Project Completion Report

PCR

Project Name: *Health Sector Reform Programme*

Country: *Trinidad and Tobago*

Sector/Subsector: *SA*

Original Project Team: *Ernesto Castagnino, Project Team Leader (RE3/SO3); Holly Wong (RE3/SO3); Silvia Raw (RE3/SO3), Pablo Adam (RE3/SO3); Gustavo Nevarez (RE3/RE3); Tomás Engler (RE1/SO1); Mario Loterszpil (DPP/MOS); Dana Martin (LEG); Brian McNish (COF/CTT); and Ethel Muhlstein (RE3/SO3)*

Loan Number (s), TC(s): *937/OC-TT*

Final Approval Date: *10 July 1996*

PCR Team:
PCR (2011): Ian Ho-A-Shu (SPH/CTT); Tara Lisa Persaud, (Consultant); Priya Ramsumair (CCB/CTT); and Martha M. Guerra (SCL/SPH)

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Annexes

Acronyms and Abbreviations

ASA	Annual Service Agreement
BP	Bearing Point
CCC	Canadian Commercial Cooperation
CMOH	Chief Medical Officer of Health
DHF	District Health Facility
DOTS	Directly Observed Treatment System
E&Y	Ernst & Young
EHC	Enhanced Health Centre
ERHA	Eastern Regional Health Authority
EWMSC	Eric Williams Medical Sciences Complex
GoRTT	Government of the Republic of Trinidad and Tobago
HC	Health Centre
HCF	Health Care Facility
HNA	Health Needs Assessment
HSRP	Health Sector Reform Programme
IDB/BID	Inter-American Development Bank
ISC	Implementation Steering Committee
MDG	Millennium Development Goals
MIS	Management Information System
MoF	Ministry of Finance
MoH	Ministry of Health
NCRHA	North Central Regional Health Authority
NHI	National Health Insurance
NHSP	National Health Sector Plan
NIPDEC	National Insurance Property Development Company
NOC	National Oncology Centre
NWRHA	North West Regional Health Authority
PAHO	Pan-American Health Organisation
PAU	Project Administration Unit
PET	Project Execution Team
PHC	Primary Health Care
POSGH	Port of Spain General Hospital
PPMR	Project Performance Monitoring Report
PS	Permanent Secretary
PSIP	Public Sector Investment Programme
PWC	Price Waterhouse Coopers
RFP	Request for Proposal
RHA	Regional Health Authority
RMC	Resources Management Consultants, Ltd
SFGH	San Fernando General Hospital
SFGHICU	San Fernando General Hospital Intensive Care Unit
SGH	Sangre Grande Hospital
SU	Sustainability
SWRHA	South West Regional Health Authority
TAP	Technical Assistance Procurement
THA	Tobago House of Assembly
ToR	Terms of Reference
TRHA	Tobago Regional Health Authority
UNV	United Nations Volunteers
VSEP	Voluntary Separation

I. Basic Information

BASIC DATA (AMOUNTS IN US$)	
PROJECT NO: TT024	**TITLE: Health Sector Reform Programme (HSRP)**
Borrower: Government of Trinidad and Tobago **Executing Agency (EA): Ministry of Health** **Loan(s): 937/OC-TT** **Sector: SA**	**Date of Board Approval: 10 July 1996** **Date of Loan Contract Effectiveness: 12 July 1996** **Date of Eligibility for First Disbursement: 23 December 1997** **1) Months in Execution** *** from Approval: 145** *** from Contract Effectiveness: 135** **Disbursement Periods** **Original Date of Final Disbursement: 12 July 2003** **Current Date of Final Disbursement: 31 August 2010** **Cumulative Extension (Months): 79 months** **Loan Amount(s)** *** Original Amount: 134,000,000 USD** *** Current Amount: 134,000,000 USD** *** Pari Passu (original): 70/30** **Were funds redirected away from [ ] or to [ ] this Project?** **[X] N/A (*Please check one)*** ***Counterpart Amount: Original – 58,000,000 USD Current: 140,600,000 USD** **Project and/or sub loan number(s) to which funds were redirected: N/A** **Project and/or sub loan number (s) from which funds were redirected: N/A** **2) Disbursements** *** Amount to date: 100 (%)** **Total Project Cost** **Original Estimate: 192,000,000 USD** **Current Amount: 274,600,000 USD** **On Alert Status** **Is project currently designated "on alert" by PAIS: NO** **If yes then why is the project on alert (DO , IP Ratings and/or relevant PAIS indicators): N/A** **Comments on relevance of "on alert" status for this project (if applicable):N/A**

Summary Performance Ratings				
DO	[ ] Highly Probable (HP)	[x] Probable (P)	[ ] Low Probability (LP)	[ ] Improbable (I)
IP	[ ] Very Satisfactory (VS)	[x] Satisfactory (S)	[ ] Unsatisfactory (US)	[ ] Very Unsatisfactory (VU)
SU	[ ] Highly Probable (HP)	[x] Probable (P)	[ ] Low Probability (LP)	[ ] Improbable (I)

II. The Project

a. Project Context

As early as 1957, the Government-appointed Julien Commission of Trinidad and Tobago recommended to Government that decentralization of the health care system could eliminate many of the persistent inefficiencies of the centralized system and could better meet the immediate and projected needs of the population. The Toby Commission (1981) also endorsed this recommendation recognizing that under the centralized system, the Ministry of Health (MOH) exercised authority over nine areas, including Tobago and

had prime responsibility for the delivery of services to the entire country. In addition, these services tended to focus on secondary and tertiary care, with limited attention to primary care.

In 1991, a technical cooperation from the Bank (ATN/SF/CD/JF-3650-TT) supported studies on comprehensive health reform including the feasibility of the regionalization of services. Based on these studies, the Government of the Republic of Trinidad and Tobago (GORTT) developed its Medium Term Policy Framework 1994-1996 which laid out the key elements of health sector reform including (1) the restructuring of the Ministry of Health into a policy-making and regulatory body, (2) the decentralization of service delivery and management, (3) a shift in resources from hospital to primary care and preventive services, and (4) the introduction of a national health insurance system.

In 1994, GORTT passed the Regional Health Authority (RHA) Act (amended in 2000) which devolved all assets, operational responsibility and management of all public health care facilities to five RHAs: North West Regional Health Authority (NWRHA); North Central Regional Health Authority (NCRHA); Eastern Regional Health Authority (ERHA); South West Regional Health Authority (SWRHA); Tobago Regional Health Authority (TRHA)

In 1994, GORTT also approved a National Health Services Plan (NHSP) which provided the overall framework to guide the development of the infrastructure and human resources required to achieve the desired shift to primary and preventive health care that formed the core of the health sector reform agenda. Based on the National Health Services Plan, GORTT and the IDB approved the HSRP in 1996 which aimed to support the first phase of the health reform agenda as conceptualized under the NHSP. The HSRP was originally scheduled for completion in 2003, however, with several, albeit unforeseen implementation challenges, it was granted two general extensions and two special extensions, with a final disbursement date of 31 August 2010.

b. Project Description

The aim of the Health Sector Reform Programme was to support the first phase of the transformation of the health sector in Trinidad and Tobago. Its design was intended to reflect an integrated approach, with mutually supportive components that addressed health sector policies, institutions, financing, human resources and infrastructure. It was to be implemented over seven years, 1996-2003 (See Annex 1 for original estimated delivery timeframe). The total project cost was estimated at US$192M, with US$134M in loan resources and $58M in counterpart financing. In 2003 the programme was extended and also re-profiled. While the programme objectives were not changed, the implementation sequencing of the components was revised and adjusted to suit government priorities at the time. In addition, it was noted that the cost of the programme had been underestimated. As a result, GORTT increased its counterpart financing from US$58M to US$140.6M, thereby increasing the overall project cost from US$192M to US$274.6M. Most of the additional financing was allocated to physical infrastructure.

