities managed according to national protocols (women) (Percentage)		0.00	10.00	20.00	40.00	50.00	60.00
Responsiveness							
Compliance with 2005 International Health Regulations (IHR) by maintaining a trained Rapid Response Team (RRT) to respond to events that may constitute a public health emergency (Yes/No)		Yes	Yes	Yes	Yes	Yes	Yes

Intermediate Results Indicators by Components

Indicator Name	DLI	Baseline	Intermediate Targets				End Target
		2019	1	2	3	4	2024
Component 1. Design and Implementation of an Essential Benefits Package							
Essential package of benefits formally adopted and reviewed on an annual basis (Yes/No)		No	Yes	Yes	Yes	Yes	Yes
Primary care service utilization rates (public health sector) (Number)		37,320.00	40,000.00	45,000.00	50,000.00	55,000.00	55,000.00
Primary care service utilization rates (public health sector) (women) (Number)		44,447.00	45,000.00	50,000.00	55,000.00	60,000.00	60,000.00
Percentage of Primary Health Care (PHC) facilities that have implemented exit surveys with service users in a one-year period and presenting results to the MOHW (Percentage)		0.00	25.00	30.00	40.00	50.00	60.00
People who have received essential health, nutrition, and population (HNP) services (CRI, Number)		60,420.00	70,000.00	80,000.00	90,000.00	100,000.00	100,000.00
People who have received essential health, nutrition, and population (HNP) services - Female (RMS requirement) (CRI, Number)		35,368.00	40,000.00	45,000.00	50,000.00	55,000.00	60,000.00
Component 2. Strengthening Service Delivery in Support of the Essential Benefits Package							
Number of public primary care health facilities equipped for NCD management (Number)		0.00	5.00	10.00	20.00	25.00	30.00
Number of public sector providers registered under the		0.00	4.00	10.00	15.00	20.00	25.00

Indicator Name	DLI	Baseline	Intermediate Targets				End Target
		2019	1	2	3	4	2024
PBF scheme (Number)							
Number of patients > 18 years screened for diabetes at public primary health facilities based on national protocols (Number)		0.00	5,000.00	10,000.00	15,000.00	17,000.00	20,000.00
Number of patients > 18 years screened for diabetes at public primary health facilities based on national protocols (women) (Number)		0.00	2,500.00	5,000.00	7,500.00	8,500.00	10,000.00
Number of patients > 18 years screened for hypertension at public primary health facilities based on national protocols (Number)		0.00	5,000.00	10,000.00	15,000.00	17,000.00	20,000.00
Number of patients > 18 years screened for hypertension at public primary health facilities based on national protocols (women) (Number)		0.00	2,500.00	5,000.00	7,500.00	8,500.00	10,000.00
Percentage of Primary Health Care facilities participating in the Performance Based Financing (PBF) scheme that have developed an action plan based on the results of the quarterly satisfaction surveys (Percentage)		0.00	25.00	30.00	40.00	50.00	60.00

Monitoring & Evaluation Plan: PDO Indicators					
Indicator Name	**Definition/Description**	**Frequency**	**Datasource**	**Methodology for Data Collection**	**Responsibility for Data Collection**
Number of people registered under the National Health Scheme	The number of people formally registered in the National Health Scheme. The scheme will be developed under Component 1 of the Project. As such, the baseline is 0.	Every three months.	National Insurance Unit of the Ministry of Health and Wellness.	Summary of information from registration database.	The Ministry of Health and Wellness.
Number of people registered under the National Health Scheme (women)		Every three months	National Insurance Unit of the Ministry of Health and Wellness	Summary of information from registration database	The Ministry of Health and Wellness
Percent of diabetic patients > 18 years at public primary health facilities managed according to national protocols	The share of people > 18 years at public primary health facilities with diabetes managed according to national protocols. These protocols will be developed under the project. As such, the baseline is 0.	Every three months	Health Information Systems of the Ministry of Health and Wellness	To be calculated from the Health Information Systems of the Ministry of Health and Wellness. Numerator = The number of diabetic people > 18 years at public primary health facilities managed according to national protocols Denominator = The	The Ministry of Health and Wellness

				total number of people with diabetes > 18 years seen at public primary health facilities. In 2017, 2183 persons with diabetes were seen in public primary health facilities where the Health Information Systems were implemented and in use (covering 85 percent of the population).	
Percent of diabetic patients > 18 years at public primary health facilities managed according to national protocols (women)		Every three months	Health Information Systems of the Ministry of Health and Wellness	To be calculated from the Health Information Systems of the Ministry of Health and Wellness. Numerator = The number of diabetic people > 18 years at public primary health facilities managed according to national protocols (women) Denominator = The number of people > 18 years diagnosed with diabetes seen at public	The Ministry of Health and Wellness

				primary health facilities (women)	
Percent of hypertensive patients > 18 years at public primary health facilities managed according to national protocols	The share of people > 18 years at public primary health facilities with hypertension managed according to national protocols. These protocols will be developed under the project. As such, the baseline is 0.	Every three months.	Health Information Systems of the Ministry of Health and Wellness.	To be calculated from the Health Information Systems of the Ministry of Health and Wellness. Numerator = The number of hypertensive people > 18 years at public primary health facilities managed according to national protocols Denominator = The total number of people with hypertension > 18 years seen at public primary health facilities. In 2017, a total of 5446 persons with hypertension were seen at public primary health facilities where the Health Information Systems were implemented and in use (covering 85 percent of the population).	The Ministry of Health and Wellness.

Percent of hypertensive patients > 18 years at public primary health facilities managed according to national protocols (women)		Every three months	Health Information Systems of the Ministry of Health and Wellness	To be calculated from the Health Information Systems of the Ministry of Health and Wellness. Numerator = The number of hypertensive people > 18 years at public primary health facilities managed according to national protocols (women) Denominator = The total number of people with hypertension > 18 years seen at public primary health facilities (women)	The Ministry of Health and Wellness
Compliance with 2005 International Health Regulations (IHR) by maintaining a trained Rapid Response Team (RRT) to respond to events that may constitute a public health emergency	This is one of the key actions which the Government is asked to comply with on a yearly basis by the World Health Organization (WHO) as a critical activity under the 13 core capacity areas of the 2005 International Health Regulations (IHR).	Annually.	The World Health Organization.	Data is reported by participating countries, including Saint Lucia, to the WHO.	The Ministry of Health and Wellness.

Monitoring & Evaluation Plan: Intermediate Results Indicators					
Indicator Name	**Definition/Description**	**Frequency**	**Datasource**	**Methodology for Data Collection**	**Responsibility for Data Collection**
Essential package of benefits formally adopted and reviewed on an annual basis	This indicator reflects whether a formal review of the essential benefits package was conducted and agreed upon by the Ministry of Health and Wellness.	Annually.	The Ministry of Health and Wellness.	The Ministry of Health and Wellness will report on whether this exercise has taken place.	The Ministry of Health and Wellness.
Primary care service utilization rates (public health sector)	The number of visits to public primary health facilities during one year relative to the total population in the same geographic area. Rates are reported per 100,000 population.	Annually.	Health Information Systems of the Ministry of Health and Wellness	To be calculated from the Health Information Systems of the Ministry of Health and Wellness. Number of visits to public primary health facilities per 100,000 population.	The Ministry of Health and Wellness.
Primary care service utilization rates (public health sector) (women)		Annually.	Health Information Systems of the Ministry of Health and Wellness.	To be calculated from the Health Information Systems of the Ministry of Health and Wellness. Number of visits to public primary health facilities per 100,000 women. The end target is higher to reflect increased use of facilities for maternal care.	The Ministry of Health and Wellness

