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DOMINICAN REPUBLIC

STRENGTHENING RESULTS-BASED MANAGEMENT IN THE DOMINICAN REPUBLIC'S HEALTH SECTOR

(DR-L1067)

LOAN PROPOSAL

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ELECTRONIC LINKS

REQUIRED

1. Plan of activities for the first disbursement and the first 18 months of project execution)
   http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=37823419
2. Monitoring and evaluation arrangements
   http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=37825101
3. Full procurement plan
   http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=37825633

OPTIONAL

1. Safeguard policy filter (SPF) and safeguard screening form (SSF)
   http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=37883098
2. Technical note on results-based financing in the health sector
   http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=37826760
3. Technical note on the Maternal and Child Center of Excellence model
   http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=37826780
4. Analysis of program costs and economic viability
   http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=37826769
5. Institutional capacity assessment of the executing agency
   http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=37835309
6. Fiscal sustainability analysis of the National Health Insurance
   http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=37835156

ABBREVIATIONS

ARS	Administratora de riesgo de salud [health risk management company]
CEMI	Centro de Excelencia Materno-Infantil [Maternal and Child Center of Excellence]
CERSS	Comisión Ejecutiva para la Reforma del Sector Salud [Executive Committee for the Health Sector Reform]
DALY	Disability-adjusted life year
DDEI	Dirección de Desarrollo Estratégico Institucional [Directorate of Institutional Strategic Development]
DIES	Dirección de Información y Estadísticas de Salud [Directorate of Health Information and Statistics]
END	Estrategia Nacional de Desarrollo [National Development Strategy]
ENDESA	Encuesta Nacional de Demografía y Salud [National Demographic and Health Survey]
MDG	Millennium Development Goals
MISPAS	Ministry of Public Health and Social Assistance
OM	Operations Manual
PAHO	Pan American Health Organization
PCU	Project coordination unit
PEP	Multiyear execution plan
PNPSP	Plan Nacional Plurianual del Sector Público [Multiyear National Plan for the Public Sector]
RBF	Results-based financing
SENASA	Seguro Nacional de Salud [National Health Insurance]
SFS	Seguro Familiar de Salud [Family Health Insurance]
SGC	Sistema de Gestión Clínico-Administrativo [Clinical/Administrative Management System]
SIGHO	Sistema de Gestión Hospitalaria [Hospital Management System]
SIUBEN	Sistema Único de Beneficiarios [Master Beneficiary System]
SNS	Servicio Nacional de Salud [National Health Service]
SPS	Sistema de Protección Social [Social Protection System]
SRS	Servicios Regionales de Salud [Regional Health Services]
UNAP	Unidad de Atención Primaria [Primary Care Unit]
WAL	Weighted average life
WHO	World Health Organization

PROJECT SUMMARY

DOMINICAN REPUBLIC
STRENGTHENING RESULTS-BASED MANAGEMENT IN THE DOMINICAN REPUBLIC'S HEALTH SECTOR
(DR-L1067)

<table>
<tr><th colspan="4">Financial Terms and Conditions</th></tr>
<tr><td colspan="2" rowspan="6">Borrower: Dominican Republic

Executing agency: The borrower, acting through the Ministry of Public Health and Social Assistance (MISPAS)</td><td colspan="2">Flexible Financing Facility*</td></tr>
<tr><td>Amortization period:</td><td>18 years</td></tr>
<tr><td>Original WAL:</td><td>15.25 years</td></tr>
<tr><td>Disbursement period:</td><td>48 months</td></tr>
<tr><td>Grace period:</td><td>11.5 years</td></tr>
<tr><td>Interest rate:</td><td>LIBOR</td></tr>
<tr><td>Source</td><td>Amount (US$)</td><td>Inspection and supervision fee:</td><td>**</td></tr>
<tr><td>IDB (OC)</td><td>146 million</td><td>Credit fee:</td><td>**</td></tr>
<tr><td>Local</td><td>0</td><td rowspan="2">Currency:</td><td rowspan="2">U.S. dollars from the Bank's Ordinary Capital</td></tr>
<tr><td>Other/Cofinancing</td><td>0</td></tr>
<tr><td>Total</td><td>146 million</td><td></td><td></td></tr>
<tr><th colspan="4">Project at a Glance</th></tr>
<tr><td colspan="4">Objective:
The general objective of the project will be to increase the efficiency and effectiveness of health expenditure for the Dominican Republic's most vulnerable population. The specific objectives are: (i) to improve the allocation of health expenditure through expansion of results-based financing (RBF), with special emphasis on the primary care level; (ii) to contribute to reducing maternal and child morbidity and mortality through expansion of a strategy for management improvements in secondary and tertiary health services; and (iii) to support the Ministry of Public Health and Social Assistance (MISPAS) in its sector stewardship through institution-strengthening and development of monitoring and evaluation instruments for decision-making (see paragraph 1.30).</td></tr>
<tr><td colspan="4">Special conditions precedent to the first disbursement (see paragraph 3.3):
(i) Creation of the project coordination unit (PCU) and appointment of a general coordinator; (ii) entry into force of the program Operations Manual (OM) with the Bank's prior no objection; and (iii) entry into force of the amendments to the management agreements incorporating RBF between MISPAS and the National Health Insurance (SENASA), and each of the five Regional Health Services (SRS) that will participate in project execution.</td></tr>
<tr><td colspan="4">Special contractual clauses (see paragraph 3.3):
(i) Any change or update to the program OM will require the Bank's prior no objection; and (ii) the concurrent audit to verify fulfillment of the enrollment and results targets will be commissioned by January 2014.</td></tr>
<tr><td colspan="4">Procurement: The Bank's procurement policies will apply (documents GN-2349-9 and GN-2350-9).</td></tr>
<tr><td colspan="4">Exceptions to Bank policies: None.</td></tr>
<tr><td colspan="4">Project consistent with country strategy: Yes [X] No [ ]</td></tr>
<tr><td colspan="4">Project qualifies as: SEQ [X] PTI [X] Sector [X] Geographic [ ] Headcount [X]</td></tr>
</table>

* Under the Flexible Financing Facility (document FN-655-1), the borrower has the option of requesting changes in the amortization schedule, as well as currency and interest rate conversions, subject in all cases to the final amortization date and the original weighted average life (WAL). The Bank will take market conditions as well as operational and risk management considerations into account when reviewing such requests.

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

I. DESCRIPTION AND RESULTS MONITORING

A. Background, problems, and rationale

1.1 Improvement in health outcomes in the Dominican Republic has not kept pace with its economic growth in recent years.[1] Although maternal and infant mortality rates in the country have fallen by over 30% in the last decade—a significant achievement—they remain among the highest in Latin America and the Caribbean (LAC) (see Table I-1). These rates are also lagging behind achievement of the Millennium Development Goals (MDGs) by 2015.

Table I-1[2]

Indicators	DR	LAC	MDG
Maternal mortality rate (deaths per 100,00 live births)	125.9	80.0	57.0
Infant mortality rate (deaths per 1,000 live births)	27.8	19.0	19.0

1.2 At the same time, a demographic and epidemiological transition is under way in the country, characterized by a double burden of disease, where high maternal and child mortality rates coexist with a high prevalence of chronic diseases. The latter account for 68% of deaths, and 40.8% and 37.4% of premature deaths among men and women, respectively. In part, this difference stems from the fact that men are less likely to use preventive services.[3]

1.3 One factor that has thwarted the attainment of better health outcomes are the delays in consolidating the sector's reform. The aims of the reform launched in 2001[4] are to achieve universal health care coverage,[5] promote equity, guarantee comprehensive assistance, and make the transformations necessary to segregate the functions of the National Health System—financing, health care delivery, and stewardship—and ensure that these functions are performed by the different institutions comprising the system.[6] A further aim is to lay the groundwork for financial sustainability of the social security system.

1.4 The reform created the Family Health Insurance (SFS), with financing based on three contribution systems according to the population's income level and type of employment. The poor population, identified by the Master Beneficiary System

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1 From 2005 to 2009, the Dominican Republic economy grew at an annual rate of 7.5%. Central Bank of the Dominican Republic (BCRD).

2 Sources: Health Indicators database (2009), Pan American Health Organization (PAHO); World Development Indicators (2010).

3 For example, among the population diagnosed with diabetes, only 89.7% of men report that they are in treatment, compared to 94.4% of women. National Demographic and Health Survey (ENDESA 2007).

4 Law 87-01 (Dominican Social Security System); Law 42-1 (General Health Law).

5 To protect all Dominicans against the financial risk of illness.

6 The Ministry of Public Health and Social Assistance (MISPAS) exercises stewardship of the sector as its apex authority; financing is the responsibility of health risk management companies, known as ARS; and health care delivery is the responsibility of the service providers, which may be public or private.

(SIUBEN) and served by a Primary Care Unit (UNAP), is covered under the subsidized system, funded entirely from tax revenue. The contribution system, for formal sector workers (public and private), is funded by employers and employees. The subsidized contribution system, for self-employed and informal sector workers,[7] is to be funded from voluntary contributions and partial tax subsidies, although it has not yet been launched.

1.5 The SFS ensures a minimum set of services to be guaranteed for the entire enrolled Dominican population (regardless of system). These services are defined in the Basic Health Plan. The population is insured through public and private entities known as health risk management companies, or ARS. The National Health Insurance (SENASA), which is the largest public ARS, insures those enrolled in the subsidized system. Those affiliated with the contribution system may be insured with any ARS, public or private. The population not yet covered by any medical insurance accesses public health services directly (at no cost) or privately (with payment).

1.6 Health care services are delivered to subsidized system members at public establishments managed by the Regional Health Services (SRSs), which are deconcentrated administrative units of the Ministry of Public Health and Social Assistance (MISPAS). Through the SRSs, MISPAS promotes networking among providers at the different care levels (primary, secondary, and tertiary) for delivery of the Basic Health Plan services, ensuring continuity of care.

1.7 Many elements of the health system reorganization included in the reform have not yet been implemented, limiting its potential impact and contributing to poor health outcomes. In particular: (i) the SRSs lack autonomy and management capacity; (ii) most financing is maintained at MISPAS via historical budget, without linking expenditure to results; (iii) there is no good territorial planning to organize service delivery on the basis of demand; (iv) primary care response capability is low, such that the population seeks health care services directly from the specialized levels; and (v) patient referral and counter-referral between care levels is weak.