i. Development Objective(s)

The overall objective of the HSRP was to improve the health status of the population of Trinidad and Tobago by promoting wellness and providing affordable quality health care in an efficient and equitable manner. To achieve this objective, the programme focused on:

a) strengthening the policy-making, planning and management capacity of the health sector;
b) separating the responsibilities for service provision from those for financing and regulation;
c) shifting public expenditures and trying to redirect private expenditures to find solutions in high-priority problem areas;
d) establishing new administrative and employment structures which encourage accountability, increased autonomy and appropriate incentives to improve productivity and efficiency; and
e) reducing preventable morbidity and mortality through lifestyle changes and social interventions.

ii. Components

The programme had five main components:

1) Reform of the MOH into a policy, planning, sponsorship and regulatory body.
2) Devolution of service delivery and management to five RHA which would contract with the MOH to provide cost effective services within global budgets, using both public and private providers.
3) Development and implementation of a comprehensive Human Resource strategy, (including the establishment of a new, funded pension plan for RHA staff), to achieve the appropriate skill mix in staffing levels to support the new organisational structures and improve productivity, efficiency and equity.
4) Rationalisation of health services and infrastructure to focus activities on cost-effective and high priority interventions that emphasise health promotion services and strengthen primary care.
5) Development of a comprehensive health sector financing strategy, including the evaluation of user charges and a national health insurance system as potential financing mechanisms.

III. Results

a Outcomes

ACHIEVEMENT OF DEVELOPMENT OBJECTIVES (DO)		
Development Objective(s) (Purpose)	**Key Outcome Indicators**	
Improve the health and wellness status of the population of Trinidad and Tobago Classification: P	**a) Planned Outcomes** By 2010 achieve: **1. 5% reduction in neo-natal mortality** Baseline: 23 per 1,000 live births (1983-87 (PAHO)) Target: 21.85 per 1000 live births **2. 5% reduction in infant mortality** Baseline: 17 per 1,000 live births (1993 (UNHDR 1996) Target: 16.5 per 1,000 live births **3. 5% reduction in maternal mortality** Baseline: 90 per 100,000 live births (1993 (UNHDR 1996) Target: 85.5 per 100,000 live births	**3) Outcomes Achieved** 23 per 1,000 live births (UNICEF 2009)[1] 31 per 1,000 live births (UNICEF 2009))[2] 55 per 100,000 live births (2008 (UNHDR2010)

i) **Reformulation. Was the objective(s) of this project reformulated? [ ]** yes **[x]** no

ii) **Were there any changes to the outcome indicators or targets?** [**x**] yes [ ] no

If yes, indicate the most recent date, and, who approved these changes. Changes were made to the indicators in 2005 and were agreed by the Bank and GORTT.

Briefly explain any changes resulting from this exercise. In 2003 the HSRP was re-profiled and extended for an additional three years (it was subsequently extended several more times). The original logframe did not identify quantitative indicators, largely due to the unavailability of data. The logframe and the respective outcome indicators were not updated at the time of re-profiling in 2003 because there were no systems in place in the MOH to capture data in a systematic manner. In 2005, when the MOH had built capacity in its new Policy and Planning Unit to collect and measure the data, the logframe was revised and the targets presented above were established. These are listed in the Logframe updated by the RMC TAP Unit in its *Final Report, 12 April 1999 – 11 June 2005*. However, at the time, no baselines or measurements were identified. This report has used available data to estimate baselines and targets, as well as outcomes achieved. The data sources are identified above. The reformulated logframe is presented in Annex 2.

In addition, in a draft PCR undertaken in 2008, an analysis was undertaken on achievements of the purpose of the programme: *to achieve effectiveness, equity, sustainability and quality of health and wellness services*. This analysis was developed using a combination of outcome indicators from the original and revised logframes. The analysis has been updated and presented in Annex 3.

iii) **PPMR Retrofitting**. **Indicate if and when the PPMR was retrofitted and explain any changes resulting from this exercise.** The PPMR was retrofitted in 2003 as part of the project's re-profiling process. It was revised again in 2008 based on a review session between the Bank and the MOH. The indicators identified in 2008 for the PPMR were considered to be more practical and to keep more with the spirit of the HSRP objectives. The PPMR indicators, updated for 2010, for both outcomes and outputs are highlighted in Annex 4.

[1] It should be noted that in the Caribbean, there was a marked increase in neo-natal mortality from 2008. UNDP (2009) has indicated that this is symptomatic of the recession. In the most recent data before the recession (2004), the number of neo-natal mortalities was well below the target set under the Health Sector Reform Programme. While the mandate of this programme did not seek to address this external variable, the need to further investigate the variance is warranted.

[2] It should be noted that in the Caribbean, there was a marked increase in infant mortality during the recession. UNDP (2009) has indicated that this is symptomatic of the recession. In the most recent data before the recession (2005), the number of infant mortalities represented the target. While the mandate of this programme did not seek to address this external variable, the need to further investigate the variance is warranted.

Summary Development Objective(s) Classification (DO):			
[ ] Highly Probable (HP)	[x] Probable (P)	[ ] Low Probability (LP)	[ ] Improbable (I)

Briefly justify DO classification, based on degree to which planned targets were met, explaining the differences between planned and achieved outcomes as well as any other relevant factors. Include references to evidence that can support these results. Based on the progress made on the indicators identified above and in the April 2010 PPMR (see Annex 4), the DO rating is Probable. It should be noted that according to PPMR records, between June 1999 to December 2006 the DO rating was Low Probability. From 2008, significant progress was made by MOH in terms of (1) implementing the reform through its MOH Business Plan (2009-2013) and a 100 day Action Plan; (2) completing the Voluntary Separation (VSEP); (3) strengthening of the Policy and Planning Unit; and (4) the engagement of key senior personnel.

However two major elements of the programme, which were critical to achieving the DO of improving the health and wellness of the population, were not completed. These are the successful implementation of an HR Change Management Strategy and an Information Systems/Information Technology (IS/IT) Strategy. The Change Management Strategy has been developed but not implemented. It was agreed that implementation is now beyond the scope and timeframe of the current HSRP. The MOH is currently pursuing the implementation of the Change Management strategy in collaboration with the Ministry of Public Administration who has been mandated to lead public sector reform efforts. The IS/IT Strategy was developed and implementation has commenced. A Central IT Unit has been established, appropriate hardware has been acquired, and a Transformation IT Plan now exists. There were intermittent efforts to move the process forward over several years but these were affected by human resource and political challenges. Full implementation of the IS/IT Strategy is now expected to be completed in 2012. In addition, the development of a comprehensive health financing system has not been realized.

Country Strategy. **Given the results described above, briefly discuss how the project contributed to the Bank's strategy in the country.** When approved in 1996 the programme was consistent with the Country Strategy at the time which focused on achieving more effective public sector administration and more equitable and efficient resource allocation. The extension of the Programme in 2003 was consistent with one of the Bank's principal areas of strategic focus for 2004-2007: *Promoting Social Development by Improving Social Public Services*. In addition, it was aligned with the Country Strategy 2004-2007, (Sept 2004), which sought to support the Government's development plan, Vision 2020, though public sector modernisation, social services improvement and private sector development. The health reform agenda forms a large part of public sector modernisation. In addition, the programme falls within the Bank's recent SPH priority areas which include strengthening health systems. The HSRP has provided the foundation for advancing the sustainable reform of the health sector. It will contribute to the Bank's current SPH strategy in Trinidad and Tobago which centres on developing the governance and institutional capacity of the MOH and the RHAs, as well as establishing the building blocks for implementing (1) the health financing system and (2) the human resources development plan (both of which were not completed under the HSRP).

b. Externalities

Positive Externalities

IDB – MOH Relations. The Health Sector Reform Programme was aligned with GORTT's national development plan, Vision 2020. As such, GORTT's commitment to the programme has remained consistent and the relationship between Bank and Ministry officials has been significantly strengthened during programme implementation. In addition, in line with the HSRP objectives, the Ministry is moving to improve its capacity to make evidence-based decisions and a national health information system is being developed to facilitate this process.