Percentage of Primary Health Care (PHC) facilities that have implemented exit surveys with service users in a one-year period and presenting results to the MOHW	This indicator will measure the number of public PHC facilities implementing exit surveys. The numerator will consist of the number of PHC facilities implementing exit surveys over the denominator which is the total number of PHC facilities. These exit surveys will be developed during the project. As such, the baseline is 0.	Annually	The Ministry of Health and Wellness will report on this	The Ministry of Health and Wellness supervision of public PHC facilities	The Ministry of Health and Wellness
People who have received essential health, nutrition, and population (HNP) services		Annually	Health Information Systems of the Ministry of Health and Wellness. The total population of Saint Lucia is 178,015 (2016, World Bank). The baseline data of 60,420 represents p eople who have received health	Assessment of the Health Information Systems.	The Ministry of Health and Wellness

			services at the public primary health care centers with HMIS in 2017.		
People who have received essential health, nutrition, and population (HNP) services - Female (RMS requirement)		Annually	Health Information Systems of the Ministry of Health and Wellness	Assessment of the Health Information Systems.	The Ministry of Health and Wellness
Number of public primary care health facilities equipped for NCD management	The number of primary care facilities in the public sector equipped with medicines, equipment and basic technologies according to national guidelines. Equipping of these facilities will be conducted under the project. As such, the baseline is 0.	Annually.	The Ministry of Health and Wellness.	A baseline survey will be conducted to evaluate primary care facilities for NCD management readiness, and will highlight gaps to be addressed. As facilities receive support to address these gaps, they will be considered appropriately equipped for NCD management.	The Ministry of Health and Wellness.
Number of public sector providers registered under the PBF scheme	This indicates the number of public sector primary care facilities registered to	Annually.	The Ministry of Health and Wellness.	MOHW will report the number of PBF agreements they have	The Ministry of Health and Wellness.

	participate in the PBF scheme. Providers are considered registered if they have signed an agreement with the MOHW to participate in the PBF. The PBF scheme will be developed under the project. As such, the baseline is 0.			signed with primary care facilities.	
Number of patients > 18 years screened for diabetes at public primary health facilities based on national protocols	The number of people from the at-risk population aged > 18 years screened for diabetes at public primary health facilities based on national protocols. These protocols will be developed under the project. As such, the baseline is 0.	Every three months.	Health Information Systems of the Ministry of Health and Wellness.	Data from primary care centers in the public sector will be summarized from the Health Information Systems.	The Ministry of Health and Wellness.
Number of patients > 18 years screened for diabetes at public primary health facilities based on national protocols (women)		Every three months	Health Information Systems from the Ministry of Health and Wellness	Data from public primary health facilities in the public sector will be summarized from the Health Information Systems	The Ministry of Health and Wellness
Number of patients > 18 years screened for hypertension at public primary health facilities based on national protocols	The number of people from the at-risk population aged > 18 years screened for hypertension at public primary health facilities based on national protocols.	Every three months.	Health Information Systems of the Ministry of Health and Wellness.	Data from primary care centers in the public sector will be summarized from the Health Information Systems.	The Ministry of Health and Wellness.

	These protocols will be developed under the project. As such, the baseline is 0.				
Number of patients > 18 years screened for hypertension at public primary health facilities based on national protocols (women)		Every three months	Health Information Systems of the Ministry of Health and Wellness	Data from public primary health facilities will be summarized from the Health Information Systems.	The Ministry of Health and Wellness
Percentage of Primary Health Care facilities participating in the Performance Based Financing (PBF) scheme that have developed an action plan based on the results of the quarterly satisfaction surveys	This indicator will measure the numerator as the number of PHC facilities participating in the PBF scheme that have developed an action plan based on the quarterly satisfaction surveys and the denominator as the total number of PHC facilities participating in the PBF scheme. The PBF scheme will be developed under the project. As such, the baseline is 0.	Annually	The Ministry of Health and Wellness	The Ministry of Health and Wellness will supervise collection of this data.	The Ministry of Health and Wellness

ANNEX 1: Implementation Arrangements and Support Plan

COUNTRY: St. Lucia
Saint Lucia Health System Strengthening Project

A. Project Management

1. The Project will be managed and implemented by a fully staffed Project Implementation Unit (PIU) throughout the life of the project. In a first phase, the fiduciary functions of the Project will be managed by the N-PCU. In a second phase, the Project will be managed by the MOHW PIU. The first phase will align with the implementation of the PPA and the second phase will transition the project management function from the N-PCU to the MOHW Project Implementation Unit (MOHW PIU) for the remaining implementation period.

2. The PPA will jump-start the process of contracting key PIU positions that will shadow the N-PCU fiduciary staff during phase 1 to then take on the project management responsibilities during phase 2. The PPA will finance the positions of a Project Manager, Financial Management Specialist, and Procurement Specialist who will be incorporated into the MOHW team as the MOHW PIU. The advertising and contracting of these three positions will be prioritized under the PPA to ensure they are contracted as early as possible during the PPA period. The project management function will transition to the MOHW PIU once the project is declared effective by which time the three positions would have been contracted and trained.

B. Financial Management and Disbursement Arrangements

3. The MOHW PIU will be a new PIU and is in the process of being established under the PPA. Gaps were identified in the current financial management arrangements at the MOHW PIU level. Hence, the FM risk at the entity level is **substantial**.

4. A financial management assessment was conducted in June 2018 during the appraisal mission. Key financial management issues that will be addressed as agreed at appraisal include : (a) the need for one additional staff to strengthen the MOHW's PIU financial management – this additional resource should be recruited under the PPA; (b) a review of the specific procedures to govern the funds flow arrangements for the capitation payments; (c) documentation the Project FM procedures; and (d) implementation of a new financial management information tool that facilitates the recording, control, and reporting of Project transactions for the provision of required financial reports.

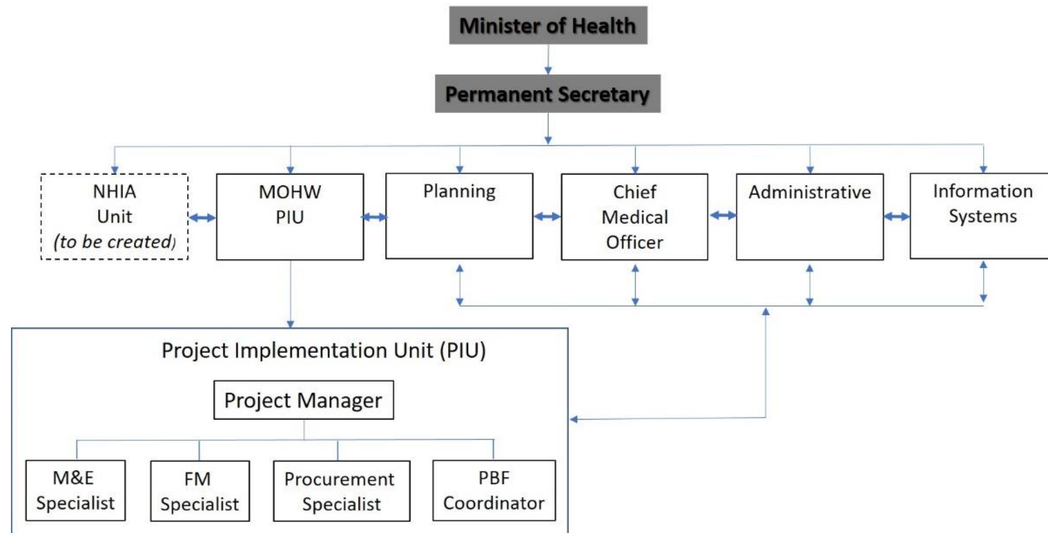
5. The Project is benefiting from a preparation advance implemented, for the FM aspects, by the existing national-level PIU of the Department of Economic Development, Transport and Civil Aviation in Saint Lucia. Mitigating actions to address the gaps in the FM arrangement will be financed under this advance.

6. The following sections describe the specific arrangements:

7. ***Organization and Staffing***. Within the MOHW a dedicated PIU will be created that will report to the MOHW Permanent Secretary. The PIU will have one dedicated accountant who will report to the Project

coordinator and to the Financial Analyst of the Accounts Department. The Financial Analyst of the Accounts Department will dedicate 20 percent of his time to the Project and oversee the accountant's work. Before the dedicated accountant is hired, the Financial Analyst of the MOHW will start working with FM team of the N-PCU for hands on training.

Figure 1. Implementation and Fiduciary Arrangements - Saint Lucia Health Insurance Project



8. ***Planning and Budgeting.*** The budget arrangements will follow the procedures that are already established in the MOHW. Following the Finance Act and the annual Budget circular, the Budget request will be reviewed and discussed by the Office of the Budget in tandem with the MOHW. Once approved the Budget Submission will form part of the Appropriation Bill and the approved Estimates for the financial year. After approval from Parliament is granted, the Project budget will be reflected in the GOSL (Government of St. Lucia) budget as a part of the MOHW's allocation. Based on the approved budget, the MOHW will update its Project-related annual work plan and procurement plan, which will be reviewed by the Bank. Quarterly estimates and review of those estimates will be part of budget management.