1.8 If progress is to be made in meeting the reform's objectives and improving the health of the population, it is fundamental for the Dominican health care system to achieve the "instrumental objectives" of a health care system: efficient resource allocation and use, service quality, transparency, and accountability in all system areas.[8]

1.9 **Efficiency of public health expenditure.** Per capita public expenditure on health in the Dominican Republic is low compared to countries of similar income levels.

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[7] An estimated 57% of the Dominican Republic's workers are in the informal sector. Source: "Cuentas nacionales de salud RD: Informe gasto público en salud" [DR National health accounts: Report on public health expenditure] (2011). MISPAS.

[8] Murray, C. and J. Frenk: "A framework for assessing the performance of health systems." World Health Organization (online). 2000, vol. 78, no. 6, pp. 717-731 (accessed on 21 May 2013).

Moreover, when Dominican health outcomes are compared with those of countries such as Jamaica,[9] inefficiencies can still be identified. In 2010, per capita GDP in the Dominican Republic (US$5,195.40) was similar to that of Jamaica (US$5,133.40), and annual per capita public expenditure on health was twice that of Jamaica (US$250 vs. US$123). However, the Dominican Republic had higher maternal and infant mortality rates (see Table I-1) than Jamaica (110 deaths per 100,000 live births, and 20.2 deaths per 1,000 live births).

1.10 Among factors contributing to the inefficiency of public health expenditure is the inefficiency of resource allocation and low levels of insurance coverage. In 2011, 39.65% of public expenditure on health was directed to curative health services, and only 3.76% was allocated to preventive and public health services, including mother and child health care.[10] The coverage of cost-effective interventions, such as childhood immunizations, is poor, especially among the poorest population segments.[11] In terms of medical insurance, although coverage has increased in the last five years, 46% of the population remains unaffiliated with any type of medical insurance. A recent study suggests that SENASA members seek more health services than do nonmembers.[12] The low level of insurance coverage is an important obstacle to accessing preventive health care services. The uninsured tend to seek health care when they are already ill, diminishing health outcomes and increasing system costs.[13] Although major challenges exist as regards financing the SFS and universal insurance coverage that must be addressed by the Government of the Dominican Republic in the medium term, in the current context of fiscal constraint[14] the country must increase the efficiency of its health expenditure. Improving the efficiency of that expenditure is the objective of this operation.

1.11 Together with the low level of insurance coverage are problems of service response capacity, especially in primary health care. Even among the poorest segments, some 15% of Dominicans prefer to use private providers for outpatient

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9 World Health Statistics 2009, World Health Organization (WHO).

10 "Cuentas nacionales de salud RD: Informe gasto público en salud" [DR National health accounts: Report on public health expenditure] (2011). MISPAS.

11 For example, there was a 14% difference in measles immunization coverage between the lowest and highest income quintiles, and the measles immunization coverage is more than 10% below the average for the region. PAHO (2011).

12 Rathe, M., 2012. "Protección financiera en salud en RD. Análisis del gasto catastrófico and empobrecedor en salud de los hogares dominicanos beneficiarios del sistema de subsidios sociales" [Financial protection in health care in the DR. Analysis of catastrophic and impoverishing health expenditure of Dominican beneficiary households of the social subsidies system].

13 According to the ENDESA (2007) survey, preventive service uptake rates are very low: 4.8% use a service and 50.1% of sexually active women have the Pap smear. PAHO (2011).

14 In 2012, the Government of the Dominican Republic launched a tax reform to improve fiscal performance. The reform focuses on increasing tax revenue intake and decreasing tax expenditure.

consultations, and 20% for hospitalization.[15] Consequently, the Dominican Republic is among the countries of the region with highest out-of-pocket expenditure, contributing to the impoverishment of some families.[16]

1.12 Lastly, it should be mentioned that the existing financing mechanism also contributes to the inefficiency of public expenditure on health. Most financing is still provided under a historical budget, via inputs (including human resources) transferred by MISPAS to the SRSs. The SRSs transfer the inputs to the UNAPs without any kind of linkage to results, in a "passive" purchase of services. This model provides no incentives for meeting health targets or accountability mechanisms. In an "active" model for purchasing services, MISPAS defines the services to be offered and the targets to be met, leading providers to offer more cost-effective preventive services and meet the health targets.

1.13 **Quality of health care services**. The high rates of maternal and infant mortality in the country are an indicator of the poor quality of health care services. Although prenatal care and institutional childbirth are virtually universal, maternal and infant mortality rates are among the highest in the region. Inequities in health outcomes are also observed that vary with the population's income level. Infant mortality rates, for example, range from 43 to 26 per 1,000 live births from the lowest to highest income quintiles.[17]

1.14 Comprehensive care is essential to ensure good maternal and infant health outcomes. It is important for the mother to receive primary care throughout pregnancy, for potential risk factors to be detected early, and for hospitals to offer quality obstetric and neonatal care before, during, and after the birth.[18] Infections and hemorrhage, for example, which are among the leading causes of maternal death in the Dominican Republic, occur mainly during the birth and postpartum period.[19] In one observational study conducted with 168 physicians at secondary and tertiary health care facilities,[20] 90% provided inadequate postpartum care for the mother. Inadequate care was provided during labor by 60% of the professionals, and 57% did not correctly follow care protocols during the delivery; and, in emergencies, errors were made in 100% of cases. Although the study sample was small, it was consistent with the findings of a number of other

[15] ENDESA (2007). Additionally, the population tends to go directly to the hospital, increasing health care costs and diminishing the role of primary care as a gateway to the service network.

[16] Rathe (2012). Over 50% of total health care expenditure is private, and 66% of that expenditure is out-of-pocket.

[17] ENDESA (2007). 96.7% of expectant mothers have more than three prenatal checkups, and 98.3% have institutional deliveries.

[18] *The Lancet Maternal Survival Series* (2006).

[19] The leading causes of maternal mortality are: hypertension (27%), sepsis (21%), and hemorrhage (12%).

[20] Péres-Then (2011).

studies,[21] which conclude that the main risk factor associated with maternal mortality in the Dominican Republic is the poor quality of public health services.

1.15 In terms of infant mortality, 70% occurs in the neonatal period (0-28 days). The leading causes are asphyxia during the birth (42%), infections such as sepsis (31%), and low birth weight (4.6%). As with maternal mortality, most risk factors are associated with complications during the birth and the postpartum period. In these cases, it is essential for hospitals to have qualified personnel for timely care during the birth, and emergency care for the mother and newborn.[22] In the Dominican Republic, an estimated 50% of neonatal deaths and 93% of maternal deaths could be avoided through initiatives focusing on improvements in hospital care quality.[23]

1.16 **Institutional capacity for stewardship of the system.** Among its areas of major focus, the health sector reform establishes that MISPAS will focus on its stewardship role, essential to ensuring the system's responsiveness to the needs and expectations of the Dominican population. At present, MISPAS devotes much of its work to direct production of health care services, and possesses low institutional capacity for exercising the role of apex authority.

1.17 Apex authority for a health care system entails the functions of sector stewardship, health intelligence, and regulation and supervision. Among the main challenges in health intelligence, identified through consultation with key system stakeholders[24] in 2011, are: under-recording of data, absence of a unified management information system (linking clinical and financial information), and absence of mechanisms for crossreferencing and linking information from different sources, including information from the private ARSs. These shortcomings tend to generate proliferation of information systems that are not interlinked and serve specific programs and needs. They also make it impossible to monitor and supervise activities and health system indicators. A national standard for health information systems needs to be developed, to facilitate data systematization and analysis at the national level.

1.18 In terms of the unified management system, the Dominican Republic has successfully implemented a Clinical/Administrative Management System (SGC) at the primary care level, with IDB support. However, there is no similar system for the secondary and tertiary levels, tied in to the SGC, to record referrals and counter-referrals. This complicates the recording of comprehensive care and the

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[21] Study conducted by the Executive Committee for the Health Sector Reform (CERSS) in 2002. Miller et al. (2003), Péres-Then (2008), Quiterio et al. (2008).

[22] A review of the evidence on the efficiency and effectiveness of interventions to reduce neonatal mortality identified timely medical care by qualified professionals during childbirth, emergency neonatal care, and emergency obstetric care. Source: *The Lancet Neonatal Survival Series* (2005).

[23] CERSS (2002).

[24] Gonzalez-Pons, S., "Sistema de monitoreo del desempeño del sistema de salud" [Health system performance monitoring system], 2011.

monitoring of UNAP response capacity, to avoid unnecessary referrals to hospitals.

1.19 Information on health production by provider establishment, compiled by systems such as the SGC, is essential for analyzing data on causes of morbidity, frequency of use, costs, inputs, and other factors that are important for both service delivery and evaluation of network efficiency. However, the lack of such information is also detrimental to sector stewardship of the system, since there is insufficient reliable data for policy-making and strategic planning.

1.20 One challenge faced by MISPAS is how to map the number of those enrolled in each contribution system and those not enrolled in each health care region, in order to assign them to the jurisdiction of a UNAP. Although recent census data is available (2010), no health map has been prepared, and MISPAS needs support in cross-referencing this data with information from SENASA and the private ARSs. This territorial allocation of population is essential for validating MISPAS's planning activities, including the hiring of human resources at the local level, distribution of inputs, and definition of secondary and tertiary care referrals for each UNAP by specialty area. In addition, to streamline decision-making, MISPAS needs a unit at the central level with responsibility for information compilation, consolidation, and analysis.

1.21 **Advances by the Government of the Dominican Republic in health care**. Since 2009, MISPAS has been implementing a system for results-based financing (RBF) of health payments at the primary care level at two of the country's nine SRSs.[25] RBF is an innovative mechanism for financing health care delivery whose aim is to improve the effectiveness and efficiency of expenditure while more quickly meeting the sector's health targets.[26] In the Dominican Republic, the RBF, under management agreements, transfers funds from MISPAS and SENASA to the two SRSs, to finance Basic Health Plan services for the uninsured and for those insured under the subsidized system, respectively. These payments represent the average unit cost to ensure timely access to preventive health care and are provided in two tranches: (i) a fixed monthly amount representing 50% of the value of the payment, which is subject to enrolment in the UNAPs (by

[25] SRSs VI and VIII have piloted RBF with World Bank financing. SRS VII will implement RBF in 2014 (with World Bank financing). The World Bank operation is financing services to the uninsured population through the second phase of an adaptable programmatic loan (APL) thru 2015. The third phase of the APL (to be approved in 2015) would continue to provide financing for RBF in those regions. CERSS is the executing agency for RBF with World Bank financing. The present operation was prepared in close coordination with the World Bank and CERSS. Its technical coordinator has taken part in missions and the formulation of a critical path for expanding RBF to the other regions. The lessons learned in the pilot areas, documented in the process of the institutional capacity assessment of the executing agency, will be included in the program OM. The lessons that require financing for implementation have been included in the financing for this operation (see paragraph 1.32(ii)).