Ministry of Health Transformation Plan. In conjunction with Health Sector Reform, in 2008, the MOH developed a Health Transformation Plan. The Plan is aligned with the HSRP and included some of its key elements, namely: (1) The Ministry of Health's Institutional Reform; (2) Strengthening of Vertical Services; (3) Strengthening of RHAs and other state owned bodies related to health ; (4) Upgrading Services and Infrastructure; (5) Skill Development and Availability; (6) Providing Quality Service; (7) Developing Information and Communication Technology; (8) Rationalizing Health Financing; (9) Continuous Improvement on all levels. The plan also included the 100 day intervention plan, which fast tracked the completion of some HSRP projects by the end of 2009.

Accreditation Standards. Accreditation standards and forty protocols and SOPs were developed and issued to all health facilities in both public and private sectors to improve health service quality. Parliament approved the policy for establishing an autonomous Health Services Accreditation Council and the legislation is being prepared.

Negative Externalities

Human Resource Challenges. The MOH continues to face the challenge of attracting competent staff to leadership positions. This results from non competitive remuneration packages and inappropriate facilities and working conditions. Additionally, among staff there are challenges of de-motivation, low morale and lack of productivity.[3]

[3] Report of the Commission of Enquiry into the Operation and Delivery of Public Health Care Services in Trinidad and Tobago, Volume One. 2004.

The lack of a robust human resource management in the MOH and the RHAs has meant that Trinidad and Tobago is experiencing both immigration and emigration of health care professionals. Local professionals have migrated to work in North America, the United Kingdom and elsewhere. In part to cope with this situation, before 2003, the MOH recruited doctors from India and Africa to work in the public sector. Since 2003, medical personnel have been recruited through the UN Volunteers programme. In addition, Cuban and Filipino personnel, including doctors, nurses, technicians and pharmacists have been recruited through government-to-government arrangements. Training activities under the HSRP have provided local and foreign individuals with specific technical knowledge. When these individuals migrate or are transferred to different responsibilities (as is common in the Public Service) this capacity is lost, therefore affecting project and programme sustainability.

Loss of Confidence in Health Sector. For example, allegations of improper use of state resources were raised about the construction of the Scarborough Hospital. This resulted in arbitration over a contract dispute. While the arbitration ended and GORTT has moved to complete construction using its own resources (USD$79M), such incidences resulted in a loss of public confidence in the reform process and in the public health sector in general[4].

Lack of Broader Public Sector Reform. The periods of political uncertainty (three closely contested General Elections between 1996 and 2002 and the appointment of six Ministers of Health between 1996 and 2008) contributed to implementation delays. Moreover, the absence of effective broader public sector reform, made it difficult for the MOH to drive reform in the sector, which required robust and ambitious institutional changes. Current signals indicate that this continues to be a challenge for the public sector.

c. Outputs

The HSRP was granted two general extensions and two special extensions. With each extension, the GORTT and the Bank took the opportunity to refine the outcome and output indicators in order to sharpen reporting requirements and also as a means of maintaining project relevance. As a result the Output indicators used below are those identified in 2005 at the time the programme's logframe was revised, which followed the 2003 re-profiling and extension (see Annex 2 for revised logframe). Analysis of the original programme indicators is shown in Annex 3.

IMPLEMENTATION PROGRESS (IP)		
Components (Outputs):	**Key Output Indicators:**	
1. Component 1: *The policy and regulatory capacity of the Ministry of Health strengthened*	**Planned Outputs**	**Outputs Achieved**
i. MoH Policy, Planning and Epidemiology Unit operational	- Health Section Vision Statement approved - Health Technology Assessment Policy approved - Medical Records Policy approved - Risk Management Policy approved	Unit established in 2007 and is operational with vision and policies approved.
ii. MoH Policy and Regulatory Management Structures and Systems Developed	- MoH Business Plan finalized and approved - MoH Purchasing Service Intention Plan finalized and approved - Annual Service Agreement (ASA) guidelines finalized and approved	MOH Transformational Plan (Business Plan) and Purchasing Service Intention Plan completed in 2008. ASA framework established in 2008
iii. National Health Needs Assessment and Disease Surveillance System Developed	- 1st Health Needs Assessment Framework completed - National Disease Surveillance 'Pilot' Project ERHA completed	**Draft framework completed in 2009** **Completed in December 2009**
Briefly explain differences between planned and actual outputs (if applicable). [X] N/A		

[4] The 2004 Report of the Commission of Enquiry into the Operation and Delivery of Public Health Care Services in Trinidad and Tobago (Volume One) highlighted the public perception that health care service in seen as poor in Trinidad and Tobago. This perception stems from poor quality service resulting from a lack of discipline, commitment, responsibility, accountability of health care workers and accompanying disciplinary procedures.

Restructuring. Indicate if this component was restructured (date of approval by Manager). Briefly discuss the consequences of these changes.
The component essentially remained the same but the outputs and indicators were refined following the 2003 approval of re-profiling and Extending the Programme. The MOH has laid the groundwork for full transformation as originally envisioned by the programme. Its Transformational Plan is intended to guide the reform and its 2009-2013 Business Plan has identified the following critical areas to be addressed: (i) lack of key senior staff at the MOH; (ii) lack of focused dedication to implementation; (iii) operational activities that were not part of the reform agenda but which continue to dilute implementation focus and absorb resources; and (iv) the lack of stakeholder buy-in. It is expected that the full reform will be completed by 2013.

2. Component 2: *RHA capacity to deliver quality health and wellness services strengthened*	**Planned Outputs**	**Outputs Achieved**
i. Information Management Strategy approved and implemented	- National Information Strategy approved - Hardware and software delivered to MOH and RHAs	Strategy completed under 100-day plan in 2008. Full implementation pending and expected by 2012.
ii. MoH-RHA Monitoring Framework implemented	- MoH Business Plan finalized - RHA Business Plan completed - ASA approved	Business Plans completed in 2007 ASAs for the RHAs in place since 2007.
iii. Quality Management programme implemented	- Waiting List Management Policy approved	Implemented as part of 100-day plan and waiting times for several services in the RHAs have been reduced.
	- Clinical Audit Policy approved	Completed in 2007.
	- Infection Prevention and Control Policy and Procedures Manual approved	Manual approved in 2005.
	- HN Ward Management Training implemented	Completed
	- Accreditation System Legislation drafted	
	- Quality Management Legislation drafted	Draft under consideration In process.

Briefly explain differences between planned and actual outputs (if applicable).
[X] N/A

Restructuring. Indicate if this component was restructured (date of approval by Manager). Briefly discuss the consequences of these changes.
No changes were made to this Component but the indicators were refined in the revised 2005 logframe. With the main physical improvements completed, the RHAs have implemented improvements in the management and institutional systems required to support decentralization including: appointment systems, patient satisfaction surveys and human restructuring. These all provide a solid foundation for the achievement of the HSRP objectives. In addition, Public-Private Partnerships are being negotiated as part of the RHA strategy to contract private sector providers for specific medical services. Further strengthening of the RHAs is presently under discussion as a possible component of a new IDB support programme.