9. ***Accounting and maintenance of accounting records.*** Project transactions will be recorded in a commercial off-the-shelf (COTS) accounting software to allow classification by expenditure categories and Project components. To maintain consistency between the PPA books, which will be maintained at the N-PCU, and the Project's books, the mission recommends using the same COTS software QuickBooks. As project accounting will be maintained in a separate system from Government's, to properly reflect project activity in the accounts of the State, project transactions will be posted into Smart stream, the GOSL IFMIS. During the transition period, once the software is acquired, the FM analyst and the FM specialist will work with the N-PCU FM team to set up the Project's chart of account.

10. ***Internal controls, including internal audit.*** The MOHW has to comply with the Finance act. The MOHW has not yet established detailed processes, procedures, controls, and monitoring tools for the project implementation. These should be finalized and reflected in the Financial Management section of the Operational Manual, including those governing capitation payments and including the key documents required in the different authorization and approval of different type of payments. The Operational Manual should be finalized under the

PPA.

11. ***Flow of Funds.*** The following disbursement methods may be used to withdraw funds from the credit: (i) reimbursement; (ii) advance payments; and (iii) direct payments. Two designated accounts (DAs) will be opened in at the Bank of Saint Lucia under the name of the Project: (i) DA-A for Performance Based Financing which will include an IPF with result-based subcomponent and an output based financing subcomponent; and (ii) DA-B for all other Project components and subcomponents. Funds deposited into the DAs as advances will follow the Bank's disbursement policies and procedures, to be described in the Financing Agreement and in the DFIL. Following the Bank's instructions in the DFIL, advances made to the DAs should be documented using IFRs and supporting documents as needed.

12. ***Flow of Funds for subcomponent 2.1 - Performance Based Financing (PBF) to Selected Health Facilities based on (i) Output based disbursements and (ii) Result-Based Financing (RBF)*** [13]. Project subcomponent 2.1 (US$ 4 million) aims at improving efficiency and efficacy of primary health care (PHC) (prevention and treatment) of non-communicable diseases (NCDs), specifically diabetes and hypertension. This subcomponent will include three different types of disbursement methods (i) traditional IPF financing, (ii) output-based financing and (iii) result-based financing:

- **Traditional IPF financing with flow of funds <u>described in paragraph 8</u>:** an additional budgetary allocation aimed at improving access to treatment by financing one complete annual laboratory analysis for each individual diagnosed as diabetic or hypertensive.
- **An incentive budgetary allocation to the PHC facilities linked to capitation and adjusted by results which includes two tranches**, one using the output based modality and the second one using the Result-Based financing as defined in Bank guidelines[14]. The PBF scheme will include two "virtual" payments to the PHC facilities which are:
    a. **Output based disbursement**: tranche 1 - incentivizing the registration of the catchment population.
    b. **Result-Based Financing:** tranche 2 -achievement of indicator targets related to NCDs.

13. ***Flow of Funds* for PBF: output based and result-based financing**- ***The total available amount (TAA), incentive budgetary allocation, for these 2 types of financing will be calculated*** as follow: the capita is initially defined as an amount equivalent to US$3.3, this **unit cost** will be confirmed in the PBF OM, multiplied by the target population registered in the PHC facility for each month. The target population registered in each PHC facility will be issued from the MOHW's information system.

a. **Output based disbursement (Tranche 1):** 40% of the TAA. The cost of each output, which is determined in advance (40%*unit cost) is linked to the financing amount. This amount will be allocated monthly to incentivize the registration of the population.
b. **Result-Based Financing (Tranche 2)**: 60% of the TAA will be available under this modality and the actual amount to be allocated to each facility will depend on results achieved in line with agreed indicator targets: (a) screening of diabetes in line with the PBF OM; (b) screening for hypertension in line with the PBF OM; and (c) treatment of diabetes and hypertension in line with the PBF OM. This amount will be allocated every three months to the PHC.

[13] As defined in the World Bank Loan Handbook for World Bank Borrowers, February 2017
[14] As defined in the World Bank Loan Handbook for World Bank Borrowers, February 2017

14. ***Flow of Funds*** –**Output based financing – Set amount of 40% of TAA**: The Specific unit cost is assigned to each output in the financing agreement or disbursement letter. The output to be financed under this Project is the additional cost related to individual registrations. Each deliverable or output has a credible cost associated with it to justify disbursements being made against qualifying expenditures, the determination of this cost (the capita) shall be detailed in the PBF OM. Summary reports, as specified in the financing agreement or disbursement letter, should be submitted along with the withdrawal applications to DA-A. The design of the summary report may include the following: (i) Schedule of outputs, i.e. monthly registration, and predetermined costs; (ii) Certified list of completed outputs, here the target population registered in the PHC facility, i.e. nominalized list of registered beneficiaries in the PHC facility; (iii) Product of the number of outputs multiplied by their unit costs, which must equal the disbursement request. A report on physical completion of outputs from an external verification agent may be required to be submitted to the Bank. The Bank would then confirm the achievement of outputs to the Borrower. The Borrower should follow the instructions set out in the disbursement letter when processing withdrawal applications. Verification will be conducted by an external agency, who will be contracted to determine the veracity of each beneficiary registered and detailed modalities will be set in the PBF manual.

15. ***Flow of Funds*** - **Result-Based Financing - Maximum of 60% of TAA available**: Requirement are as follow: (i) Need for eligible expenditures; (ii) achievement of results; (iii) Applicability of Bank procurement regulations for Borrowers. Results, which will include a nominalized list of registered beneficiaries in the PHC facility for the TAA calculation, and the list of eligible expenditures will be finalized during the implementation of the PPA. Verification will be conducted by an external agency, who will be contracted to determine the veracity of the progress on achievement of results. Supporting documentation for disbursement would include summary reports as listed in the DFIL and letter from the Bank confirming the achievement of the tracer target and a verified list of registered beneficiaries.

16. ***Flow of Funds*** - **The ceiling for advances to be made into the DAs will be specified in the DFIL**. Eligible expenditures paid out of the DAs must be documented on a quarterly basis. Advances to the DA-A will be made based on quarterly forecasts, and a customized report will be submitted that gives information on the achievement of the tracers/indicators measuring performance.

17. **In the case of PBF payments (output and RBF), no funds will be transferred to the beneficiary health facility, but the financing will be made available to them as an additional budget allocation through one specific budget line.** The PHC facilities will use budgetary credits based on existing country systems. This will involve the MOHW-PIU communicating to the MOHW finance department the amount to be allocated to the PHC facility under the PBF on a quarterly basis based on the total of the 40% of the TAA reflecting the beneficiaries registered by the PHC facility reached and the 60% of the TAA based on the results achieved. In turn, the MOHW finance department will inform the PHC facility of the budgetary credit they have been allocated and the PHC facility will indicate quarterly how they would like to spend their budgetary credit. The MOHW finance department will then communicate this to the MOHW central purchasing unit, who in turn purchases the items or contracts the services requested by the PHC facility via the MOHW-PIU using DA-A.

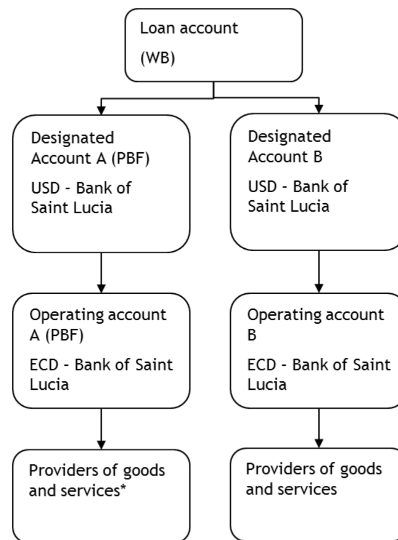
18. **For IPF operations that are using results-based financing, the Borrowers ensure that results are achieved before they request disbursement of eligible expenditures.** To document spending of eligible expenditures for the result based portion of the PBF, the MOHW-PIU would furnish to the Bank per PHC facility:

a. for the first disbursement: proof of achievement of the results and supporting documentation

(including invoices) for funds spent on eligible expenditures before the first payment from the Bank

b. subsequent disbursements: proof of achievement of the results and supporting documentation (including invoices) for funds spent on eligible expenditures

Figure 2: Flow of Funds



* The goods and services purchased through DA-A will be purchased on behalf of the PHC.

19. ***Financial Reporting.*** The PIU will be responsible for preparing Interim Financial Reports (IFRs) on a quarterly basis to be submitted to the Bank. The IFRs should cover: (a) the sources and uses of funds, reconciling items, and cash balances, with expenditures classified by project component and /cost category; and (b) a statement of investments reporting the current trimester and the accumulated operations against ongoing plans, as well as footnotes explaining the important variances. The reports will be prepared both in the local currency and in U.S. dollars. The IFRs should be submitted for the World Bank's review no later than 45 days after the end of each half-year.