[26] See (Technical note on results-based financing in the health sector) for a review of the literature on RBF models.

completing a Family Health Card)[27]; and (ii) a variable amount representing 50% of the value of the payment, which is transferred based on progress in meeting the four-monthly targets set in the agreements and reported through the SGC. The performance tranche is disbursed in proportion to targets met for each indicator, based on the findings of concurrent independent audits.[28] This system has 10 indicators of effective coverage and quality, aimed at promoting preventive health care services aligned with the population's epidemiological profile, specifically the double burden of disease.[29]

1.22 Thus far, the model has achieved positive results: (i) the percentage of expectant mothers evaluated for risk symptoms prior to the fifteenth week of pregnancy rose from 0.43% to 13%; (ii) the percentage of children under 15 months who had received a full immunization panel rose 25%; (iii) the percentage of adults over age 18 screened for hypertension rose from 0.9% to 38%; and (iv) the percentage of adults diagnosed with type II diabetes and in treatment rose from 0.8% to 10%. Additionally, 70% of the SGC records are from the SRSs where RBF has been implemented.[30] These results are consistent with those observed in Argentina's "Plan Nacer," which is implementing an RBF system similar to the one proposed under this operation.[31]

1.23 Based on these results, MISPAS and SENASA have decided to expand RBF nationwide. However, this will require strengthening the management capacity of the both institutions for: (i) rolling out the process of enrolling the population with the UNAPs; (ii) administering the management agreements; (iii) monitoring the evolution of targets; and (iv) validating the reports of services delivered by the SRSs. It will also entail strengthening the SRSs for implementation and management of the RBF model, and accounting to MISPAS and SENASA regarding the targets, use of resources, and resource distribution to the UNAPs.

1.24 In 2009, USAID launched an intervention known as Maternal and Child Centers of Excellence (CEMI) at 10 hospitals in the Dominican Republic. The strategy consists of quality certification through improvements that combine: (i) incorporation of evidence-based clinical practices; (ii) training for professionals on incorporating these practices; and (iii) reorganization of the hospitals' clinical and administrative services, including managerial improvements and changes in work processes. The strategy's approach is based

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[27] Enrollment entails the identification, assignment, and registration of an individual with a UNAP.

[28] Concurrent external audits are technical audits to verify the data pertaining to enrollment of the population and achievement of the results reported by the SRSs.

[29] See list of indicators.

[30] The SRSs where RBF has been implemented have linked the financing of services to the SRS records in the SGC.

[31] The number of prenatal checkups increased 17.5%, and the likelihood of attending prenatal checkups in the first three months of pregnancy increased 8.5%.

on motivating and changing attitudes of professionals, which is fundamental to achieving lasting changes in the services.[32]

1.25 In the hospitals where it has been implemented, the strategy has achieved major improvements in quality-of-care indicators, such as greater use of the partograph and more active management of the third stage of childbirth, as well as a significant reduction in the number of maternal and infant deaths. Especially noteworthy were the 49% reduction from 2010 to 2011 in the number of maternal deaths and the 18.3% reduction in the number of infant deaths. In 2013, the Government of the Dominican Republic adopted the CEMIs as the model for delivery of quality maternal and child health care services in the country.[33]

1.26 Despite the delays in consolidation of the health sector reform, this process has gained momentum in the past few years, with the Government of the Dominican Republic laying the groundwork for universal coverage. Public insurance coverage increased from 6% (some 500,000 people in 2007) to 46% (some 4.6 million people in 2012), while public spending on health doubled between 1995 and 2010 (from 21% to 43.4%). At the same time, to advance consolidation of the health sector reform, the government has ratified the amendment to Law 1-12 of 2012 and sent a proposal to Congress for consideration to create the National Health Service (SNS) as managing authority of the SRSs, so as to ensure coordination and quality of service delivery. Thus, it is essential to strengthen the role of MISPAS as apex authority, to establish rules and regulations enabling the SNS to operate effectively and efficiently.

1.27 Based on the above-described evidence, this program will support: (i) expansion of the financing system to five of the nine SRSs where 45.6% of the Dominican population is located. A total of nearly 1.5 million people will benefit directly, representing 45.9% of the extremely poor or moderately poor, and 15.3% of the total population. Analysis of program costs and economic viability show that the RBF mechanism is highly cost effective. Each dollar invested generates a net social benefit of US$27 in disability-adjusted life years (DALYs) avoided; (ii) expansion of the CEMI model to six new hospitals, and the certification process for six of the ten hospitals that have begun its implementation. The six new hospitals, prioritized based on the number of birth and deaths, are responsible for 34% of births occurring in the country, and 66% and 54% of the maternal and infant deaths, respectively;[34] and (iii) strengthening of the institutional capacity of MISPAS for sector stewardship, and of SENASA for the expansion of RBF.

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[32] See the Technical note on the Maternal and Child Center of Excellence model for a more detailed description of the strategy. Péres-Then (2011) noted that, although 70% of doctors evaluated by written exam received high scores for knowledge, only 9% received high scores during the practicums evaluated by direct observation.

[33] MISPAS Resolution 00012 of 3 April 2013, adopting the Center of Excellence model for quality assurance in health care service delivery.

[34] Directorate of Health Information and Statistics (DIES), MISPAS.

1.28 **Bank support.** Under the multiphase program, "Support for the Social Protection Program" (PAPPS);[35] and the project, "Support for Consolidation of the Social Protection System" (loan DR-L1053, 2733/OC-DR), the Bank is supporting the "Solidaridad" conditional cash transfer program (now known as "Progresando con Solidaridad" [Progressing with Solidarity]), which promotes the use of preventive health care services geared to the life cycle of the extremely poor or moderately poor population. On the supply side, these operations have supported health care quality. Achievements as of 2012 are: (i) licensing of 349 UNAPs, corresponding to 35%[36] of the total service offerings; (ii) training for primary care doctors and nurses on the clinical guidelines and protocols established by MISPAS for quality care; and (iii) implementation of a Clinical Management System to maintain records of primary care consultations. In 2013, the operation "Support for the "Progresando con Solidaridad" program" (loan DR-1059) will support the country in continuing to promote demand for preventive health care services among the poorest of the poor, and will also benefit this operation.

1.29 **Dominican government priorities in the health sector and strategic alignment.** This operation contributes to the government's goals set in the Dominican Republic's 2010-2030 National Development Strategy and 2013-2016 Multiyear National Plan for the Public Sector (PNPSP), namely: (i) universalization of health insurance coverage; (ii) priority implementation of a prevention and primary care strategy emphasizing a family- and community-based health care model; (iii) reduction of maternal mortality to 50 per 100,000 live births; and (iv) reduction of infant mortality to 15 per 1,000 live births, as well as the crosscutting goal of more efficient, transparent, and results-based management. The operation also contributes to: (i) the expected outcome of the **Bank's country strategy with the Dominican Republic 2010-2013 (document GN-2581)** of "improved levels of nutrition, health, and education among children in the poorest families;" and (ii) two of the targets of the **Ninth General Capital Increase (document AB-2764)**: (a) support the development of small and vulnerable countries, and (b) reduce poverty and enhance equity. This operation also incorporates the recommendations of the country program evaluation conducted in 2010 by the IDB's Office of Evaluation and Oversight (OVE). In particular, it takes a programmatic approach aimed at supporting programs and providing sustained support for medium-term government initiatives.

[35] The stages of the PAPPS are: DR-L1039 (2176/OC-DR), DR-L1044 (2426/OC-DR), and DR-L1047 (2623/OC-DR). As of the time of preparation of this document, their respective levels of execution were 100%, 88.7%, and 53.8%. The health component of operation DR-L1053 seeks to raise the quality of health care services accessed by the poorest of the poor by closing the coverage gap in primary care in urban areas. Its level of execution is 34.6%.

[36] By project end, 60% of the country's UNAPs will be licensed.

B. Objectives, components, and cost

1.30 The general objective of the project will be to increase the efficiency and effectiveness of health expenditure for the Dominican Republic's most vulnerable population. The specific objectives are: (i) to improve the allocation of health expenditure through expansion of results-based financing (RBF), with special emphasis on the primary care level; (ii) to contribute to reducing maternal and child morbidity and mortality through expansion of a strategy for management improvements in secondary and tertiary health services; and (iii) to support the Ministry of Public Health and Social Assistance (MISPAS) in its sector stewardship through institution-strengthening and development of monitoring and evaluation instruments for decision-making.

1.31 **Component 1: Results-based financing of health services (US$130 million).** The objective is to expand the RBF model to five of the country's SRSs (I-V).[37] This component will finance: (i) the cost of capitated services at the primary care level for the uninsured population and the population affiliated with the subsidized system;[38] (ii) technical assistance in strengthening SRS capacity to implement and manage the RBF model; (iii) the supplies required for enrolling the population; (iv) concurrent audits for verification of RBF results; (v) technical assistance, hardware, and software for strengthening SENASA in expanding the RBF model; and (vi) the design of an RBF operating model with a consolidated budget within the SNS framework.[39]

1.32 **Component 2: Strengthening the quality of maternal and child health services (US$9.4 million).** The objective is to contribute to reducing maternal and infant morbidity and mortality by expanding the Maternal and Child Center of Excellence (CEMI) strategy. This component will finance consolidation of the model at six of the 10 public hospitals where it is being implemented, and expansion of the strategy to six new hospitals, so that all achieve CEMI certification.[40] It will also finance broadening of the model to include gender issues: (i) actions for humanization of childbirth, including the father's presence during labor, delivery, and postpartum; (ii) birth preparation classes, including talks on the importance of the father's involvement in caring for the baby; and (iii) advice during the postpartum period. Involvement of fathers in the pregnancy

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[37] SRSs VI-VIII are receiving World Bank financing. SRS 0 (National District, Santo Domingo, and Monte Plata) will implement RBF once MISPAS has completed the map of service offerings in that region and signed management agreements with the private providers and nongovernmental organizations that receive financing from MISPAS to provide coverage to the uninsured population. Operation DR-L1053 (2733/OC-DR) is providing support to MISPAS for these activities.