3. Component 3: *Health Sector Human Resource Strategy Implemented*		**Outputs Achieved**
i. Health Sector Human Resource Strategy implemented	- Primary Health Care Training Programmes implemented - Technical Training Programmes implemented - Management Training Programmes implemented - Oncology Training Programmes implemented	While the full HR strategy has not been implemented, several training programmes have been undertaken and one of the institutional priorities emphasized in the Transformation Plan is the development of a renewed and enhanced Primary Health Care Strategy.
ii. Managed RHA Pension Plan	- Pension Fund USD$8.175m 2004-5 - Pension Fund USDTT$8.17m 2005-6	Book Value USD$84.00m (May 2011) Market Value USD$94.00m (May 2011)
iii. Public Servants Transferred to RHA employment	- 3554 perm. employees transferred - 431 temp. employees transferred - 241 Public Servants Retired	Audits completed 1745 accepted VSEP 724 transferred to RHAs. VSEP is completed.

Briefly explain differences between planned and actual outputs (if applicable).
[X] N/A

Restructuring. Indicate if this component was restructured (date of approval by Manager). Briefly discuss the consequences of these changes.
Significant progress has been made in implementing components of the Human Resource Strategy. In November 2009, GORTT approved the establishment of a Health Sector Human Resources Planning and Development Unit in the MOH to engage in manpower planning and human resource activities for the Health Sector. However the Change Management component of the Strategy remains incomplete. A change management plan has been developed by PriceWaterHouse Coopers consultants, however it was agreed that implementation of the plan would be removed from the HSRP as completion would take several more years. At the time, the Government intended to implement this Plan using its own resources. However, with a change of Administration in May 2010, it remains to be seen whether implementation will proceed.

4. Component 4: *The delivery of quality health and wellness services rationalized*	**Planned Outputs**	**Outputs Achieved**
i. Primary Health Care Services Strengthened	- Primary Health Care and Health Promotion Model implemented	Partially implemented. Primary Health Care Strategy is a priority
	- National Health Promotion Strategy implemented	In implementation.
	- 10 Primary Health Care Chronic Disease 'Pilot' Projects completed	Technical Advisory Committee for NCDs created. Pilots in progress.
ii. Primary Health Care Facilities Construction and Renovation Programme completed	- 4 new DHF operational - 1 DHF operational - 2 new EHC operational - 1 EHC renovated - 10 new HC operational - 2 HC renovated - 4 new OC operational - 15 OC renovated	88 (of the 93) health facilities earmarked for construction, refurbishment or upgrade have been completed(Reference: MOH 2009 report)
iii. Hospital Services Strengthened	- New Scarborough Hospital operationalised - Old Tobago Hospital decommissioned - SFGH ICU, Burns Unit, Day Surgery operationalised - Pharmacy and Laboratory Services upgraded	Under the programme, loan resources in the sum of US$63M funded the renovation of 22 health centres, the completion of four new District Health Facilities, renovations to three hospitals and procurement of modern biomedical equipment and hospital equipment. (as per PPMR)
iv. Hospital Construction and Upgrade Programme completed	- Phases 1 – 3 Eric Williams Medical Sciences Centre (EWMSC) Upgrade complete - New Scarborough Regional Hospital completed - SFGH construction upgrades complete - Upgrade Port of Spain General Hospital (PoSGH) completed - New Point Fortin Hospital completed - SGH/EHC integration complete - National Oncology Centre	Scarborough foundation constructed Feasibility study funded. GORTT finalized US$24M to fund construction.
v. National Community Care Policy 'Pilot' Project implemented	- 78 St James Medical Complex patients placed in Community Care - 64 St Ann's Hospital patients placed in Community Care - 13 SFGH patients placed in Community Care - 9 PoSGH patients placed in Community Care - 39 Sangre Grande Hospital (SGH) patients placed in Community Care	Community Care project was developed in 2007 and was then subsumed within the Ministry of Social Development.

Briefly explain differences between planned and actual outputs (if applicable). The Community Care Project output was eliminated after that activity was subsumed under the Ministry of Social Development in 2007.

The original component included the establishment of an ambulance service. The ambulance service was detached from HSRP in 2003 (during re-profiling) and the GORTT undertook this component separately. A national ambulance service with a complement of 100 ambulances was established in 2004.

Restructuring. Indicate if this component was restructured (date of approval by Manager). Briefly discuss the consequences of these changes.
As with the other components this one was not significantly restructured during the re-profiling exercise. However, this component was the one in which the original cost estimates were significantly underestimated. As a result much of the increase in counterpart funding committed by GORTT in 2003 (86%) was channelled to infrastructure development in this component. The following should be noted:

- Under the Programme, loan resources in the sum of $63 M funded the renovation of 22 health centres, the completion of four new District Health Facilities, renovations to 3 hospitals and procurement of modern biomedical equipment and hospital equipment
- As a result of the original underestimation of costs, several planned activities were not financed with loan resources. For example, while Bank resources funded the feasibility study for the National Oncology Centre (NOC), GORTT secured private financing (US$24M) to construct the NOC. Construction commenced in April 2007 but was suspended in 2008 due to contract disputes and arbitration. The centre is expected to be completed at the end of 2010.
- Work on the Scarborough Hospital was also subject to a lengthy arbitration process due to a contract dispute which commenced in December 2005. Construction has recommenced and is being completed without loan resources. Completion is due at the end of 2010 with GORTT funding of approximately US$79M.

5. Component 5: *The financing of quality health and wellness services improved*	**Planned Outputs**	**Outputs Achieved**
i. Develop a financing strategy for the health sector	- NHI System Cross-Functional Steering Committee appointed - Technical Secretariat hired	Both the Steering Committee and the Technical Secretariat were established. Several studies were completed by the Secretariat. No strategy has been agreed upon.

Briefly explain differences between planned and actual outputs (if applicable). A National Health Insurance (NHI) Task Force was set up in 2004 after the re-profiling of the HSRP. A draft NHI System model was developed in February 2006. However, it did not receive Cabinet approval at that time. As part of its Transformation Plan, the MOH hired the Health Economics Unit of UWI in 2008 to undertake the costing exercise to inform the final basket of services to be covered under the NHI. UWI completed initial work in December 2009. The MOH Health Policy Unit is collecting further data to feed into the costing exercise and model options are expected by the end of 2010.

Restructuring. Indicate if this component was restructured (date of approval by Manager). Briefly discuss the consequences of these changes. The activities in this component were pared down during the re-profiling exercise in 2003 to incorporate only the development of the strategy for a NHIS. However such a system is politically sensitive and no agreement could be reached on an approach. As a result work on this component stagnated after several studies were undertaken and the technical secretariat was disbanded in 2008.

Summary Implementation Progress Classification:

[ ] Highly Satisfactory (HS) [x] Satisfactory (S) [ ] Unsatisfactory(U) [ ]Very Unsatisfactory (VU)

d. Project Costs

Source of Financing (US$M)				
Investment Category	**Original**		**Revised**	
	BID (1)	**Local (2)**	**BID (3)**	**Local (4)**
Administration	5.455	0.986	12.411	6.83
Hospitals	33.312	0.0	33.312	60.453
District Health Facilities	6.981	0.0	6.981	11.556
Health Centres	11.702	0.0	14.378	14.548
Ambulances	1.685	0.0	0.0	0.0
IS/IT Equip & Software	6.173	0.0	12.473	0.0
HR Strategy	29.783	17.564	29.783	17.564
Technical Assistance	11.181	0.0	15.093	0.603
Training	3.657	0.0	3.657	0.0
Pre-investment Studies	0.520	0.0	1.223	0.0
Ambulance Services	11.447	1.931	0.0	0.002
Community Care	1.551	0.182	1.551	0.182
Early Mgmt Costs: RHA	0.589	0.00	1.016	0.079
Unallocated	8.613	0.823	0.0	0.0
Financial Costs	1.340	36.513	2.113	28.736
TOTAL	**133.989**	**57.999**	**133.991**	**140.553**
Source: Adapted from Cost Table, Annex 5				

Total Project Cost – Planned (US$000)	Total Project Cost – Actual (US$000)	% Difference
192,000	274,600	143%

Briefly explain any differences.
The original costs for the Programme were underestimated, particularly in the area of infrastructure development/upgrade given the unanticipated increases in costs arising from a booming local construction market. This combined with the significant delay in the approval and implementation of critical activities put the programme in jeopardy of being cancelled in 2003. In order to prevent this and to extend the loan, the Government of Trinidad and Tobago decided to and did contribute and additional US$82.6M to support the critical infrastructural projects still to be completed. The Extension and Re-Profiling of the HSRP was agreed in November 2003 and the program was extended for three years. This was followed by a further general extension and two special extensions. The original anticipated implementation period was seven years, while actual implementation has taken twice the time.