20. ***External Audit.*** <u>(i) Annual financial audit:</u> The MOHW PIU will contract with Office of the Director of Audit (SAI) under defined terms of reference approved by the Bank, no later than six months after effectiveness. The audit firm will review and provide an opinion on the Project's annual financial statements covering the fiscal year. The auditors will present the World Bank with audited financial statements no later than six months after the end of the fiscal period. <u>(ii) PBF payments verification</u>: An independent technical audit firm with TORs acceptable to the Bank will be hired to assess the management of the PBF payments. Technical audit reports will be submitted every three months. Details on external verifications will be included in the DFIL.

21. ***Financial Management Action Plan***. Based on Bank recommendations, an action plan to ensure that adequate financial management systems are in place will be implemented under the PPA by the MOWH PIU. The

mitigation measures included in the action plan are aimed at reducing or eliminating the financial management risks associated with the Project.

Table 1: Action Plan for Financial Management

Action	Responsible Entity	Completion Date*
1. Acquire and implement project accounting system that facilitates the recording, control and reporting of project transactions for the provision of required financial reports and maintain consistency with PPA books.	MOHW	Under PPA
2. Provide the Project's financial management staff with formal training in financial management and disbursements.	World Bank	To set once new FM staff are hired
3. Provide the Project's financial management staff with hands-on training in financial management and disbursements.	National PCU/ MOWH	To set once new FM staff are hired

**Note*: This represents the estimated completion dates and is not an indication of any legal conditions related to the Project.

22. ***World Bank Financial Management Supervision Plan.*** A World Bank financial management specialist completed a review prior to the Project's negotiations and verified the implementation of the action plan and reviewed all financial management arrangements for the Project. After effectiveness, the financial management specialist will review the annual audit report and the financial sections of the quarterly IFRs including a monthly reconciliation of accounts, and perform at least two complete supervision missions per year. This supervision strategy would be reviewed periodically and adjusted based on performance and risk.

C. Procurement Arrangements

23. Under both phases of project implementation arrangements, the PIUs will include procurement responsibilities. The N-PCU will designate a procurement specialist to support the project procurement functions during the PPA period. Under the PPA, a procurement specialist will be hired to be housed at the MOHW PIU to then take over the project procurement functions.

24. While the MOHW has limited exposure to Bank procurement procedures, the N-PCU has long-standing experience and capacity in having managed the procurement activities under other World Bank-funded projects. The capacity assessment of the N-PCU shows satisfactory quality and adequate capacity to handle procurement activities under this Project. Specific procedures for the Project will be detailed in the operation manual of the Project, which will be developed under the PPA. The N-PCU procurement specialist will transfer knowledge to the MOHW PIU selected procurement officer.

ANNEX 2: Economic and Financial Analysis

COUNTRY: St. Lucia
Saint Lucia Health System Strengthening Project

Conceptual framework and context

1. **The economic analysis of the Project consists of the cost-benefit analysis (CBA)**. CBA expresses costs and benefits in monetary terms, adjusted for the time value of money. CBA is used primarily for two reasons: to determine the soundness of an investment (justification/feasibility) and provide a comparison among projects. It compares the total expected cost of each intervention with the total expected benefits, to see whether the benefits outweigh the costs. The CBA conducted here follows four main steps: i) Identify the project interventions to be analyzed; (ii) Identify the costs related to each intervention; (iii) Estimate the evolution of indicators' coverage thanks to the proposed interventions to assess potential benefits at the end of the project and (iv) Compute the difference between the net present value NPV (value discounted in time) of both costs and benefits, also called the net benefits of the project.

2. **The rationale of CBA in health projects**. In the health sector a CBA converts the health gains achieved by a project or intervention into monetary terms. This approach can be useful for policy purposes, and typically serves to underline the very high value attached to better health, although it also leaves many non-observable elements unaccounted for. The standard economic approach for quantifying the benefits of better health in monetary terms is based on the concept of the "value of statistical life" (or life-year). The estimated benefit of the project is the economic value of the lives saved and serious disability averted by the investments made in the project.

3. **Components included in CBA**. The analysis presented here focuses on interventions funded through Component 1 of the Project "Design and Implementation of an Essential Benefits Package", specifically the interventions in subcomponent 1.2 "Implementation of the Essential Benefits Package." For Component 2 "Strengthening Service Delivery in Support of the Essential Benefits Package" the interventions considered here are in Subcomponents 2.1 "Improving Service Delivery Through Performance-Based Financing" and 2.2 "Strengthening the supply of health care services." Since interventions in Component 3 "Institutional Capacity Building, Project Management and Coordination" deal mostly with project management, fiduciary tasks and monitoring and evaluation, whose benefits are not easily inferred and measured, this component was not considered in the impact and benefits for the CBA conducted here.

Costs and Benefits Considered in the Analysis

4. **Accounting for health benefits**. The basic framework involves projecting the epidemiological scenario in Saint Lucia in a period of 10 years, from 2019-2029, expressed in the number of Disability-Adjusted Life Years (DALYs) estimated for the country under the baseline scenario and then estimating how many DALYs might be averted with the implementation of the project. A DALY is defined as 1 lost year of "healthy" life, and the sum of these DALYs across the population represents the burden of disease, which functions as measurement of the gap between current health status and an ideal health situation where the entire population lives to an advanced age, free of disease and disability. DALYs are calculated as the sum of the Years of Life Lost (YLL) due to premature mortality in the population and the Years Lost due to Disability (YLD) for people living with health conditions or its consequences.

5. **For the CBA, two general type of benefits are applied**. The first one is the reduction in DALYs due to reduced mortality and morbidity derived from the adoption of the essential benefits package and the PBF scheme to increase screening and treatment of diabetes and hypertension patients. These interventions are reflected in the key and intermediate indicators "Number of people registered under the National Health Scheme", "number of patients screened for diabetes/hypertension according to protocol' and "number of patients with diabetes/hypertension managed according to protocol".

6. **The second type of benefit contemplated is the reduction in the general rate of hospitalizations**, from the interventions devoted to strengthening primary care programs, as suggested by the indicators "essential package of benefits formally adopted and reviewed on an annual basis" and "increase in primary care service utilization rates", as well as the "number of primary care health facilities equipped for NCD management". Here the rationale comes from the concept of ambulatory or primary care sensitive conditions (ACSCs), which are conditions for which hospital admission could be prevented by interventions in primary care. Rates of hospital admission for ACSCs are increasingly used as a measure of the effectiveness of primary care. The excess costs from avoidable admissions can be calculated from the number of hospital discharges due to health problems that, according to the literature, should be addressed at the primary care level and, if well managed, should not lead to hospital admissions.

Assumptions of the analysis

7. **The current exercise relies on the following key assumptions**:

- **Temporal horizon.** The flow and the Net Present Value (NPV) are estimated for 2019-2029. Even though the project will only disburse until 2023, the health impacts of the project are expected to materialize after the official termination of the operation. For simplicity a period of 10 years is utilized, except for the benefits derived from reductions in hospitalization rates, which are computed for the length of the project (until 2023).
- **Benefits.** As stated, the health impacts of the project were estimated on reductions in the burden of disease for the adoption of services covered under the basic service package to be implemented, as well as the reduction in hospitalization rates from improved primary care services. The benefits in reductions of DALYs are accounted for until 2029, although is expected that the benefits will continue well beyond that year. Later benefits are not considered, given that no DALY tables are available after that date.
    - **DALYs:** The monetary value of DALYs is typically equivalent of a value of the local yearly GDP per capita. In this case, the value observed at 2016 was US$9,365 and the projections utilize the expected growth rate in a conservative scenario of 1.6 percent annually
    - **Hospitalization:** The reductions in the number of hospital admissions among the target population creates cost savings for the health care system in terms of fewer admissions. The analysis assumes a reduction of up to 10 percent in total hospital admissions and estimates a unitary daily hospitalization costs of about US$180 in 2018, which is adjusted by inflation for the temporal horizon.
- **Discount rate.** The Program's costs and benefits are discounted at 6 percent, which includes inflation and the general opportunity cost for investments in a conservative scenario. The country has had an average inflation rate of 2.19 percent in the last 16 years, which leads us to utilize a slightly lower discount rate than the one typically used in other projects, which range between 7 and 10 range. This is one of the

variables used for sensitivity analysis.