[38] The financing for services to the population affiliated with the subsidized system will decrease: 100% in 2013, 50% in 2014, 35% in 2015, 25% in 2016, and 10% in 2017. The SGC will be the reporting mechanism used for service delivery, which will encourage its use at the UNAPs.

[39] This will pilot the transformation of the historical budget into payments, enabling MISPAS to make a cash transfer to the SRSs based on RBF, rather than inputs and human resources.

[40] The public hospitals provide care at no cost.

and birth strengthens the father-child bond and promotes shared responsibility, contributing to the child's development, the couple's relationship, and gender equity in the division of work and responsibilities.[41] To meet the objective, financing will be provided under the component for technical assistance, equipment, and small adjustments to existing infrastructure enabling centers to comply with the standards of care and achieve CEMI certification.

1.33 **Component 3: Institution-strengthening for stewardship of the health sector (US$3.5 million).** The objective of this component is to support MISPAS in sector stewardship of the through institution-strengthening. The component will finance technical assistance for: (i) updating the territorial assignment of the population to UNAPs (sectorization); (ii) preparing the Ten-year Health Plan 2016-2025; (iii) updating the licensing standards and guidelines for health care facilities; (iv) establishing a performance monitoring and evaluation unit at MISPAS; (v) designing and implementing national legislation to standardize the functions of the health care information systems; (vi) developing and implementing a clinical/administrative management system for secondary and tertiary health care, linked to the SGC; (vii) analyzing the implications of repealing the medical internship law; (viii) reviewing the membership of health care teams and designing human resource incentive systems for working in remote geographical areas; (ix) analyzing the feasibility of implementing an electronic health care card linked to the SGC; and (x) strengthening the Directorate of Institutional Strategic Development (DDEI) of MISPAS, which is responsible for execution of this project.

1.34 **Component 4: Evaluation (US$50,000).** The objective of this component is to evaluate the impact of the RBF model on primary health care. Technical assistance will be financed to conduct a quasi-experimental analysis study of the model.

1.35 **Costs.** Table I-2 summarizes the breakdown of financing.

Table I-2: Table of costs

Component	US$ (OC)
1. Results-based financing of health services	130,000,000
2. Strengthening the quality of maternal and child health services	9,416,100
3. Institution-strengthening for stewardship of the health sector	3,533,900
4. Evaluation	50,000
5. Audits, administrative costs, and contingencies	3,000,000
Total	146,000,000

[41] See WHO's "Essential antenatal, perinatal and postpartum care: training modules," 2002, and Technical note on the Maternal and Child Center of Excellence model. Some of these activities have now been piloted by USAID in the Dominican Republic, with positive results.

C. Key results indicators

1.36 The expected impacts are greater access to health care services by the poor population and reductions in maternal and infant morbidity and mortality. Expected outcomes include: (i) a higher percentage of children between 15 and 24 months with a full immunization panel; (ii) a higher percentage of adults diagnosed with hypertension or diabetes in treatment in accordance with the national protocol, differentiated by gender; and (iii) a higher percentage of maternal deaths and incidents audited by the safe maternity committees, with at least one corrective measure implemented at the hospitals where CEMI will be implemented. A quasi-experimental impact assessment of expansion of the RBF model at the primary health care level will be conducted, for both management indicators and target population health indicators. The SGC, the concurrent audits, and the National Demographic and Health Surveys (ENDESA 2007 and 2013) will enable progress toward the targets set for the indicators to be measured.

II. FINANCING STRUCTURE AND RISKS

A. Financing instruments

2.1 The project will be financed through an investment loan that will begin execution in 2013. The project execution period is four years. The loan amount is US$146 million, drawn on the Bank's Ordinary Capital. The borrower is the Dominican Republic.

B. Environmental and social safeguard risks

2.2 The ESR classified the program as category "C," in accordance with the Environment and Social Safeguards Policy (Operational Policy OP-703). Since the project includes works for small internal adjustments to existing infrastructure for implementation of the Maternal and Child Center of Excellence (CEMI) strategy in hospitals, an environmental and social management plan will be prepared to prevent, control, and offset occupational health and safety risks and to manage hospital waste. The project's technical team will ensure compliance with Operational Policy OP-703.

C. Fiduciary risks

2.3 An institutional capacity assessment was done of the Directorate of Institutional Strategic Development (DDEI) of MISPAS, the executing agency for the operation, yielding a satisfactory level of institutional capacity and low risk. The assessment also revealed fiduciary risks in the procurement and financial management areas. In the first case, the main risk is potential delays in procurement execution. In the second case, the risks relate to the generation and delivery of accounting and financial reports with the timeliness and quality required by the Bank, specifically due to inexperience in use of the UEPEX/SIGEF financial module, which is mandatory in the Dominican Republic for the financial and accounting management of public projects with external

financing. This would create delays in submitting disbursement requests. These risks will be mitigated through: (i) training for the executing agency and the SRSs in procurement and financial management; and (ii) agreements with the Integrated Financial Management Program of the Ministry of Finance, so that, prior to project start, the UEPEX/SIGEF system is operational at the DDEI and the responsible personnel have been trained in its use.

D. Other risks

2.4 **Expansion of the RBF model.** Potential difficulties of coordination between MISPAS and the Executive Committee for the Health Sector Reform (CERSS), executing agency for RBF in the regions that have piloted the model, may limit the transfer to MISPAS of knowledge and experience for expansion of RBF to the regions included in the project. To mitigate this risk, MISPAS has included the CERSS in the preparation and planning missions for expanding the RBF model and will include the lessons learned by the CERSS in the operation's Operations Manual (OM).

2.5 **Insufficient institutional capacity of hospitals to achieve CEMI certification.** This risk may generate delays in execution. However, the strategy itself provides for close technical supervision of execution, and the lessons learned by USAID in implementing CEMI will be incorporated in the OM. Furthermore, MISPAS, by ministerial order, has adopted the CEMI strategy as the model to ensure the quality of the services provided.

2.6 **Macroeconomic.** Limitations of physical space and budgetary reductions during program execution may lead to execution delays. The project is considered a priority for the Dominican Republic and has the full backing of the Ministry of Finance. During program execution, MISPAS will take the steps necessary to ensure an effective resource flow in keeping with the programming included in the project's multiyear evaluation plan (PEP). This will ensure that execution of the operation and the respective disbursements by the Bank are not interrupted.

2.7 **Sustainability of RBF.** There is a risk that the government will not continue RBF after the end of this operation. The aim of RBF is to improve the efficiency of National Health Insurance (SENASA) and MISPAS expenditure, achieving better health outcomes for each investment made, mainly in primary health care. In particular, this operation directs the financing of contributions to services towards attainment of several of the health care targets of the Multiyear National Plan for the Public Sector (PNPSP). It also: (i) is consistent with the objectives of the Dominican Republic's National Development Strategy 2010-2030, a law establishing a consensus-based long-term vision for the country; and (ii) is one of a group of protected programs established in the 2013-2016 PNPSP, which ensures its financing and sustainability in the medium term. Additionally, the proposed benefit system provides for decreasing financing levels for the subsidized system population over time; the uninsured population that is eligible under the subsided system will be channeled to SENASA for incorporation in

subsidized insurance in keeping with the government's insurance expansion targets.

III. EXECUTION AND ACTION PLAN

A. Summary of implementation arrangements

3.1 **Execution framework.** The executing agency for the operation is the Borrower through the Ministry of Public Health (MISPAS) and its Directorate of Institutional Strategic Development (DDEI). This office has responsibility for executing projects with multilateral organization financing. The DDEI is now executing two components of an investment operation with the World Bank. For project execution, the DDEI will have support from a project coordination unit (PCU), to be responsible for procurement and payments. A coordinator and financial and administrative procurement specialists, as well as other necessary technical and other specialists, will be hired to support the DDEI in project execution. At project end, the PCU's tasks will be assumed by DDEI staff.

3.2 **Procurement.** Goods, services, and consulting services will be procured in accordance with the IDB policies in this area. Procurement will be subject to ex post review for: (i) works whose estimated cost is under US$3 million; (ii) goods whose estimated cost is under US$250,000; and (iii) consulting services whose estimated cost is under US$200,000. Project resources will be used to finance the direct contracting, pursuant to the single-source selection policy (document GN-2350-9), of: (i) personnel trained in the CEMI model, hired to provide technical assistance to hospitals to continue providing services they now provide (see paragraph 5.4(a)); (ii) a firm to perform the concurrent audits to verify fulfillment of the RBF results indicators, since the new services are a natural extension of services now provided by the firm (see paragraph 3.10(a)); and (iii) services to improve the health care system management system software for secondary and tertiary level hospitals, which MISPAS has already acquired. The rationale is the exceptional value of the firm selected, since the same company participated in the initial development of the software (see paragraph 3.10(a)).

3.3 **Contractual conditions. The special conditions precedent to the first disbursement are as follows: (i) creation of the project coordination unit (PCU) and appointment of a general coordinator; (ii) entry into force of the program Operations Manual (OM) with the Bank's prior no objection; and (iii) entry into force of the amendments to the management agreements incorporating RBF between MISPAS and the National Health Insurance (SENASA), and each of the five Regional Health Services (SRS) that will participate in project execution.** The special contractual obligations are: (i) A statement will be obtained from the Bank that it has no objection to any change or update to the program OM; and (ii) contracting of a concurrent audit engagement. This audit will examine evidence to validate compliance, as established the project Operations Manual, of: (i) the population enrolled with the UNAP; and

(ii) the four-monthly targets to be agreed upon between the executing agency and the Bank.