The majority of GORTT's additional contribution was directed to Infrastructure and Related Activities in the Investment Categories of Hospitals, District Health Facilities, Enhanced Health Centres and Health Centres. This infusion allocated for these Categories would absorb approximately 61 percent of total counterpart contribution of US$140.6M. The total counterpart contribution accounts for some 51% of the total Programme financing (US$276.6M), up significantly from their earlier share of 36%.

[Annex 5 provides further details on costs by investment category and their distribution.]

IV. Project Implementation

a. Analysis of Critical Factors

The original timeframe for programme execution was seven years (1996-2003). However, actual implementation took twice that long (1996-2010). It is significant to note that in 2000, four years into the programme, 18% of funds had been disbursed. In 2003, the originally anticipated end of the programme, cumulative disbursement stood at only 55%. The programme was extended four times and was re-profiled in 2003 to maintain relevance and meet the priorities of the Government. The factors affecting implementation included:

Programme design and implementation time frame. The HSRP was designed to include a large variety of activities that were complementary and integrated but also very complex for the original seven year time frame. A significant challenge of the overall programme was the need for the considerable institutional transformation of the Ministry of Health itself. Such a transformation required a cultural shift and the ceding of substantial authority over the control and provision of health care services from the Ministry to the RHA. In the absence of larger public sector transformation, it was difficult for the Ministry to pioneer such shifts. Institutional inertia therefore seriously impacted programme implementation. In addition, in an effort to propel implementation, the 'soft' components which required such organisational shifts were neglected in favour of the physical infrastructure components.

Project Co-ordination. The coordination between the PAU and the Ministry proved to be difficult. As a result, program initiatives were to a large degree implemented as stand-alone activities as opposed to a systemic approach which also hampered the type of program synergies that were originally expected. Despite attempts to bridge this issue, the coordination challenge remained till the end of the project. In addition, the perception that the PAU was an outside unit of the Ministry as opposed to an integrated department of the Ministry compounded the problem.

Slow Start-Up and Senior Administrative Changes. A significant delay of over 18 months was experienced during the start-up phase of the Programme. Challenges arose in meeting the terms and conditions of the loan prior to first disbursement including recruiting staff for the Project Execution Team and, the Project Administration Unit and assigning ministerial staff to the Implementation Steering Committee. In addition, three national elections between 1996 and 2002, and another in 2007, (and the resulting changes in Ministers of Health and Permanent Secretaries in the MOH) contributed to intermittent periods of implementation. These political developments also resulted in the exercise of caution and tentative, tardy or deferred decision making on the part of government officials. This was particularly the case for activities with politically sensitive elements such as the Human Resources Strategy which required the recruitment, retirement or voluntary separation of large numbers of medical personnel. As such, the administrative units of the HSRP were not able to facilitate change in the way that was originally anticipated. Similarly, turnover in the staff of these Administrative Units over the 14 years of execution had a significant impact on delaying the implementation of the recommendations made after the Mid-Term Evaluation of July 2000. For example, one of the major priority areas of action recommended was the

engagement of a change management consultant to assist the MOH in implementing its new organisational structure which was not initiated until 2008.

Procurement Delays. The procurement process was particularly problematic and affected implementation of the Programme considerably. The IDB-funded activities were required to adhere to IDB procedures as well as the national Central Tenders Board regulations, while activities funded by GORTT adhered to national regulations. Requirements were often unclear to bidders, thereby hindering contracting and progress. In addition, the development of appropriate Terms of Reference was a clear weakness. For example, procurement for technical assistance for the Change Management Strategy began in 2000. By 2005, the Terms of Reference had underdone at least 23 revisions and had still not proceeded to identify or contract a suitable provider. As a result, implementation of the strategy was removed from the Programme and GORTT will undertake this activity separately. This reflects an ongoing problem within the Programme: the lack of capacity of the MOH to identify and articulate needs and/or the lack of agreement among stakeholders on the needs. Further to this, there was a challenge in sourcing appropriately skilled and experienced consultants for both advisory and implementation functions.

Stakeholder understanding and commitment. The lack of a systematic communication framework to facilitate the information sharing among the programme's primary stakeholders and decision-makers led to limited understanding of, and agreement on, key issues in a timely way. This included communication among the Steering Committee, the various administrative units, the MOH officials and the RHA personnel. In addition, there was no effective public/stakeholder awareness campaign on the HSRP for the general public, public service employees, medical personnel or other affected persons. As a result, a lack of understanding of the programme, its objectives and intended benefits limited the creation of a sense of programme ownership and acceptance. This particularly affected the transition of services to the RHAs and the associated VSEP. The lack of pre-emptive strategy to deal with the initial "dual track" employment (MOH or RHA) led to system dysfunction when uncertainty about authority and responsibility arose. The development of Annual Services Agreements between the RHAs and the MOH has helped this situation.

Emphasis on "hard" development components. During implementation, progress on the "hard" development aspects of the HSRP, such as infrastructure and equipment, did not match the slower progress made on the institutional reform or 'soft' components. The disbanding of the Central Regional Health Authority in 2000 and ongoing difficulties over human resource management, financing and delivery of quality services dampened enthusiasm for the programme. In addition, in an attempt to advance implementation, the sequencing of the integrated components was altered. This slowed the momentum for initiating and completing the institutional activities, some of which, including the IS/IT Strategy and the Change Management Strategy, remain incomplete. In this regard, the mutually reinforcing benefits of implementing the physical and the institutional activities together were lost.

Programme management tools – performance management. The original logframe for the project was very general and did not specify measurable output and outcome indicators that could help to monitor progress. It lacked final and intermediate targets as well as any baseline measurements. There was no development results framework or results-based project management framework. As such, it was difficult to both measure the performance of the Programme during its execution and make adjustments or changes to improve implementation based on such evaluation. In 2005 the logframe was reformulated following the re-profiling of the programme in 2003. Some measurable outputs were identified for the overall development outcome, but again, no baselines were set. During administrative missions and other meetings the PPMR indicators were developed and adapted several times to try to measure progress better.

b. Borrower/Executing Agency Performance

While the Ministry of Health was committed to the success of the HSRP, significant challenges were encountered because several co-entities were charged with executing the various aspects of the Programme. These entities had varied strengths and capabilities but lacked an effective communication framework. They were, therefore, significantly challenged to perform efficiently and effectively as an integrated system, thus negatively affecting the implementation of the Programme. These units included:

The Implementation Steering Committee (ISC) – comprised of high-level inter-ministerial officials including the Ministers of Health (Chair), Planning and Development, and Finance, the Tobago House of Assembly, the RHAs and the Permanent Secretaries. The ISC was accountable to the Cabinet and responsible for the overall delivery of the HSRP. While it was supposed to meet monthly, the ISC met only sporadically and did not operate consistently.

The Project Execution Team (PET) – comprised senior officials from the RHAs and the MOH and was responsible for guiding overall execution of the Programme at the technical level. However, changes in administrations and related shifts in priorities affected the decision making of this group. For example, the implementation of the critical Annual Service Agreements between the MOH and the RHAs fell under its responsibility but was significantly delayed due to the time needed to build consensus.