- **Covered population.** The exercise considers that interventions will affect the entire population of Saint Lucia, hence the utilization of total number of DALYs in the country for all conditions. The population has been projected until 2029 considering both the official projections of the region and the average of population growth observed since 2000, which is 0.81 percent annually. However, according to the demographic transition, population growth has been decelerating – this is accounted for in the projections.
- **Disbursements.** The analysis considers that the Project funds will be released according to the disbursement table available in datasheet section of the PAD. It is expected that the total disbursements will be completed in 2024.
- **Economic growth.** The present analysis assumes a conservative annual economic growth rate of 1.6 percent, which corresponds to the observed average growth rate of the last 15 years (World Bank Data).
- **NPV and IRR calculations.** The project will be implemented in the period 2019-2024, but the impacts from implementation are expected to go beyond that year. The NPV is calculated for the reductions in DALYs until 2029 and for the Internal Rate of Return (IRR) this time horizon is applied as well.
- **Sensitivity analysis.** The sensitivity analysis gauges the vulnerability of the project to high variability of key assumptions. In this line, the current study analyzes the results' sensitivity to alternative discount rates, effects in DALYs and growth scenarios. At baseline scenario, the NPV and IRR have been estimated with an inflation rate of 2.2 percent, 6 percent discount rate and a nominal GDP growth of 1.6 percent.

Results of CBA

8. **The results show that the project is cost-effective.** In a conservative scenario, with reductions of DALYs close to 3 percent, the project is expected to save around 9000 DALYs, and 1400 hospitalizations, which might be translated into a net present value of benefits close to US$43.2 million. Following WHO guidelines, the project is considered to be highly cost-effective, since it is substantially below the threshold set for this category.[15] In this case, the cost per DALY averted is $2,200, which is less than 25 percent of the GDP per capita in 2018, estimated to be $9,500. This result can be explained by the relatively low level of investment and the expected high marginal returns of the interventions, which are standard in many countries by now.

Table 1: Summary of Cost-Benefit Analysis

Concept	Base Scenario	Pessimistic Scenario

[15] The threshold for cost–effectiveness as the cost of the intervention per disability-adjusted life-year (DALY) averted less than three times the country's annual gross domestic product (GDP) per capita (WHO 2002).

NPV Costs (M$)	16.37	16.37
NPV Benefits (M$)	62.8	19.1
Diff DALYs (M$)	61.7	15.6
Reduction Hospitalization (M$)	1.1	3.5
Internal Rate of Return	43.2	10.1
Benefit	**46.41**	**2.73**
Total DALYs Saved	**9,049**	**4,572**
Total Hospitalizations Averted	**1,560**	**785**
Total reductions DALY (%)	**2.81%**	**1.42%**
Total reduction hospitalizations	**11.36%**	**5.84%**

Source: IHDM, WB Data Indicators, own calculations

Table 2: Benefits in DALY reductions – Base scenario

CONCEPT	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029
DALYs baseline	48,245	48,431	48,599	48,749	48,882	**48,996**	49,092	49,170	49,230	49,271	49,293
DALYs project	48,129	48,198	48,249	48,283	48,299	**48,297**	48,277	48,240	48,185	48,112	48,022
GAINS DALY	116	233	350	466	583	**699**	815	930	1,045	1,158	1,271
Value DALYs baseline (M$)	473	482	492	501	510	**519**	528	537	546	555	564
Value DALYs project (M$)	472	480	488	496	504	**512**	520	527	535	542	550
Difference (M$)	1.1	2.3	3.5	4.8	6.1	**7.4**	8.8	10.2	11.6	13.1	14.6

Source: IHDM, WB Data Indicators, own calculations

Table 3: Benefits in Hospitalizations Averted – Base scenario

CONCEPT	2019	2020	2021	2022	2023
Hospitalizations baseline	10,447	10,487	10,523	10,556	10,585
Hospitalizations project	10,355	10,304	10,250	10,192	10,130
Difference hospitalizations	91	183	274	364	455
Hospitalizations cost per event	186	190	194	199	203
Hospitalizations rate (x 10.000)	574	569	564	559	554
Hospitalizations cost total baseline (M$)	1.94	1.99	2.05	2.10	2.15
Hospitalization cost project (M$)	1.93	1.96	1.99	2.02	2.06
Difference hospitalizations (M$)	0.02	0.03	0.05	0.07	0.09

Source: IHDM, WB Data Indicators, own calculations

9. **Sensitivity analysis.** The variables here modeled were the rate of reduction of DALYs and hospitalizations, as well as the coefficient of GDP for valuation of DALYs. Given the historical low levels of inflation, and the relative stability in terms of GDP growth, these variables were not included in the modeling of alternative scenarios. Even with extreme low levels in terms of hospitalization reduction (5.84 percent for the project duration) and burden (1.42 percent of reduction in DALYs), the project closes with net benefits of US$2.73 million and an IRR of 10.5 percent, which is closer to the discount rate used (6 percent). No negative NPV is expected even in the most conservative scenario of the Project.

ANNEX 3: Theory of Change and Detailed Component Descriptions

The Results Chain highlighting the link between Project activities and achievement of the PDO is illustrated below. Investments made under the Project complement each other to result in an overall strengthening of the health system.

Figure 1. Saint Lucia Health System Strengthening Project: Theory of Change

Impact	Outcomes	Outputs	Activities
The Project aims to improve the accessibility, efficiency, and responsiveness of key health services.	by ...ensuring that key health services are provided to the eligible population	as a result of ... development and implementation of an essential benefits package	achieved through • Review of the proposed essential benefits package, including improvements in HIS and development of case management procedures. • Implementation of the essential benefits package including purchaser-provider agreements, investments in IT and communication campaigns
	...ensuring that treatment is provided according to protocol (as measured using tracer conditions)	...providing financial incentives to healthcare facilities to improve performance ...improved institutional readiness for service delivery	• Design and implementation of PBF scheme focused on NCDs • Strengthened integration of primary care systems, including facility improvements and referral systems
	...ensuring that health systems are adequately prepared for and can respond to public health emergencies	...improved surveillance and information systems, laboratory capacity and health emergency response	• Enabling primary care centers to serve as first point of detection for selected infectious diseases • Improvements in laboratory facilities, data management, transportation and storage • Development of health emergency plans, establishment of emergency operations centers, rapid response teams and outbreak communications

Detailed Component Description

1. **Efforts to reform the health sector are not new, going back as far as 2000 and outlined in the National Strategic Plan for Health 2006-2011, which continues to remain valid.** Universal Health Coverage (UHC) was seen as a way to ensure access to services regardless of ability to pay, and to ensure the quality of services.[16] In addition, UHC was explored as a route to ensuring adequate financing of the sector given the willingness of users to pay for services through premiums instead of out-of-pocket payments. The establishment of UHC through a national scheme would allow prepayment, sharing of risks, and pooling of funds. However, the economic downturn that occurred shortly thereafter the strategic plan was drafted hindered UHC efforts at the time.

2. **Recent expenditure pressures associated with the opening of the Owen King-European Union (OKEU) Hospital have reignited the push for reform.** The hospital was completed in 2017, and is meant to replace Victoria Hospital, which will be turned into the urban Castries polyclinic. The OKEU has 200 beds compared to the approximately 160 beds at Victoria Hospital. A study conducted in 2011 estimates that adequately staffing and operating the OKEU Hospital will require at least EC$20 million (US$7.4 million) more than the 2010 Victoria Hospital budget; more recent estimates are not available.[17] The same study notes that a budget of EC$5.5 million (equivalent to US$2 million) will be needed to run Victoria Hospital once it is converted to a polyclinic. Meanwhile, St. Jude Hospital was damaged in a 2009 fire and is expected to continue operating out of the stadium for at least the next year and a half. While some savings may be possible due to the aversion of offshore referrals for services that will be provided at OKEU, these are likely to be limited. Further, it remains unclear whether the OKEU Hospital will be successful at addressing some of the limitations currently seen at Victoria Hospital and St. Jude Hospital – namely low occupancy rates in inpatient services in general, but very high occupancy rates in certain wards. However, the OKEU Hospital is expected to be statutorized, which would allow it to manage its own financing and thus be responsible for revenue collection, thereby reducing the need for tax funds to run the hospital.[18] The OKEU Hospital is expected to be fully open by December 2018, with the fee schedule determined by the Board (and approved by the Minister of Finance) as outlined in the Millennium Heights Medical Complex Act 2015.