3.4 **Disbursements**. The project disbursement period is 48 months. Component I resources will be used to recognize costs incurred, apart from the first disbursement, which will be disbursed as an advance for the strengthening of the technical and administrative capacities of the SRS to implement and manage the RBF model. The Bank may recognize costs of contributions to health care services under the subsidized system, up to a maximum of 20% the loan resources, incurred by the Borrower prior to the loan approval date, provided requirements substantially similar to those established in the loan contract have been met. These costs must have been incurred since the date of approval of the project profile, 15 May 2013, but in no case will include costs incurred more than 18 months prior to the loan approval date. The costs of the concurrent audits will be financed with the proceeds of this loan. The disbursements for the other components will be made as advances in accordance with the programming of the agreed activities.

B. Summary of arrangements for monitoring results

3.5 **Monitoring and evaluation.** The project coordination unit (PCU) will have responsibility for implementing the project Monitoring and Evaluation Plan. By agreement with the Borrower, the referent for the monitoring and evaluation measures will be the Results Matrix. The main monitoring mechanisms established are: (i) the six-monthly reports detailing the status of physical and financial execution; (ii) the concurrent audits associated with Component I; (iii) the multiyear execution plan and annual work plan; (iv) the procurement plan; (v) the Clinical/Administrative Management System (SGC) and Hospital Management System (SIGHO).[42] The evaluation agenda is consistent with the objectives of the operation's Component 1 and is aimed at evaluating the impact of expanding the RBF model within the health sector.

[42] The SGC will be the sector information source on primary health care services, and the SIGHO will be the information source for secondary and tertiary level services.

Development Effectiveness Matrix			
Summary			
I. Strategic Alignment			
1. IDB Strategic Development Objectives	**Aligned**		
Lending Program	**i) Lending to small and vulnerable countries, and ii) Lending for poverty reduction and equity enhancement.**		
Regional Development Goals	**i) Extreme poverty rate, ii) Maternal mortality ratio, and iii) Infant mortality ratio.**		
Bank Output Contribution (as defined in Results Framework of IDB-9)	**Individuals (all) receiving a basic package of health services.**		
2. Country Strategy Development Objectives	**Aligned**		
Country Strategy Results Matrix	**GN-2581**	**Improved levels of nutrition, health, and education among children in the poorest families.**	
Country Program Results Matrix	**GN-2696**	**The intervention is not included in the 2013 Country Program Document.**	
Relevance of this project to country development challenges (If not aligned to country strategy or country program)			
II. Development Outcomes - Evaluability	**Highly Evaluable**	**Weight**	**Maximum Score**
	9.3		**10**
3. Evidence-based Assessment & Solution	**9.7**	**33.33%**	**10**
4. Ex ante Economic Analysis	**10.0**	**33.33%**	**10**
5. Monitoring and Evaluation	**8.2**	**33.33%**	**10**
III. Risks & Mitigation Monitoring Matrix			
Overall risks rate = magnitude of risks*likelihood	**Medium**		
Identified risks have been rated for magnitude and likelihood	**Yes**		
Mitigation measures have been identified for major risks	**Yes**		
Mitigation measures have indicators for tracking their implementation	**Yes**		
Environmental & social risk classification	**C**		
IV. IDB´s Role - Additionality			
The project relies on the use of country systems (VPC/PDP criteria)	**Yes**	**Financial Management: i) Budget, ii) Treasury, and iii) Accounting and Reporting. Procurement: i) Information System.**	
The project uses another country system different from the ones above for implementing the program			
The IDB's involvement promotes improvements of the intended beneficiaries and/or public sector entity in the following dimensions:			
Gender Equality	**Yes**	**The project's second component, which aims to strengthen the quality of maternal and child health services, will expand existing models as to include gender aspects related to the involvement of the father during pregnancy and delivery.**	
Labor			
Environment			
Additional (to project preparation) technical assistance was provided to the public sector entity prior to approval to increase the likelihood of success of the project	**Yes**	**Through technical cooperation DR-T1077, the Bank has financed support for the reengineering of processes related to the stewardship function of the health system (Ministry of Health), such as improvements in management agreements and assessments of the Basic Health Care Plan.**	
The ex-post impact evaluation of the project will produce evidence to close knowledge gaps in the sector that were identified in the project document and/or in the evaluation plan	**Yes**	**RBF is a new approach to financing the provision of health care and an insufficient number of studies have been conducted so far to assess the effectiveness of this mechanism. The impact evaluation that will be conducted at the end of the project is going to contribute with the generation of knowledge on RBF schemes in health.**	

The operation is an investment loan to the Dominican Republic for US$146 million, to be financed by the Bank's ordinary capital. The objective of the project is to increase the efficiency and effectiveness of health expenditures targeted to the poorest population in the country, through the expansion of a results based financing model and a strategy of managerial improvements in the maternal and child health services.

The loan proposal presents an adequate diagnosis that identifies the challenges faced by the country in terms of chronic diseases and maternal and child health, based on empirical evidence. The proposal identifies and documents the causal factors associated with this problem, including topics like the efficiency in the assignment of expenditures, the quality of the services offered and the levels of accountability and transparency. The document also presents empirical evidence on the effectiveness of the proposed models, using the experience of the Dominican Republic itself, as well as of other countries in the region.

The proposal follows a solid vertical logic, as reflected in a results matrix with well-defined impacts, outcomes and outputs, and SMART indicators to measure them. Monitoring and evaluation mechanisms have been adequately planned and budgeted. The project's evaluation plan contemplates a quasi-experimental design to measure the effectiveness of the results based financing model. The project's economic analysis consists of a cost effectiveness analysis of the results based financing model.

The risk matrix identifies and rates the project's risks, and proposes mitigation measures with indicators to measure their implementation.

RESULTS MATRIX –MATRIX OF INDICATORS	
PROJECT OBJECTIVE	To increase the efficiency and effectiveness of health expenditure for the Dominican Republic's most vulnerable population.
EXPECTED IMPACT	Improved access by the poor population to health services and reduced maternal and infant morbidity and mortality rates.

RESULTS INDICATORS	Baseline	Year 1 2014	Year 2 2015	Year 3 2016	Year 4 2017	Target at project end[1]	Reporting frequency	Data compilation instrument	Parties in charge/Observations
Size of the poor population Master Beneficiary System (SIUBEN) categories I and II in the five project health care regions **not covered by any system** guaranteed access to primary care services with results-based financing (RBF).[2]	0	14,405	72,025	158,455	288,100	288,100	Three times a year	Concurrent audit reports	External auditing firm / Directorate of Institutional Strategic Development (DDEI)
Maternal mortality rates in the six hospitals[3] where the Maternal and Child Center of Excellence (CEMI) model will be implemented (expresses the number of expectant mothers who die in a given period as a percentage of the total number of expectant mothers reported on that date).[4]	To be estimated in project year 1	2% reduction	8% reduction	18% reduction	30% reduction	30% reduction in maternal mortality rates in CEMI hospitals	Annual	Form EPI-2 / Hospital Management System (SIGHO) reports	General Office of Epidemiology and DDEI and General Mother-Child and Adolescent Office (DIGEMIA)

1 The targets for the indicators without RBF-related baselines were determined based on the experience of the Regional Health Services (SRS) where the model is now in operation. The targets for the indicators without CEMI-related baselines were determined based on the experience of the certified hospitals.

2 The five project regions are Regional Health Services I to V.

3 The six hospitals where the CEMI model will be implemented for the first time.

4 Numerator: number of maternal deaths from pregnancy, birth, or postpartum complications each year in the six hospitals where the Center of Excellence model will be implemented. Denominator: total number of expectant mothers in the same period. This indicator is interpreted based on the value obtained in computing the formula. Therefore, a minimum value of this indicator denotes improvement in the living conditions of expectant mother. Likewise, if results approaching 100 are obtained, these are critical, since they indicate deterioration in the living conditions of expectant mothers, and a marked decline in their life expectancies.

RESULTS INDICATORS	Baseline	Year 1 2014	Year 2 2015	Year 3 2016	Year 4 2017	Target at project end[1]	Reporting frequency	Data compilation instrument	Parties in charge/Observations
Infant mortality rates in the hospitals where CEMIs will be implemented.	To be estimated in project year 1 [5]	2% reduction	8% reduction	18% reduction	30% reduction	30% reduction in infant mortality rates in CEMI hospitals	Annual	Form EPI-2 / SIGHO reports	General Office of Epidemiology and DDEI

COMPONENT I: Results-based financing of health services									
	Base 2013	Year 1 2014	Year 2 2015	Year 3 2016	Year 4 2017	Cumulative target	Reporting frequency	Data compilation instrument	Parties in charge/Observations
Output indicators									
1. Higher percentage of the poor population (SIUBEN 1 and 2) in the five project regions assigned to a primary care center.	1,074,435	1,174,405	1,232,025	1,318,455	1,448,100	1,448,100	Three times a year	Completed family file reports	Regional Health Offices and DDEI
2. Higher percentage of poor population (SIUBEN 1 and 2) in the five project regions enrolled in a system whose primary care has RBF.	0	14,405	72,025	158,455	288,100	288,100	Three times a year	Completed family file reports / Concurrent audit reports	Regional Health Offices and DDEI
3. Higher percentage of poor population (SIUBEN 1 and 2) in the five project regions enrolled in the subsidized system whose per capita care has RBF.	1,074,435	1,160,000	1,160,000	1,160,000	1,160,000	1,160,000	Three times a year	Reports based on the UNIPAGO dispersion database	National Health Insurance (SENASA) and DDEI

[5] Numerator: number of deaths each year among children under age 1 in the six Center of Excellence hospitals. Denominator: total number of live births in the same period in the six CEMI hospitals.

COMPONENT I: Results-based financing of health services									
	Base 2013	**Year 1 2014**	**Year 2 2015**	**Year 3 2016**	**Year 4 2017**	**Cumulative target**	**Reporting frequency**	**Data compilation instrument**	**Parties in charge/Observations**
Interim results indicators									
1. Higher percentage of expectant mothers in the five project regions evaluated for pregnancy risk factors prior to the 15th week of pregnancy.[6]	To be estimated in project year 1[7]	5%	15%	30%	50%	50%	Three times a year	Primary health care reports of the Clinical/Administrative Management System (SGC)	DDEI
2. Higher percentage of women in the five project regions who have just given birth referred by the hospital to their primary care unit with adequate documentation contained in the health care center's clinical files.[8]	To be estimated in project year 1[9]	10%	20%	40%	60%	60%	Three times a year	SGC primary health care reports	DDEI
3. Higher percentage of children over 15 months in the five project regions with a full immunization panel in accordance with the national protocol.[10]	To be estimated in project year 1	10%	20%	40%	60%	60%	Three times a year	SGC primary health care reports	DDEI
4. Higher percentage of children between 15 and 24 months in the five project regions with a full immunization panel in accordance with national protocol[11].	To be estimated in project year 1	10%	20%	40%	60%	60%	Three times a year	SGC primary health care reports	DDEI

[6] Numerator: Number of expectant mothers in the target population who, in the four month period, have to a risk evaluation prior to the 15th week of pregnancy; Denominator: Estimated number of expectant mothers in the target population for the corresponding four month period.