The Project Administration Unit (PAU) - comprised dedicated programme staff, funded primarily from loan resources and charged with the daily management and implementation of the programme's activities. This unit suffered from insufficient staff, particularly in the early years of the programme. In addition, the expertise in the Unit could have been more complementary. It contained strengths in infrastructure and civil works, but was significantly weaker in the area of institutional/organisational management. The effectiveness of the Unit was constrained by tardy decision making at the higher levels. It was also affected by the performance of entities responsible for infrastructure, technical cooperation and procurement.

The Technical Assistance Project Unit (TAP) – the firm, Resource Management Consultants (RMC), was engaged as the TAP firm to support the PAU, particularly in the area of procurement of technical services. Challenges were evident in the lack of agreement over terms of references (TOR) and other parts of the procurement process, including the selection and monitoring of service providers. In some cases this resulted in the termination of contracts and necessitated the re-initiation of procurement for such services, resulting in further delays. The RMC contract was terminated at the end of 2004 and the TAP Unit was dissolved in 2005.

The National Insurance Property Development Company Ltd (NIPDEC) – the state company charged with facilitating project management in the area of Civil Works/Infrastructure lacked strengths in health facility construction and in the management of large projects. NIPDEC also admitted the relative slowness of its procurement processes, which significantly affected the achievement of Programme timelines.

It must be noted that between 2003 and 2008 the implementation of the HSRP advanced at an increased and steady rate, with a demonstrated commitment. This was evident in the increase in counterpart funding, and allocation of additional funds to finance components that were delinked from the HSRP, and the commitment to sectoral reform. In 2008, the momentum for the completion of the project was increased by the MOH's 100 Day Plan which incorporated the outstanding elements of the HSRP.

Borrower/Executing Agency			
[ ] Highly Satisfactory (HS)	[x] Satisfactory (S)	[ ] Unsatisfactory (U)	[ ] Very Unsatisfactory (VU)

c. Bank Performance

The Bank worked closely with the Project Administration Unit and the TAP firm throughout the life of the project. Bank resources were deployed at various levels (the Sector Specialist, the Country Office and the IDB Headquarters) to provide support including:

- guidance and recommendations during project implementation;
- familiarization of officials from the MOH and its executing units with the Bank's Policies and Procedures to minimize and forestall unnecessary delays in achieving project timelines;
- the completion of the Mid-Term Evaluation Report of 2000;
- the development and presentation of Requests for Extension in 2003, 2006 and 2007
- IDB Missions to assist in re-invigorating and driving the Programme forward. In particular there was a Portfolio Mission of May 2002, approximately six months following the national elections of December 2001, as well as an Administration Mission in 2003.
- Provision of flexible and innovative solutions to challenges and timely 'non-objections';
- several technical assistance projects tailored to the training needs of professionals.

One area of improvement that has been identified is the Bank's design of the original programme which lacked a results-based project management framework on which to base and measure project implementation and progress.

Bank Performance			
[ ] Highly Satisfactory (HS)	[X] Satisfactory (S)	[ ] Unsatisfactory (U)	[ ] Very Unsatisfactory (VU)

V. Sustainability

a. Analysis of Critical Factors

Commitment of the Ministry of Health to Health Reform. Both the MoH, and by extension the Government of Trinidad and Tobago, are firmly committed to the continued reform of the health sector. This is evident in the ongoing engagement of the MOH with the Bank throughout this programme, despite the delays and setbacks, and in the fact that GORTT significantly increased its counterpart funding to ensure the fullest possible implementation of programme activities. In 2008 the MOH formulated its Transformation Plan which identified key deliverables and fiscal priorities on an annual basis until 2013 (see Annex 10).

RHAs. Health Sector Reform reorganized health services delivery by shifting responsibility from the Ministry of Health to the five RHAs. The transition to full autonomy of the RHAs needs to be reinforced and the full transition of personnel to the RHAs must be fully completed in order to eliminate the dual system of staff management. The fact that new personnel will not be exposed to this dual system will contribute to sustainability. The Annual Service Agreements between the Government and the respective RHAs, based on rigorous needs assessments, as well as the Purchasing Services Intent (which allows for collective procurement), are intended to facilitate the strengthening of the RHAs. They should contribute to the more efficient provision of health services to the respective communities, and attract highly skilled personnel to the RHAs.

Stakeholder Involvement. The Ministry has begun to emphasize stakeholder involvement in the Ministry's policy making, including staff and officials from the vertical services of the MOH, the RHAs, the Public Service Association (PSA), various Chambers of Commerce, the Manufacturing Association, and health NGOs such as the Cancer Society. The reform process, along with currently increasing awareness among the population and the dissemination of information through the media, has now led to higher expectations for the health sector by the general public. A Directorate of Health Services Quality Management has developed "The Patient's Charter of Rights and Obligations" and a system for lodging complaints. In addition, the RHAs are mandated to hold annual public meetings to report their activities and received feedback and input from the populations they serve. They also use customer satisfaction surveys in an effort to create a more client-focused approach to the delivery of health care. It is anticipated that as customer satisfaction and quality care improve, patients will be less likely to visit private care facilities.

Ongoing activities. Several activities that began under the programme have not yet been completed. These are critical institutional or 'soft' reforms that are essential to improving the functioning of the sector, its service delivery, and ultimately the health of the population. These include: (i) The full implementation of the IS/IT Strategy that was developed. Completion is estimated to be in 2013; (ii) The implementation of the Change Management Strategy as part of the Human Resources Strategy; (iii) The agreement on and development of sustainable financing mechanisms for national health Insurance.

b. Potential Risks

Six risks to programme implementation were accurately identified in the original Project Document. Mitigation strategies for these risks were put in place but weakened by several factors, including the ramifications of three unprecedented national elections which affected the leadership and the timely decision making during the programme. The sustainability of the programme can be viewed in terms of: (a) the ability of the

government to continue the programme even after Bank funding has expired; and (b) the ability of the reform to continue to benefit the national community and contribute to better the health of the population.

The main risk to sustainability is the continued imbalance between infrastructure development and the introduction of new models of primary health care (the organisational reform). The need to provide additional assistance, at both the MOH and the RHA levels, to effectively operationalise the new/upgraded health facilities across the country was identified in the Ministry's Transformation Plan (2009-2013). The Ministry has developed strategies to address this need. Sustainability is also affected by the ability of the MOH to recruit and keep personnel with the required skills and competencies to manage and direct the implementation of the non-infrastructural components of the programme. In November 2009 the Ministry received the approval of the Cabinet to establish a Health Sector Human Resource Planning and Development Unit to engage in manpower planning and human resource activities for the health sector.