3. **The Government has requested World Bank financing for a Project to support its strategy for achieving UHC.** The Project will strengthen Saint Lucia's health system, focusing on the establishment of an essential benefits package, strengthening institutional readiness and performance particularly at the primary care level, and improving public health emergency preparedness and response. An essential benefits package has been drafted (see Annex 5), and will be refined and rolled out using a phased approach. Following the deployment of similar programs in other countries in the region, it would begin with a minimum, essential benefits package which fits within the government's fiscal space, with benefits added over time as efficiency gains are made and administrative systems (and revenue collection) improve.

4. **To support the services delivered through the essential benefits package, the Project will strengthen service delivery, with a focus at the primary care level.** This will be done through three specific areas. First, through the Project, the Government will introduce Performance-based Financing (PBF) to enhance service delivery at the primary care level. Second, the Project will strengthen health infrastructure by properly equipping health facilities at the primary health care level. Finally, the Project looks to improve preparedness and response for public health emergencies by integrating care provided at the primary care level. Activities conducted under the Project will take place alongside ongoing developments, such as the expected transition of Victoria Hospital to a polyclinic. The rollout of the essential benefits package, which is expected to be conducted in phases, will take upcoming transitions and expenditure pressures into

[16] USAID. Saint Lucia Health Systems and Private Sector Assessment 2011. 2012.
[17] USAID. Saint Lucia Health Systems and Private Sector Assessment 2011. 2012.
[18] A board was recently appointed for the OKEU Hospital, and includes representatives from the MOHW.

consideration.

5. **The Project has four Components as described below.** Component 1 will focus on the demand-side of health services by supporting the Government to develop and implement a coverage scheme that would allow its population to receive access to services outlined in the essential benefits package. The delivery of an essential benefits package will require improvements in institutional readiness, ensuring that facilities are adequately equipped to deliver the proposed package of services. In addition, a focus on results instead of inputs will be necessary to ensure efficiency gains, thereby enabling an expansion of the essential benefits package over time. As such, the supply-side of services will need to be strengthened. This will be done through Component 2 of the Project, which will focus on the supply-side of service delivery. Through PBF, incentives will be provided to ensure a focus on results. In addition, primary care and ancillary facilities (such as laboratory services) would be assessed and equipped to ensure they are able to deliver the services promised through the essential benefits package. This component would support the Government in strengthening the integration of primary care systems to enhance the role of primary care facilities and encourage their use as the first point of contact for health services, particularly NCDs and public health emergencies, by equipping them through the needed works, equipment, and supplies; and as importantly, with the needed operational protocols to establish a coordinated pathway of care and referral. Component 3 of the Project would provide support to overall project management and monitoring and evaluation to gauge project progress. Lastly, Component 4 provides flexibility to address potential public health outbreaks in case an eligible emergency is experienced. A detailed description of the various Components and activities to be supported under the Project is provided below.

Component 1. Design and Implementation of an Essential Benefits Package (US$5.5 million)

6. Component 1 focuses on the demand side and includes the review of the design and implementation of the benefits package, including administration, purchasing and contracting arrangements, regulations surrounding the scheme, and potential sources of additional revenue for expanding health service coverage. The Project will finance the analytics to support the Government in its design of the package and the roll-out of information technology and systems platforms in support of the implementation of the package. Public funds will finance the provision of the package and the Project will complement this funding by financing a bonus incentive, through Subcomponent 2.1, to be provided to the health facilities for their achievement of results related to providing diabetes and hypertension pre-screening and care. Activities described under Component 1 will be undertaken in parallel. A summary of the proposed benefits package is provided in Annex 5.

7. **Subcomponent 1.1. Review of the Essential Benefits Package (US$1 million).** This subcomponent would support the review of the essential benefits package. Proposed activities under this subcomponent, which will be undertaken in parallel, include: (i) a review of public sector expenditure in health, including recommendations for efficiency gains and improvements in equity, and recommendations for the development of National Health Accounts; (ii) analytical review of current insurance payment systems and coverage, including reviews of existing structural mechanisms with a potential role in the financing of the benefits package (e.g. NIC), and of the proposed essential benefits package and costing, including actuarial assessments, and periodic update mechanisms (including health technology evaluation mechanisms); (iii) evaluation of coverage options for those in the informal (e.g. farmers and taxi drivers) and nonwork sectors; (iv) review and simulations of the essential benefits package to identify possible phases for rollout and associated cost and coverage implications; (v) the development of Standard Operating Procedures (SOPs)/clinical procedures for case management (e.g. diabetes); (vi) an in-depth assessment of the national health information system (HIS), including interoperability and integration; and (vii) review and development of legislation governing the proposed benefits package.

8. **Subcomponent 1.2. Implementation of the Essential Benefits Package (US$4.5 million).** Findings from the previous subcomponent will support direct actions to roll out the implementation of the benefits package. Proposed activities under this component would include: (i) an assessment of and investments in IT systems and infrastructure for administration of the benefits package, including HIS, SOPs for data entry/management, computer equipment, and a benefits package management system (which will also track referrals); (ii) development/review of purchaser provider agreements; (iii) review of and improvements to existing and proposed financial control mechanisms and technical audits (such as financial audits and strategic purchasing arrangements); and (iv) a communications campaign surrounding the benefits package. In addition, this subcomponent would also support necessary capacity building and training efforts for MOHW staff, as well as the rollout of the benefits package among the population, including a helpline for the startup phase. Dependent on the outcome of the evaluation of coverage (Subcomponent 1.1 above), the selection criteria and targeting mechanisms of the potential beneficiaries will be determined to ensure inclusion of the vulnerable population.

Component 2. Strengthening Service Delivery in Support of the Essential Benefits Package (US$13 million)

9. **Subcomponent 2.1. Improving Service Delivery through Performance-Based Financing (PBF) (US$4 million).** This subcomponent proposes to include a PBF scheme focused on diabetes and hypertension to improve the efficiency of health expenditure by providing bonuses based on performance. PBF for health has been implemented in several countries to achieve health outcomes by linking incentives with results. Commonly referred to as pay for performance or performance-based incentives, programs reward the suppliers of health services, healthcare providers or facilities, upon achieving certain results such as immunizing a percentage of the population or increasing the number of preventative screenings in an area. In the case of Saint Lucia, the proposed PBF scheme will focus on strengthening NCD management at the primary care level. It would aim to strengthen the quality of care for diabetes and hypertension based on standard care protocols, and would provide financial rewards for health facilities according to the achievement of results. The primary health care (PHC) facilities will have flexibility in use of the funds received provided they are considered eligible expenditures (see Annex 6); for example, they may choose to distribute them as bonuses for the health providers or to use the funds as resources for improvements of the facilities. A draft Operations Manual for the PBF scheme was developed independently of the National Health Scheme, and will be revised to reflect the revised reimbursement structure to ensure it is appropriately linked to the National Health Scheme.

10. **Activities to be financed under this subcomponent include:** (i) the revised design of the proposed PBF scheme, including M&E plan and utilization of indicators from the HIS; (ii) health facility outreach; and (iii) PBF bonus payments based on performance. Project funds for PBF bonus payments will be included in a separate disbursement category. The PBF scheme will be rolled out in all PHC facilities in regions 3 and 4 in the first two years of the Project, will be scaled up to regions 6 and 7 in years three and four of the Project, and will continue in four of the eleven regions in the fifth and final year of project implementation, targeting a total population of 35,000 people. The participating PHC facilities will receive a bonus credit for providing the services to be incentivized and outlined in the basic benefits package. The MOHW and PHC facilities will agree on the results to be achieved in two areas, number of patients $\geq$ 18 years screened for diabetes/hypertension based on national protocols; and percent of patients $\geq$ 18 years with diabetes/hypertension diagnosed and managed according to national protocols; and number of patients $\geq$ 18 years screened for diabetes/hypertension based on national protocols. The bonus will consist of an additional budget allocation to the PHC facilities and an incentive budget allocation consisting of an output and result-based disbursement. The additional budget allocation from the MOHW to the PHC facilities will finance one complete annual laboratory analysis to each individual diagnosed as diabetic or hypertensive. The incentive budget allocation includes an output-based allocation provided to each PHC facility for 40% of an amount defined as the capita (US$3.3) multiplied by the registered beneficiaries, paid based on the verified nominalized list of registered beneficiaries. The result-based disbursement is for 60% of an amount defined as the capita (US$3.3) multiplied by the registered beneficiaries adjusted based on results

achieved paid against the verified nominalized list of registered beneficiaries and the results achieved in line with the agreed indicators and results targets. The target population will consist of individuals that: (i) are ≥ 18 years of age; and (ii) have one encounter registered in the HIS of a specific PHC facility in the last 18 months or resides in one of the target regions. Annex 6 provides a detailed overview of the design of the PBF scheme.