[7] The baseline and follow-up values are originated in the Primary Care Unit (UNAP) as a result of health care actions being implemented in the target population served, and entered in the Hospital Management System These will be defined in project phase 1 by the Ministry of Public Health (MISPAS) in conjunction with the SRS, SENASA, and the Executive Committee for the Health Sector Reform (CERSS).

[8] Numerator: Number of postpartum mothers in the program target population for whom a consultation is recorded during the four-month period that meet the following conditions: (1) the consultation is made by 15 days from the birth. The counter-referral documentation (summary case history) is available in the primary care clinical files; Denominator: Estimated number of births to mothers in the program target population during the year.

[9] The baseline and follow-up values are originated in the UNAP as a result of health care actions being carried out in the target population served by the UNAPs that is entered in the Hospital Management System These will be defined in project phase 1 by MISPAS in conjunction with the SRS, SENASA, and CERSS.

[10] Numerator: Number of children under 15 months in the target population with a full immunization panel in accordance with the national protocol for their age. Denominator: Estimated number of children under age 15 months in the target population on the last day of the four-month period.

[11] Numerator: Number of member children over 15 months and under 24 months of age in the target population in the four month period with a full immunization

COMPONENT I: Results-based financing of health services									
	Base 2013	**Year 1 2014**	**Year 2 2015**	**Year 3 2016**	**Year 4 2017**	**Cumulative target**	**Reporting frequency**	**Data compilation instrument**	**Parties in charge/Observations**
5. Higher percentage of children under 24 months in the five project regions with full development and growth checks in accordance with the national protocol.[12]	To be estimated in project year 1	10%	20%	40%	60%	60%	Three times a year	SGC primary health care reports	DDEI
6. Higher percentage of respiratory symptomatic individuals in the five project regions identified with bacillosopy results documented in a primary care center.[13]	To be estimated in project year 1	5%	10%	30%	50%	50%	Three times a year	SGC primary health care reports	DDEI
7.1 Higher percentage of men over age 18 in the five project regions screened for hypertension in accordance with the national protocol.[14]	To be estimated in project year 1	5%	10%	30%	50%	50%	Three times a year	SGC primary health care reports	DDEI
7.2 Higher percentage of women over age 18 in the five project regions screened for hypertension in accordance with the national protocol.	To be estimated in project year 1	5%	10%	30%	50%	50%	Three times a year	SGC primary health care reports	DDEI
8.1 Higher percentage of men in the five project regions diagnosed with hypertension in treatment in accordance with the national protocol.[15]	To be estimated in project year 1	5%	10%	30%	50%	50%	Three times a year	SGC primary health care reports	DDEI

panel in accordance with the national protocol for their age; Denominator: Estimated number of children over 15 months and under 24 months of age in the target population on the last day of the four month period.

[12] Numerator: Number of children under 24 months of age in the target population who have received all check-ups in accordance with the national protocol. Denominator: Estimated number of children under age 24 months in the target population on the last day of the four month period.

[13] Numerator: Number of respiratory symptomatic individuals in the target population identified in the four month period with bacillosopy results documented in a primary care center. Denominator: Estimated number of respiratory symptomatic individuals in the target population for the four month period in question.

[14] Numerator: Number of men over age 18 in the target population whose blood pressure was taken in the four month period. Denominator: Estimated number of men over age 18 in the relevant target population in the four month period.

[15] Numerator: Number of hypertensive men in the target population whose are in treatment in accordance with the national protocol; Denominator: Estimate number of hypertensive men over age 18 in the target population for the year in question.

COMPONENT I: Results-based financing of health services									
	Base 2013	**Year 1 2014**	**Year 2 2015**	**Year 3 2016**	**Year 4 2017**	**Cumulative target**	**Reporting frequency**	**Data compilation instrument**	**Parties in charge/Observations**
8.2 Higher percentage of women in the five project regions diagnosed with hypertension and in treatment in accordance with the national protocol.	To be estimated in project year 1	5%	10%	30%	50%	50%	Three times a year	SGC primary health care reports	DDEI
9.1 Higher percentage of men over age 18 in the five project regions screened for diabetes in accordance with the national protocol.[16]	To be estimated in project year 1	5%	10%	30%	50%	50%	Three times a year	SGC primary health care reports	DDEI
9.2 Higher percentage of women over age 18 in the five project regions screened for diabetes in accordance with the national protocol.	To be estimated in project year 1	5%	10%	30%	50%	50%	Three times a year	SGC primary health care reports	DDEI
10.1 Higher percentage of men in the five project regions diagnosed with Type II diabetes and in treatment in accordance with the national protocol.[17]	To be estimated in project year 1	5%	10%	30%	50%	50%	Three times a year	SGC primary health care reports	DDEI
10.2 Higher percentage of women in the five project regions diagnosed with Type II diabetes and in treatment in accordance with the national protocol.	To be estimated in project year 1	5%	10%	30%	50%	50%	Three times a year	SGC primary health care reports	DDEI
11. Higher percentage of SIUBEN I and II population in the five project regions who are subsidized system members with membership cards.[18]	To be estimated in project year 1	10%	30%	50%	80%	80%	Three times a year	Reports of firm engaged to prepare and provide identity documents / Concurrent audit reports	SENASA

[16] Numerator: Number of men over age 18 in the target populations screened for diabetes in the four-month period. Denominator: Estimated number of men over age 18 in the target population for the relevant four-month period.

[17] Numerator: Number of men over age 18 in the target population diagnosed with Type II diabetes and in treatment in accordance with the national protocol. Denominator: Estimated number of men over age 18 in the target population with Type II diabetes for the year in question.

[18] Numerator: Number of SIUBEN I and II individuals indicated by the concurrent audit reports to have subsidized system membership cards. Denominator: Total number of subsidized system members.

COMPONENT I: Results-based financing of health services									
	Base 2013	**Year 1 2014**	**Year 2 2015**	**Year 3 2016**	**Year 4 2017**	**Cumulative target**	**Reporting frequency**	**Data compilation instrument**	**Parties in charge/Observations**
12. Higher number of dependents in the five project regions who are subsidized system members with birth certificate information in the SENASA member database.	To be estimated in project year 1	20,000	50,000	80,000	120,000	120,000	Three times a year	SENASA database report	SENASA

COMPONENT II: Strengthening the quality of maternal and child health services									
	Base 2013	**Year 1 2014**	**Year 2 2015**	**Year 3 2016**	**Year 4 2017**	**Cumulative target**	**Reporting frequency**	**Data compilation instrument**	**Parties in charge/Observations**
Output indicators									
1. More hospitals certified as Maternal and Child Centers of Excellence (CEMIs).	0	0	0	5	10	10	Annual	Evaluation reports prepared by the General Office for Authorization	Office of Hospitals / General Office for Authorization/ DDEI/ Deputy Ministry of Quality Assurance
2. Training provided for medical, nursing, and administrative personnel of hospitals where CEMIs will be implemented in SIGHO.	0	0	200	400	750	750	Annual	Lists of participants in the training sessions and participate certificate issued by the DDI upon course completion	Office of Hospitals / DDEI
3. Training provided through emergency obstetric care programs for health personnel of hospitals where CEMIs will be implemented.	0	100	200	---	---	200	Annual	Lists of participants in the training sessions and participate certificate issued by the DDI upon course completion	Office of Hospitals / DDEI
4. Training to prevent neonatal sepsis provided for perinatal health personnel in hospitals where CEMIs will be implemented.	0	50	150	---	---	150	Annual	Lists of participants in the training sessions and participate certificate issued by the DDI upon course completion	Office of Hospitals / DDEI

COMPONENT II: Strengthening the quality of maternal and child health services									
	Base 2013	**Year 1 2014**	**Year 2 2015**	**Year 3 2016**	**Year 4 2017**	**Cumulative target**	**Reporting frequency**	**Data compilation instrument**	**Parties in charge/Observations**
5. Training provided for expectant mothers in birth preparation classes in hospitals where CEMIs will be implemented.[19]	To be estimated in project year 1	20%	50%	75%	90%	90%	Annual	Lists of participants in birth readiness classes / Prenatal care records of each center.	Office of Hospitals / DDEI
Interim results indicators									
1. SIGHO implemented and in operation in the hospitals where CEMIs will be implemented.	0	0	3	6	12	12	Annual	Annual evaluation reports issued by the Office of Information Technology of the Ministry of Public Health	Office of Hospitals / DDEI.
2. Percentage of maternal deaths and incidents audited by the safe maternity committees with at least one corrective measure implemented at the hospitals where CEMIs will be implemented.[20]	0%	0%	30%	60%	95%	95% of cases	Annual	Minutes of the meetings of the Committee (minutes signed by all Committee members specifying the cases discussed and corrective measures to be taken)	Safe maternity committee / Office of Hospitals / DDEI
3. Percentage of neonatal deaths and incidents audited by the safe maternity committees with at least one corrective measure implemented in the hospitals where CEMIs will be implemented.[21]	0%	0%	30%	60%	95%	95%	Annual	Minutes of the meetings of the Committee (minutes signed by all Committee members specifying the cases discussed and corrective measures taken)	Safe maternity committee / Office of Hospitals / DDEI

[19] Numerator: the number of expectant mothers who have participated in birth preparation classes. Denominator: the total number expectant mothers who received prenatal care in the center.

[20] Numerator: the number of cases of maternal morbidity/mortality audited by each hospital's committee, with at least one corrective action applied. Denominator: the total number of cases of maternal morbidity/mortality in each hospital.

[21] Numerator: the number of cases of neonatal morbidity and mortality with corrective measures applied audited by each hospital's committee. Denominator: the total number of cases of neonatal morbidity and mortality in each hospital.