There are several other potential risks to this sustainability which include:

i. Budget shortfalls and their potential impact on the operations of an RHA. This is particularly significant at a time of global economic downturn and large national debt. However the anticipation is that the financing and costing mechanisms would have been sufficiently tested and improved by now to anticipate and forestall such an eventuality.
ii. Continuing institutional weakness in some RHAs. Some officials have expressed concern at their need for resources in areas such as project management, information systems, and the procurement process. Limited capacity in these areas may result in institutional inefficiencies and poor decision making. Technical support with any necessary financial support should minimize such a risk.
iii. Failure of an RHA to adequately estimate its demographics, (population increase or internal migration), and their service needs; for example, where there may be a surge in demand due to significant housing development. The dynamic nature of providing health care implies periodic monitoring and evaluation of existing and potential supply capability and capacity. Effective application of such tools should elicit the corresponding action.
iv. Failure of Change Management strategy developed by PWC to be implemented and sustained. The institutionalizing of the structure, process and culture of performance is critical to the success of this strategy.
v. Weakness of the IS/IT System Strategy. This strategy remains to be implemented. While the MOH has established a Central IT Unit and a Transformational IT Plan, as well as obtained the hardware to implement a National Health Information System, the implementation of this pivotal system is yet to be fully developed or staffed.
vi. Weak Procurement and Contracting Policies and Procedures. As observed during programme execution, problems with procurement and contracting hampered and aggravated the effective implementation of the HSRP. Therefore, it would be advisable to find more streamlined procurement practices that allow transparency and would mitigate the likelihood of such a recurrence in the future.

c. Institutional Capacity

The HSRP has succeeded in building institutional capacity in the health sector of Trinidad and Tobago. The RHAs can respond more quickly to human resource and other resource needs. They have the ability to hire staff and purchase supplies to meet pressing needs, thereby increasing effective service delivery. The RHAs, with additional institutional strengthening support in place, are better equipped to capture and maintain efficiency gains in providing health care services to their respective communities. The MoH now has a greater focus on national planning and priority setting, policy making, working with the regions on strategies and targets and allocating financial resources. Over the medium-term, as these institutions continue to develop and reinforce a culture of performance, the likelihood is high that programme results will be sustained.

Knowledge transfer did take place during project implementation. However, in a few instances expectations were not fulfilled. For example, critical skills and expertise dispensed by the PAU, such as project management, do not seem to have been transferred or entrenched into the operations of the Regional Health

Authorities (RHAs). With the phasing out of the PAU and its support to the RHAs, the operations of some RHAs were diminished by the loss such an invaluable resource. This capacity will need to be strengthened.

Sustainability Classification SU:			
[ ] Highly Probable (HP)	[x] Probable (P)	[ ] Low Probability (LP)	[ ] Improbable (I)

VI. Monitoring and Evaluation

a. Information on Results

Overall the HSRP did not have a sound data-gathering system. The original logframe did not contain quantitative indicators, largely due to the unavailability of data. The logframe and the respective outcome indicators were not updated at the time of re-profiling in 2003 because there were no systems in place in the MoH to capture data in a systematic manner. In 2005, when the Ministry had built capacity in its new Policy and Planning Unit to collect and measure the data, the logframe was revised and the measurable targets were established. However, neither quantifiable indicators nor baseline information were identified. Monitoring of the respective activities was undertaken by the various entities responsible for their implementation: the PAU, the TAP, the RHAs and NIPDEC. Deliverables were monitored based on TORs and project progress or lack thereof was discussed with the implementing entity, with project cancellation a consequence for consistent failure to comply with the relevant agreed contract.

The PAU experienced some challenges in establishing and following efficient and appropriate management systems and practices. This is documented in internal and external evaluations, as well as annual progress reporting. For example the fiduciary capacity of the PAU was often severely limited as demonstrated by its inability to submit accurate reports in a timely manner, delays in submissions of disbursements with adequate documentation and a general tardiness of follow-up. In fact, difficulty in providing adequate supporting documentation for several items that formed part of the committed amounts that the Bank agreed to disburse risked these amounts being cancelled during execution.

The Mid-Term Evaluation (MTE) for the project was held in July 2000. Five recommendations were made at the MTE: (1) Strengthen the operations of the ISC and the Project Execution Team, (2) Strengthen the administration and execution of the PAU, (3) Move forward in the staffing of the new directorates of the MOH, (4) Transfer public sector staff to the RHAs, and (5) Contract a change management consultant to assist in implementing the new MOH organizational structure and its new roles and responsibilities. While progress on these recommendations was very slow, they were all implemented by the end of 2008. In particular. In 2006, the M&E capacity was strengthened by the creation and staffing of a Policy and Planning Unit in MOH. In addition, in 2007 a decision was taken to integrate the PAU into the Ministry of Health's robust projects office. This portends well for the sustained success of the programme after the Bank's involvement ends. GORTT conducted a final evaluation of the HSRP in April 2010 which identified similar findings and recommendations as outlined in this PCR.

b. Future Monitoring and Ex-Post Evaluation

The Ministry of Health and the RHAs have developed their own monitoring and evaluation mechanisms which can be used to monitor programme effectiveness in the future. An Ex-Post Evaluation is planned for 2012.

VII. Lessons Learned

Institutional capacity and availability of skilled local staff must be well assessed, understood and acknowledged in order to create the appropriate organizational structure, project cycle, division of tasks, management systems, etc. when a programme is being developed. In several areas skill sets and expertise were lacking, including professionals in senior management positions, both in the executing entities and in the Ministry of Health at large. This hampered progress significantly, particularly in the first 6 years of the programme.

To attract individuals with more skills and experience a more attractive employment package may be helpful. Performance based contracts for personnel, including in the executing units, may also be useful.

Strong and committed leadership and senior management are critical to effective implementation. The tardiness and reluctance of senior managers to make decisions in a timely manner created significant delays. Oversight and management need to be robust to ensure performance. Clear measurement of management performance with objective indicators would help.

Stakeholder engagement is necessary early on and throughout the life of the project, particularly in one which requires substantial changes to the status quo. There was resistance to the institutional aspects and some stakeholders had neither the interest nor the incentive to 'buy in' to any drastic changes that would affect employment status or responsibilities. Such stakeholders included trade unions, health service employees, public servants, and other professional staff. A promotion campaign to facilitate an understanding of the reform process and a negotiating strategy to address the resistance were needed. For example, if there had been ongoing consultations, a HR strategy and a bargaining authority for potential transferees from MOH to the RHAs could have been established earlier (in 1996 rather than in 2007) in order to lay the groundwork for more timely implementation of the VSEP and employee transfer process. Similarly, promotion and awareness was needed in the MOH itself. As the principal architect of its own change, it seemed to experience innate resistance to such change. Positions critical to driving change and transformation were left unfilled for significant periods (e.g. the new directorate positions). Only when general 'buy in' was elicited from MOH officials did the programme gain and sustain momentum.

A complete institutional assessment of all the entities involved in the execution of the programme is needed prior to its commencement. For the HSRP the several co-entities charged with the execution of different activities had varied strengths, capabilities and commitment to the goals and objectives of the programme. The PAU suffered from insufficient staff and skills deficiencies in some areas. NIPDEC lacked strengths in health facility construction and large projects and had uneven technical capacity. The ISC performed sporadically and the PET was unable to take timely decisions and find consensus. **Clear planning, coordination and feedback mechanisms among the various entities would have been important in driving their collective and individual effectiveness.**

A better sequencing design for the implementation of the components of complex programmes is required. The lack of a cohesive and integrated approach to implementation slowed the thrust for initiating and completing activities. The technical components lagged behind the physical infrastructure components. As a result the Change Management, which was started in 2003, only gained momentum in 2008 and is still not completed. Similarly the IS/IT system is now being implemented with completion targeted at 2013. Such a system is essential to be able to measure and improve performance in both the MOH and the RHAs. The Human Resource strategy commenced in 2007. To drive the reform agenda, an appropriate human resource base should have been built in as a first priority throughout the public sector. As a second priority, there should have been the incremental introduction of RHAs informed by the a-priori development of appropriate and robust management support systems, business plans, operation manuals and protocols.

Functioning project management tools, including a Management Information System (MIS) with linkages to financial and works management systems, should be put in place at programme inception. This would have been particularly useful for a programme of this large a dimension. An analysis of the information needs required for management decisions could have been integrated into such a system early on in the programme. Efficient document management would have prevented the misplacement of critical documents, which affected the PAU and its ability to report, evaluate, procure, disburse, etc. Ex-post evaluations of individual projects would also have been useful to identify and investigate bottlenecks, document lessons learned and promote project cycle and organizational development. Such evaluations could be included in the operating manual and in the budget.