11. **Subcomponent 2.2. Strengthening the Supply of Health Care Services (US$4.5 million).** This subcomponent focuses on the supply-side and would involve strengthening the integration of primary care systems to enhance the role of primary care facilities and encourage their use as the first point of contact for health services, particularly NCDs. This component would finance goods, minor refurbishments, consultancy services, trainings/workshops, and operational costs in support of key investments/activities. Activities conducted under this subcomponent include: (i) a comprehensive survey of health facilities to ensure institutional readiness to deliver NCD services under the essential benefits package; (ii) improvement of health facilities including refurbishment, provision of equipment and medical supplies; and (iii) development of a health facility network to improve tracking of patients across the care pathway. Other possible activities under this component include the roll-out of mobile clinics, Geographic Information Systems, and radio systems for communication with health facilities.

12. A survey of primary health facilities including equipment inventory, procedures provided, and infrastructure would be conducted to ensure that facilities can deliver the necessary services as described in the benefits package and as required by the National Healthcare Quality Policy 2016-2026 which aims to provide national commitment, direction and guidance for improving quality in healthcare. Where possible, this survey would utilize available information (such as the Smart Health Facilities Assessment) and available tools such as the World Health Organizations' Service Availability and Readiness Assessment (2005). Subsequently, improvements (such as refurbishment or provision of equipment) to health facilities will be made based on survey outcomes. The type of refurbishments envisioned could include minimal infrastructure adjustments such as establishing partitions in existing structures, improving lighting, and painting. The magnitude of such refurbishments is minor as potential adverse environmental impacts due to these interventions potentially involve dry-wall installation, installation of new lighting fixtures, and properly disposing of unused paint. It is also possible that additions, expansions, or annexes will be rehabilitated or raised, though these are expected to be limited and will not require new land acquisitions, for example, a small area dedicated for storage of medical waste. Where feasible, energy efficient improvements such as improvements in lighting, appliances and equipment will be made. Under the Project, the national health care waste management plan will be updated for activities that include the minor refurbishments and the proper disposal of medical equipment. This may involve improvements to wastewater disposal systems and/or medical waste storage facilities. In addition, the care pathway across the health system will be reviewed to potentiate the use of less costly primary health care services as the entry point into the system of care. Other possible activities under this component include the roll-out of mobile clinics, Geographic Information Systems, and radio systems for communication with health facilities.

13. **Subcomponent 2.3. Public Health Emergency Preparedness and Response (US$4.5 million).** As part of efforts to strengthen the health system and address the growing threat posed by climate change, this Project also aims to address weaknesses in public health emergency preparedness and response. Activities conducted under this subcomponent involve strengthening of surveillance and information systems, laboratory capacity, and preparedness for public health emergencies. Activities under this subcomponent include: (i) the development of protocols and the provision of equipment to primary health care centers to enable them to serve as the first point of detection for selected infectious diseases; (ii) investments in laboratory facilities (such as equipment), data management, transportation and storage to enable rapid testing for pathogens of interest, including those associated with vector-borne diseases; and (iii) the development of health emergency preparedness and response plans, establishment of emergency operation centers

and rapid response teams for public health emergencies, and outbreak communications. Where relevant, investments will also be made in IT systems, e.g. strengthening communication between HIS and MOHW for notification of selected diseases. For example, this subcomponent will support the development of a maternal and child registry following the impact of Zika on microcephaly. Under the Project, the National Health Care Waste Management Plan will be updated to include measures for how to manage equipment distribution and installation in the case of a disease outbreak.

Component 3: Institutional Capacity Building, Project Management and Coordination (US$1.5 million)

14. This Component would cover project implementation efforts, including project management, fiduciary tasks and monitoring and evaluation (M&E) associated with supervision of the Project. This Project will be managed by a stand-alone Project Implementation Unit (PIU) housed within the MOHW, whose duties will include oversight of refurbishment activities as well as compliance with safeguards and local permit requirements during refurbishment/rehabilitation, and implementation of the Health Care Waste Management System (HWMS) during operation. The Project also secured a Project Preparation Advance (PPA) to allow selected Project activities to begin during the preparation process. Activities to be financed by the PPA will be implemented with oversight from the existing national-level Project Coordination Unit (N-PCU), and will consist solely of consultancies and hiring of staff for the PIU within MOHW. As such, support is envisioned for financial management and procurement functions, in addition to the development of a HWMS in accordance with the Terms of Reference in the Environmental and Social Management Framework (ESMF).

Component 4. Contingent Emergency Response Component (CERC) (US$0 million).

15. This Component will provide funding following an eligible emergency.[19] This Component will include conditions for the use of funds, and will only be triggered when certain actions, as agreed by the Government and the Bank teams, are met. These actions include the following: (i) the country experiences an eligible emergency; and (ii) presents a sound and actionable country-level response plan. This component provides a platform for country-level discussions on the importance and need for country-level readiness to respond to disease outbreaks. Once triggered, the component will be guided by Investment Project Financing (IPF) Policy, Paragraph 12, which enables rapid reallocation of funds between project components following an emergency. Together with the operational, fiduciary, procurement, disbursement and financial management arrangements that underpin its implementation, the component provides a conduit for additional emergency funds into the project. The Pest Management Policy (OP 4.09) has not been triggered. Support for emergency response or outbreaks will not include pesticide use for vector control, but rather technical, logistic, training, and planning activities. Any minor quantities of pesticides would be addressed by specific measures and procedures in the ESMF for storage, handling and application of pesticides.

[19] An eligible emergency means the imminent or actual occurrence of a natural or man-made crisis or disaster, which, in the opinion of the Bank, has the capacity to cause major adverse economic, health and/or social impacts in the Recipient's population.

ANNEX 4: Saint Lucia Health Information System (SLUHIS)

Health Information Management Systems in Saint Lucia

The Saint Lucia Health Information System (SLUHIS) currently has several efforts ongoing in parallel. At the primary care level, it has been rolled out to 32 out of 34 primary health care centers as well as the Medical Supplies Unit/Central Procurement and the Ministry of Health.

In addition to collecting information on patient demographics, vitals such as blood pressure and well, reason for visit, clinical diagnosis and other related areas, electronic prescriptions can also be generated and printed from SLUHIS, and the system is linked to patient appointments and referrals.

At the hospital level, SLUHIS is being rolled out in several modules, beginning with patient registration and scheduling. In addition, an extensive data cleaning exercise is currently underway to facilitate a “one patient, one record” system across primary and secondary care services.

A separate platform is currently under development for the Environmental Health Department of the MOHW, which will be interfaced with SLUHIS for vector-, food- and water-borne conditions. Plans are also in place to integrate the Laboratory Information System with SLUHIS to facilitate immediate access to lab results.

Health information systems will eventually be comprehensive, allowing for active surveillance, improved monitoring and evaluation efforts and informing budgetary allocations and performance, as well as tracking of medical supplies.

ANNEX 5: Current Coverage Options for Different Population Groups in Saint Lucia and Services Covered Under the Proposed Essential Benefits Package

A summary of the current coverage options is provided below, highlighting the differences among the various segments of the population as well as challenges associated with the available coverage options.

Table 1. Current Coverage Options for Different Population Groups in Saint Lucia

Population	Services covered	Number covered and challenges
General population	• Public primary care (no user fees) • Public hospitals[20] (user fees) • Care at private facilities are not covered (OOP payments) • Overseas care possible but assessed on a case-by-case basis with application to Cabinet needed once funds within MOHW exhausted	• Even after accessing public primary care services, patients may still need to pay out-of-pocket for pharmaceuticals, etc. • Higher-level care may not be accessible for some due to user fees • OOP payments for accessing private facilities range between EC$100-EC$200 (US$37-US$74) for a primary care visit, though accompanying costs and secondary/tertiary care may be high
Active members of the National Insurance Corporation	• Compensation for days of work missed (after three days) due to sickness/injuries.	• Covers approximately 50,000 formal sector workers (about half the labor force) • The NIC transfers a flat fee (EC$5.5 million in 2013) to Victoria and St. Jude Hospitals to cover hospital services provided to its members. • The NIC does not cover additional primary care expenditures, pharmaceuticals or offshore medical care.
Private insurance policy holders/members	• Public and private sector visits are covered. • Comprehensive coverage including physician, hospital, diagnostic, overseas care, prescription drugs, with options for dental, optical and life insurance. • Controlled through fee-for-service payments with deductibles and coinsurance. • Overseas referrals done through managed care with beneficiaries paying a higher price if they go out of network.	• Covered 17,371 people in 2014 through individual and group policies. A total of EC$24,720,000 (US$9.1 million) in premiums, while a total of EC$17,467,481 (US$6.5 million) was paid out in claims. • Coverage is not offered in some instances (based on preexisting conditions, age, or claims above a certain amount for eligible conditions (e.g. EC$30,000 or US$11,111) • A major limitation is the resettable lifetime limit. When reached, an individual has to self-pay or rely on public/charity care until the 3-year period has passed and limit is reset.