COMPONENT II: Strengthening the quality of maternal and child health services									
	Base 2013	**Year 1 2014**	**Year 2 2015**	**Year 3 2016**	**Year 4 2017**	**Cumulative target**	**Reporting frequency**	**Data compilation instrument**	**Parties in charge/Observations**
4. Higher percentage of women receiving active care during third stage of the birth in hospitals where CEMIs will be implemented.[22]	To be estimated in project year 1	10%	25%	60%	90%	90%	Annual	Birth reports obtained at the first stage of physical registration of each patient. When SIGHO has been implemented, these reports can be obtained through it.	Office of Hospitals / DDEI

COMPONENT III: Institution-strengthening for stewardship of the health sector									
Output indicators	**Base 2013**	**Year 1 2014**	**Year 2 2015**	**Year 3 2016**	**Year 4 2017**	**Cumulative target**	**Reporting frequency**	**Data compilation instrument**	**Parties in charge/Observations**
1. Ten-Year Health Plan 2016-2025 completed.	N/A	0	1	0	0	1	Annual	Consultancy report	DDEI
2. MISPAS unit for analysis of performance monitoring and evaluation in operation.	Not yet created	1	0	0	0	1	Annual	Ministerial resolution creating the Unit; Unit Operations Manual and data evaluation reports.	DDEI
3. National standards and authorization guidelines updated.	Authorization standards and guidelines for 2005	0	1	0	0	1	Annual	Ministerial resolution establishing the updated authorization standards	Deputy Ministry of Quality Assurance
4. National rules for standardization of the functions of the health information systems prepared.	0	0	0	1	0	1	Annual	Ministerial resolution instituting the rules	DDEI / Office of Information Technology
5. Hospital management systems for secondary and tertiary level care developed.[23]	0	0	0	1	1	1	Annual	Annual evaluation reports issued by the Office of Information Technology of the Ministry of Public	DDEI / Office of Information Technology

[22] Numerator: is the number of women who received active care during the third stage of birth by a trained provider. Active treatment is: (a) administration of a uterotonic within one minute of the birth; (b) expulsion of the placenta by controlled umbilical cord traction; and (c) fundal massage following expulsion of the placenta. Denominator: the total number of births in the same reference period.

[23] Numerator: number of modules developed and implemented. Denominator: Total number of modules to comprise the system, depending on its design.

COMPONENT III: Institution-strengthening for stewardship of the health sector									
Output indicators	**Base 2013**	**Year 1 2014**	**Year 2 2015**	**Year 3 2016**	**Year 4 2017**	**Cumulative target**	**Reporting frequency**	**Data compilation instrument**	**Parties in charge/Observations**
								Health	
6. Hospital management systems for secondary and tertiary level care installed in CEMI hospitals.[24]	0	0	0	0	1	1	Annual	Annual evaluation reports issued by the Office of Information Technology of MISPAS	DDEI / Office of Information Technology
7. Analytical study completed on the implications of repealing the law on medical internships.	N/A	0	1	0	0	1	Annual	Consultancy report	DDEI
8. Analytical study completed of systems of incentives for health personnel to work in remote areas.	N/A	0	0	1	0	1	Annual	Consultancy report	DDEI
9. Analytical study completed of the feasibility of implementing an electronic health card linked to SIGHO.	N/A	0	1	1	1	1	---	Consultancy report	DDEI

COMPONENT IV: Knowledge generation and evaluation									
Output indicators	**Base 2013**	**Year 1 2014**	**Year 2 2015**	**Year 3 2016**	**Year 4 2017**	**Cumulative target**	**Reporting frequency**	**Data compilation instrument**	**Parties in charge/Observations**
Quasi-experimental analytical evaluation study of the expansion of the RBF model.	0	0	1	1	1	1	---	Consultancy report	DDEI

[24] Numerator: number of modules developed and implemented. Denominator: Total number of modules to comprise the system, depending on its design.

FIDUCIARY AGREEMENTS AND REQUIREMENTS

Country:	Dominican Republic
Project number:	DR-L1067
Name:	Strengthening Results-based Management in the Dominican Republic's Health Sector
Executing agency:	Ministry of Public Health and Social Assistance (MISPAS)
Prepared by:	Vinicio Rodríguez (Financial Management) and Willy Bendix (Procurement), both FMP/CDR

I. EXECUTIVE SUMMARY

1.1 The institutional capacity assessment of MISPAS was performed utilizing the components Institutional Capacity Assessment System (ICAS) tool, which includes: (i) planning and organizational capacity (activity planning system and administrative organization system); (ii) execution capacity (personnel management system, goods and services management system, and financial management system); (iii) control capacity (internal and external control systems); and (iv) procurement system. As part of the analysis, information was compiled on the strengths and weaknesses of the National Health Insurance (SENASA), and the 2010 and 2011 public expenditure and financial accountability (PEFA) evaluations prepared. The Project Coordination Unit (PCU) will utilize the UEPEX, a subsystem of the Financial Management Information System (SIGEF), developed for financial and accounting management of externally financed public projects. The country's internal and external control systems are now being strengthened. As regards public contracting, the Bank has provided technical assistance and supervision for the OECD Methodology for Assessing Procurement Systems (MAPS) assessment prepared. Its findings make evident that the system has strengths, such as the structure of its legal framework, but that challenges exist that will gradually be overcome until a level of development consistent with international standards is achieved so that SIGEF can be utilized in Bank operations.[1]

II. FIDUCIARY CONTEXT OF THE EXECUTING AGENCY

2.1 The Bank's most recent direct experience in the health sector in the Dominican Republic was the Health Sector Modernization and Restructuring (loan 1047/OC-DR), executed through the Executive Committee for Health Sector

[1] An a prior determination has been made of the need to amend the Regulations to the Procurement Act in force; develop and implement the Public Procurement Transactions Portal; build capacities of public officials tasked with procurement management; and improve control mechanisms.

Reform]. In that context, this is the first time that the Ministry of Public Health (MISPAS) will serve as executing agency in an operation with the Bank. To that end, a Project Coordination Unit (PCU) will be created in the Directorate of Institutional Strategic Development (DDEI). The DDEI is the MISPAS office tasked with executing externally-financed projects and is now executing two components of an investment operation with the World Bank. The PCU in MISPAS will be accountable to the Bank for the financial management of all components, and for procurement and payments at the request of the DDEI. Although the PCU does not have experience of executing programs financed by the Bank, it has prior experience of executing a World Bank loan, which will facilitate and flatten the learning curve in executing this operation. Nonetheless, a strengthening process is proposed for the fiduciary areas through the engagement of additional personnel. This will enable knowledge acquired to be preserved and balance to be struck in the workload to manage the IDB and the World Bank operations.

III. ASSESSMENT OF FIDUCIARY RISK AND ACTIONS TO OFFSET IT

3.1 The Institutional Capacity Assessment[2] of the operation with the Bank indicated that although the Directorate of Institutional Strategic Development (DDEI), to be the Project Coordination Unit (PCU), does not have prior experience of operations with the Bank, its level of institutional capacity is satisfactory, and it was assigned a low risk rating. That analysis also indicated fiduciary risks and opportunities for improvement in the procurement and financial management areas. In the first case, the main risk is potential delay in or the impossibility of carrying out procurement operations. As regards financial management, the observed risks pertain to the generation and submission of accounting and financial reports after the required time, and not of the required quality, owing to lack of knowledge and experience of handling and using the UEPEX/SIGEF financial module, whose use is required in the financial and accounting management of externally-financed public projects. Delays may potentially ensue in submitting disbursement requests, with impact on execution of the operation.

3.2 The above-described risks will be mitigated by concluding agreements with the Integrated Financial Management Program of the Ministry of Public Finance so that, prior to project launch, proper operation of the UEPEX/SIGEF system is verified and training and support provided to the personnel tasked with its use. The procurement and financial management capacities of the executing agency and the Regional Health Units (SRS) will be strengthened, and appropriate personnel responsible for the two areas selected.

[2] See the institutional capacity assessments of the Ministry of Public Health (MISPAS) and the National Health Insurance (SENASA).

IV. ASPECTS FOR CONSIDERATION IN THE SPECIAL CONTRACTUAL CONDITIONS

4.1 To expedite contract negotiations by the project team and, primarily, the Legal Department (LEG), provided below are those agreements and requirements to be included in the special conditions:

a. **Conditions precedent to the first disbursement:** (i) Creation of the PCU and designation of the General Coordinator; (ii) the entry into force of the PCU's Operations Manual on terms satisfactory to the Bank; and (iii) the entry into force of the modifications to the management agreements to incorporate results-based financing concluded between the Ministry of Public Health (MISPAS) and National Health Insurance (SENASA) and each of the five health regions participating in the project.

b. **Exchange rate agreed with the executing agency for accountability purposes.** The exchange rate to be used will be the effective U.S. dollar/local currency rate at the time of conversion of the resources disbursed by the Bank. (Article 4.09 (a) (1).

c. **Audited financial reports:** Submission of: (i) the executing agency's audited annual financial reports by 120 days following the close of each fiscal year during the original disbursement period (36 months), or of any agreed extension, as well as the project's financial reports, duly audited by an independent auditing firm acceptable to the Bank. The final financial report will be submitted by 120 days from the date stipulated for the last disbursement; and (ii) submission of audited financial reports during the original disbursement period by 60 days after June 30, for the period January 1 to June 30, by the same firm that will audit these reports at the close of each fiscal year. The annual external audit contract includes financing for the interim reports so that additional financing is not required.

V. AGREEMENTS AND REQUIREMENTS FOR EXECUTING PROCUREMENT OPERATIONS

5.1 The Procurement and Fiduciary Requirement Agreements contain provisions applicable to all project procurements.

1. **Procurement operations. The Directorate of Institutional Strategic Development (DDEI), with support from a Project Coordination Unit (PCU), will have responsibility for program procurement selection, bidding, hiring, supervision, and receiving processes.**

a. **Procurement of works, goods, and services other than consulting.** Contracts generated under the project for works, goods, and consulting services procured through International Competitive Bidding (ICB) will be executed utilizing the standard bidding documents (SBDs) issued by the Bank. National Competitive Bidding (NCB) processes will be implemented using project bidding documents. The Sector Specialist/Team Leader will have

responsibility for reviewing procurement technical specifications during the preparation of the selection process.

b. **Selection and hiring of consultants.** Contracts for consulting services generated under the project will be implemented utilizing standard bidding documents (SBDs) issued by or agreed with the Bank. The Sector Specialists/Team Leader will have responsibility for reviewing the terms of reference for procuring consulting services. Selection of individual consultants: At the discretion of the executing agency, international or national announcements of bidding processes to hire individual consultants may be issued to draw up a shortlist of qualified individuals. Training: The training procedures identified will be conducted by individual consultants or consulting firms hired for that purpose, in accordance with the operation's consultant procurement policies and procedures.

c. **Shopping.** The shopping process will be financed from loan resources to engage: (i) Maternal and Child Centers of Excellence (CEMIs) personnel to continue to provide services they now provide; (ii) the firm to be responsible for the concurrent audits to verify fulfillment of the results monitoring indicators defined for the results-based financing (RBF) model, since the new services are a natural extension of services now performed by the firm; and (iii) services to improve the health care system management software for secondary and tertiary level hospitals, which MISPAS has already procured. The rationale for this is the selected firm's exceptionally valuable experience of developing this hospital management software, since it participated in its initial development.

d. **Recurring costs.** Running and maintenance costs incurred for project operation during execution, to be financed by the project under the procurement plan and executed in accordance with procedures agreed with the Bank. Recurring costs also include the costs of consultants hired to assist the PCU during the execution period. Operating costs do not include salaries of public officials or other ordinary running costs of the Social Policy Coordination Council (GCPS), which are to be accorded priority in the entity's institutional budget during program execution.

e. **Early procurement/cost recognition.** The Bank may recognize contributions to health care under the subsidized system, up to a maximum of 20% of the loan resources, incurred by the Ministry of Public Health (MISPAS) prior to the loan approval date, provided requirements substantially similar to those established in the loan contract have been fulfilled. These costs must have been incurred after May 15, 2013, but in no case will include costs incurred more than 18 months prior to the loan approval date.

2. Table of threshold amounts (US$1000s)

Works	Goods	Consulting services	
International Competitive Bidding	International Competitive Bidding	International Consulting Assignment Announcements	Short list 100% national
> US$3,000	> Over US$250	≥ US$200	< US$200

3. **Main procurements.** The main procurement operations envisaged in this operation are described below.

Activity	Type of bidding process	Estimated date	Estimated amount (US$000s)
Goods			
Hardware for implementing the Hospital Management System (SIGHO) at 6 hospitals.	ICB	QI 2015	1,500
LAN network cable at 6 hospitals	ICB	QIII 2015	600
Physical modifications at 6 hospitals in some areas	ICB	QIII 2015	1,200
Concurrent audits to verify fulfillment of monitoring and results indicators	Shopping	QIII 2013	2,500
Adjustments to SIGHO modules and development of new modules	ICB	QII 2015	800
Development and implementation of the Hospital Management System	ICB	QI 2015	3,000
Adjustments, furniture, and equipment at 6 hospitals	ICB	QIV 2015	600

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

4. **Procurement supervision.** In accordance with the fiduciary risk identified for the project, procurement will be subject to ex post review. These reviews will be made on a half-yearly basis, in accordance with the project supervision plan. Ex post review reports will include at least one visit for physical inspection of the procurement processes subject to ex post review.

Table of ex post review threshold amounts (US$000s)		
Works	**Goods**	**Consulting services**
< US$3,000	< US$250	< US$200
All consulting services procured by the shopping method by companies and individuals, and the different consulting services, goods, and works procured will be subject to ex post review by the Bank, regardless of the contract amount.		

5. Special provisions

a. **Measures to reduce opportunities for corruption:** Fulfillment of the provisions of the "Policies for the Procurement of Goods and Works

Financed by the Inter-American Development Bank" (document GN-2349-9) and the "Policies for the Selection and Contracting of Consultants Financed by the Inter-American Development Bank" (document GN-2350-9) on prohibited practices (multilateral organization lists of ineligible companies and individuals).

b. **Other special procedures:** The Bank, at its discretion, may change the procurement review arrangements, based on its experience of execution and updates to the institutional capacity assessment or fiduciary visits made.

6. Records and files. The PCU will have responsibility for maintaining procurement files and supporting documentation and all evidence of payments made with project resources, in accordance with established procedures.

VI. FINANCIAL MANAGEMENT

6.1 **Programming and budget.** The annual budget is prepared by the Ministry of Finance through the General Office of Budget, in coordination with the Ministry of Economy, Planning, and Development and other government entities. Although counterpart funds are not required in this operation, the Project Coordination Unit (PCU) will have responsibility for ensuring that the project's budgetary allocations are available for implementation of the activities included in the Bank's planning tools (annual work plan, multiyear execution plan, and procurement plan) and for submitting requests to the Bank for budgetary modifications (transfers) when the Component amounts are insufficient to meet actual liquidity needs.

6.2 **Accounting and information systems**. The program will utilize cash basis accounting. For accounting records and financial reporting, the PCU will use the UEPEX/SIGEF module, which is the official national system and is generally utilized by executing agencies receiving financial resources from international organizations. This module enables users to view online available program resources, budgetary oversight, and contract supervision, and can be used for automatic generation of disbursement requests and their annexed forms for presentation to the Bank. As of 2013, the General Directorate of Government Accounting (DIGECOG) was tasked with managing the UEPEX/SIGEF module, and that office is now in the process of adopting the International Public Sector Accounting Standards (IPSAS), which would enable the nonfinancial public sector to use accrual basis accounting in the medium term.

6.3 **Disbursements and advances of funds**. The funds to be advanced for Component I will be subject to the following rules:

(i) For the disbursements corresponding to the first two four-month periods of 2014, the Bank will recognize the equivalent of 100% of the per capital outlays by the

executing agency for the UNAP-enrolled population, for whom enrollment has been verified by the concurrent audit.[3]

(ii) For the subsequent four-month periods, except as otherwise agreed by the Bank with the executing agency, the Bank will recognize: (i) the equivalent of 50% of the value of the per capita outlays disbursed by the executing agency for the UNAP-enrolled population, for whom enrollment has been verified by the concurrent audit; plus (ii) the equivalent of 50% of the value of the per capita outlays disbursed by the executing agency, in proportion to compliance with the four-monthly targets to be agreed upon between the Bank and the executing agency, as verified by the audit.

6.4 The resources provided as advances of funds to be administered by the executing agency may: (i) be deposited in a special bank account opened (in U.S. dollars) by the Borrower at the Central Bank in the name of the project, and at the Reserves Bank (in Dominican pesos) through the National Treasury; and (ii) be posted to the Borrower's general account (in the event that prior to eligibility for program disbursements, the Treasury's "Single Account," now at the pilot stage, comes on stream), and then, for accounting purposes, in a separate subaccount in the project's name, where all movements of funds received and payments corresponding to this Bank-financed operation will be recorded (provided this mechanisms is satisfactory to the IDB). The PCU will transfer to the National Health Insurance (SENASA) the contribution to services provided to subsidized system members under the RBF model. The PCU and SENASA will ensure that they have the budgetary allocations under the National Budget Act that are required. The PCU will also have responsibility for justifying project expenditures and their eligibility and for channeling requests to obtain a statement from the Bank that it has no objection. The Borrower and the executing agency will utilize project resources solely for eligible costs, and will have an adequate financial management and supervision system for executing this expenditure in accordance with loan contract procedures, which will also be reflected in the Operations Manual, in accordance with the financial plan agreed periodically with the Bank.

6.5 **Internal control and internal audits**. The Office of the Comptroller General of the Republic (CGR) is the executive branch agency responsible for the design, effectiveness, update, and oversight of the National Public Sector Internal Control System, which includes the operation of the internal audit units. Despite efforts of recent years that yielded the Basic Internal Supervision Standards (NOBACI) issued, a series of guidelines and norms defining the supervision and risk management environment, control, communication, monitoring, and accountability activities for public entities, these mandatory norms have not been applied as envisaged. The CGR does not perform internal audits of control processes and continues to concentrate on reviewing payments made. This situation may impact

[3] The executing agency will commission a concurrent operational audit, chargeable to the loan proceeds. This audit will examine evidence to validate compliance, as established the project Operations Manual, of: (i) the population enrolled with the UNAP; and (ii) the four-monthly targets to be agreed upon between the executing agency and the Bank.

payment times for project goods and services and, hence, execution. Therefore, the PCU will remain in close communication with the Internal Audit Unit (UAI), and, in turn, launch a process to implement the NOBACI.

6.6 **External supervision and control reports**. The Chamber of Accounts (CC) is the highest external entity overseeing public resources, administrative processes, and State assets. However, its institutional weaknesses make it ineligible to perform external program audits. Therefore, this function will be fulfilled by an independent auditing firm acceptable to the Bank. The external audit reports and terms of reference will meet the requirements and guidelines established in the guidelines for financial reports and reports of external audits of operations financed by the Bank.

6.7 **Financial supervision plan.** Bearing in mind that the PCU has no prior experience with the Bank, financial supervision, training, monitoring, and evaluation will be fundamental to the success of program financial execution. Therefore, in project year 1, an intensive program of visits will be required that includes the above-described activities and implementation of the strengthening actions indicated in the ICAS assessment. An external auditor and process auditors will also be engaged for incorporation in the review of internal controls, and a meeting of the executing agency and the Bank will be held by the end of each fiscal year to review the findings of the preliminary audit report. The operation's risk will be monitored by the project team on an ongoing basis, especially during the project year one.

6.8 **Execution mechanism**. The executing agency for this operation will be the Ministry of Public Health (MISPAS), the entity with stewardship of the health system. The project will be executed by the Directorate of Institutional Strategic Development (DDEI), with the support of a PCU. The DDEI is the MISPAS office tasked with executing projects with multilateral financing. The PCU will have responsibility for procurement and payments, at the request of the DDEI and of SENASA. The latter will have a technical coordinating team responsible for preparing the technical specifications for its investment activities, consultant selection, and contract supervision. SENASA's technical team will coordinate with the PCU to provide all documentation and meet all requirements to enable the PCU to request disbursements from the Bank. The PCU is the general program coordinator and has responsibility for execution and achievement of the objectives of the operation.

6.9 **Other agreements and financial management requirements**: None.