The table below outlines all areas that will be covered under the essential benefits package. The areas in bolded text are

[20] Hospital fee payment is governed by Hospital Fees Regulations, SI No. 68 of 1992. Medical coverage is provided for those who (a) receive an income of less than US$2,222.00 per annum; (b) are registered paupers; (c) is a child of a person described in (a) or (b); (d); has attained sixty (60) years of age and is in receipt of an income of less than six thousand dollars per annum; (e) is a member of the Nursing Service of the State; (f) is a member of the Police Force, Fire Service, or Prison Service of the State; or (g) is a contributor to the National Insurance.

those proposed as part of the first phase of rollout of benefits during the first year of implementation.

Table 2. Services Covered Under the Proposed Essential Benefits Package

Area	Primary Care			Secondary/Tertiary Care	
	Screening	Management	Other	Inpatient/ Outpatient/ Emergency/ Laboratory Services	Other
a) Diabetes **b) Hypertension**	✔	✔	**Pharmaceuticals**	✔	**Operating Room Services (Diabetes only), Radiology/Diagnostic Services, Physiotherapy Sessions, Dialysis (Diabetes only)**
c) Injuries/Trauma	✔	✔	×	✔	Operating Room, Radiology/Diagnostic Services, Physiotherapy Sessions
d) Respiratory Conditions	✔	✔	Pharmaceuticals	✔	Radiology/Diagnostic Services, Physiotherapy Sessions
e) Sexual and Reproductive Health (Including Family Planning)	✔	✔	Pharmaceuticals	×	X
f) Maternal and Child Health	×	×	**Antenatal and postnatal care; Child Health/Immunization; Adolescent Health**	✔	**Operating Room Services, Delivery Room, Radiology/Diagnostic Services**
g) Selected Communicable Diseases[21]	✔	✔	Pharmaceuticals	✔	Radiology/Diagnostic Services
h) Selected Cancers[22]	✔	×	×	✔	Operating Room Services, Radiology/Diagnostic Services, Day Surgery, Chemotherapy, Physiotherapy, Radiotherapy
i) General Cancer Services	×	×	×	✔	Radiology/Diagnostic Services, Day Surgery, Chemotherapy, Physiotherapy
j) Dental	×	×	Cleanings, Fillings, Root Canals	×	×
k) Hearing Health	✔	✔	×	×	×
l) Mental Health	✔	✔	Pharmaceuticals	No Outpatient Services	Radiology/Diagnostic Services
m) Substance Abuse	✔	×	Counseling	✔	X
n) Cardiovascular Disease	✔	✔	Pharmaceuticals	✔	Radiology/Diagnostic Services; Surgery (Pacemaker/Defillibrator implantation/ Pericardiocentesis/Pericardial Tap/Pleural Tap – Overseas Care)
o) Eye Health	✔	✔	×	✔	Day Surgery
p) Sickle Cell Anemia	×	×	×	✔	Radiology/Diagnostic Services, Surgery, Physiotherapy Services
q) Surgery r) Gynecology s) Medicine	×	×	×	✔	Operating Room Services, Radiology/Diagnostic Services, Physiotherapy Services

[21] Communicable diseases covered are Dengue, Schistomiasis, Hansen's, Tuberculosis, and Leptospirosis.
[22] Cancers covered are Prostate, Cervical, Breast, Colon, and Stomach.

ANNEX 6: Performance Based Financing (PBF) Scheme

Details of the PBF scheme under Component 2.1 are summarized below:

Target Population

a) The PBF scheme will be rolled out in two phases. In the first phase, representing the first two years of project implementation, regions 3 and 4 will be included. In a second phase, years 3 and 4 of the project, two additional regions will be added which are regions 6 and 7. In the fifth and final year of project implementation, the implementation will continue in all four regions.
b) All primary health care (PHC) facilities in the target regions (3, 4, 6 and 7) will participate in the roll-out of the PBF scheme.
c) The target population will consist of individuals that: (i) are ≥ 18 years of age; and (ii) have one encounter registered in the Health Information System (HIS) of a specific PHC facility in the last 18 months or resides in one of the target regions. The total target population will be around 35,000 persons in the four regions.

Technical Focus

d) The PBF scheme aims to improve efficiency and efficacy of primary health care (prevention and treatment) of non-communicable diseases (NCDs), specifically diabetes and hypertension. The PBF scheme will include two "virtual" payments to the PHC facilities which are: (i) an additional budgetary allocation aimed to improve access to treatment by financing one complete annual laboratory analysis for each individual diagnosed as diabetic or hypertensive; (ii) an incentive budgetary allocation to the PHC facilities based on a capitation partially adjusted by results. The PBF scheme will also finance devices for the implementation of a self-care program for diabetes and hypertension.

Incentive Structure

e) The incentive budgetary allocation will have the following characteristics: (i) the capita is initially defined as an amount equivalent to US$3.3 multiplied by the target population registered in the PHC facility; (ii) 40% of this amount will be allocated on a monthly basis and 60% of this amount will be allocated every 3 months adjusted based on results achieved in line with agreed targets.

Results Indicators

f) The result targets are related to: (i) screening of diabetes in line with the PBF operational manual (OM); (ii) screening for hypertension in line with the PBF OM; and (iii); treatment of diabetes and hypertension in line with the PBF Operational Manual (OM).
g) The data source for determining the achievement of the indicator targets is the SLU HIS which is currently collecting data to assess, confirm, and report on results achieved. The SLU HIS is installed in the PHC facilities.
h) The PBF scheme includes the following monitoring procedures: external verification of data, follow-up activities, management reporting, analysis of data, ongoing capacity building, technical assistance, and impact evaluation.

Flow of Funds

i) Each PHC Facility will have two Budget lines assigned by the MOHW, one for the additional budget allocation (laboratory analysis) and one for the incentive budgetary allocation (the capitation adjusted for results).

j) The MOHW-PIU will determine the amounts that will periodically be assigned to these two MOHW budget lines based on the following:
   - Additional Budget Allocation (laboratory analysis). The amount and type of analysis expected to be carried out for a diagnosis of diabetes and/or hypertension will be calculated at the beginning of each year taking into account the number of registered patients (and the expected annual increase) at the PHC facility. This amount will be communicated to the MOHW finance department. If more patients are registered than initially estimated, the MOHW-PIU will be able to correct the estimates and expand the budgetary allocations in agreement with the World Bank.
   - Incentive Budget Allocation (capitation adjusted for results). The MOHW-PIU will determine on a monthly basis the amount corresponding to the 40% allocation in line with the value of the capita and the registered population at the end of the month. The MOHW-PIU will determine the amount to be assigned to the 60% transfer on a quarterly basis considering the registered population in each month of the quarter, the value of the capita, and the level of achievement of results based on the SLU HIS data.
   - The PHC facilities will use budgetary credits based on existing country systems. This will involve the MOHW-PIU communicating to the MOHW finance department the amount to be allocated to the PHC facility. In turn, the MOHW finance department will inform the PHC facility of the budgetary credit they have been allocated and the PHC facility will indicate how they would like to spend their budgetary credit. The MOHW finance department will then communicate this to the MOHW central purchasing unit, who in turn purchases the items for the PHC facility.
   - The following restrictions apply on how the PHC facilities can request to use the budgetary credit they receive. For the Additional Budget Allocation, only laboratory costs can be paid and for the Incentive Budget Allocation, funds can be used for eligible expenditures defined by the Project (upkeep of health Facility, purchase of equipment and supplies, etc.)

k) The MOHW Finance Department will make the payments from these two Budget lines using the Project Designated Account and will periodically replenish the account based on the established World Bank procedures.