A single procurement regime would have increased efficiency. The use of two different procurement regimes, one following IDB processes for IDB loan resources and another following Central Tender Board

regulations for counterpart funding (and even another used by NIPDEC), invited misunderstanding, delays and unnecessary scrutiny. For future IDB-funded projects in Trinidad and Tobago and based on a satisfactory country systems assessment, the Bank can explore with GORTT the greater reliance on national procurement systems.

Logical framework indicators should be clearly defined from the beginning of the programme with existing reliable data sources and baselines. Both the original and revised logframes lacked quantitative and measurable indicators. Better use of the logical framework would help to monitor and guide the pace of implementation. In addition, survey exercises could have been incorporated into the design phase to establish or update benchmarks which could be measured at mid-term to track progress. For example, patient waiting time, diseases treated and morbidity statistics could have been tracked. Similarly, such surveys could have provided information at the start, and during implementation, on satisfaction levels of: (a) staff, doctors and other practitioners with their working environment and employment benefits; and (b) patients with the quality and timeliness of care received.

While these are the most significant lessons learned, there are others that are noteworthy such as the need for orientation for those involved in implementation to include training in the policies and procedures such as procurement; the need for refresher training for staff due to the significant extensions of the programme; the continued alignment of the programme with Borrower priorities; the need for flexibility and innovation during a lengthy implementation period; and the overarching importance of the level of commitment of the Borrower to the timely and effective achievement of programme goals.

Lessons learned from the HSRP must be considered in the context of: (a) the complexity of structural reform in any health sector; (b) the numerous programme components, including technical cooperation, civil and infrastructure work, pre-investment activities, a IS/IT system, a HR strategy, and a health financing system ; (c) overlapping timeframe of three closely contested elections between 1996 and 2002; (d) appointment and incumbency of six MOH between 1996 and 2008, combined with changes of Permanent Secretaries over the same period; and (e) an overly ambitious timeframe, (seven years), for programme execution.

Annexes:

1. Technical Assistance: Timing and Summary by Components
2. HSRP Reformulated Logical Framework following re-profiling (2005)
3. Analysis of Programme Achievements based on Purpose (Draft PCR 2008)
4. Retrofitted PPMR indicators (updated for 2010)
5. Project Cost Table by Component and by Funding Source (Planned and Actual)
6. Borrower Evaluation Form
7. Minutes from Project Exit Workshop
8. Persons Interviewed
9. Documents Reviewed
10. Key Pillars of MOH Transformation Plan 2008-2013

Annex 1
Technical Assistance: Timing and Summary by Components

TECHNICAL ASSISTANCE: TIMING AND SUMMARY BY COMPONENTS HSRP, 1996-2003								
	PM*	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7
COMPONENT 1: REFORM OF THE MOH	**764**							
Management systems development	22							
Management development training	32							
Health planning/policy analysis	24							
Quality assurance and auditing	24							
Technology assessment	4							
Training and staff development	12							
Audit of vertical programmes	18							
Information systems**	520							
Health sector reform advisor	36							
Communications coordinator	36							
PR/media support	36							
COMPONENT 2: DECENTRALISATION	**172**							
Management systems development	22							
Management development training	114							
Training and staff development	36							
COMPONENT 3: HUMAN RESOURCES STRATEGY	**238**							
HR advisor	18							
HR implementation support	214							
Pension consultant	6							
COMPONENT 4: RATIONALISATION	**346**							
PHC development	36							
PHC training	20							
Ambulatory/day care	12							
Family medicine	3							
Hospital commissioning	24							
Ambulance services	126							
Community care	113							
Feasibility study – Scarborough	12							
COMPONENT 5: HEALTH FINANCING STRATEGY	**113**							
Health financing	67							
National health insurance	46							
Population registration system	TBA							
ADMINISTRATION	**792**							
PAU Director	84							
Health infrastructure procurement	48							
Finance controller	84							
Office manager/administrator	84							
Administrative staff	420							
Technical assistance management	36							
Technical assistance administration	36							
TOTAL	**2,425**							

Source: IDB, Loan Proposal (TT- 0024), 18 June 1996 Annex II-6 (reproduced)

- Person/Month

** Technical Assistance covers both MoH and RHAs

Annex 2

HSRP Reformulated Logical Framework following re-profiling (2005)

HSRP Logical Framework (Adapted)			
Narrative Summary	**Indicators**	**Means of Verification**	**Assumptions**
Goal			
Improve the health and wellness status of the Population of Trinidad and Tobago	5% reduction in neo-natal mortality by 2010 5% reduction in infant mortality by 2010 5% reduction in maternal mortality by 2010 10% reduction in Communicable Disease Morbidity by 2010	National Disease Surveillance Reports Central Statistical Office (CSO) Reports Reports on alcohol consumption, tobacco use, etc	Adequate numbers of qualified MoH, RHA, and CSO staff to collect and analyse data ERHA Surveillance Pilot Project Roll-out throughout the country
Purpose			
To achieve greater efficiency, equity, sustainability, and quality of public and private health services	Stabilised costs, optimized utilization rates, increased accessibility, defined medium- and long-term financial plans, medical audits implemented to monitor quality of services, increased consumer satisfaction, reduced waiting times, more efficient and rational allocation of resources	Annual Service Agreements (ASA) MoH and RHA Budgets Clinical Audit Reports Quality Wellness Audit Reports Household Surveys Patient Surveys	Reform of MoH, decentralization of service delivery, implementation of human resource strategy, infrastructure rationalization and development of financing strategy are sufficient to achieve greater efficiency, equity, sustainability and quality through better allocation of resources, cost containment, increased accessibility and greater consumer satisfaction

Proposed Outcomes (Components)			
1. The policy and regulatory capacity of the Ministry of Health strengthened	MoH Policy Planning and Epidemiology Unit fully operational MoH Policy and Regulatory Management Structures and Systems Implemented 1st Health Needs Assessment Completed National Disease Surveillance System Implemented National Promotion/Wellness Strategy Implemented	MoH Business Plan RHA Business Plan HRIS Reports ASAs Quality Council Minutes HNA Reports Disease Surveillance System Reports Site visits Actuarial Review Reports Pension Plan Reports Hospital Admissions and Discharges Reports PSIP Financial Reports	Financial resources available Adequate numbers of qualified staff available Director Policy, Planning and Epidemiology Unit hired Technical Assistance completed in a timely manner, e.g., MoH Change Management, Health Needs Assessment, Risk Management, Infection Prevention and Control etc ERHA Disease Surveillance 'Pilot' Project completed and rolled-out throughout the country No legal challenges to transfer of public service staff to RHA employment Pension Fund fully funded RHA-Community Home Care Contract approach approved by GoRTT GoRTT accepts the advice of the NHI System Cross-Functional Steering Committee GoRTT agrees on a 'basic package' of services to be insured
2. RHA capacity to deliver quality health and wellness services strengthened	MoH-RHA Monitoring Framework implemented Information Systems/Information Technology Strategy Implemented Quality Management Programme implemented		
3. Health Sector Human Resource Strategy Implemented	Transfer of Public Servants to RHA Employment Completed Health Sector Training Plan implemented		
4. The delivery of quality health and wellness services rationalised	Primary Health Care Services Model Implemented Primary Health Care Facilities Construction and Renovation Programme completed Strengthening of Hospital Services completed Hospital Construction and Renovation Programme completed National Community Care Policy 'Pilot' Project completed		
5. The financing of quality health and wellness services improved	Long-term Health Financing Strategy Implemented		

Component Outputs			
1. The policy and regulatory capacity of the Ministry of Health strengthened i. MoH Policy, Planning and Epidemiology Unit operational ii. MoH Policy and Regulatory Management Structures and Systems Developed iii. National Health Needs Assessment and Disease Surveillance System Developed	Health Section Vision Statement approved Health Technology Assessment Policy approved Medical Records Policy approved Risk Management Policy approved MoH Business Plan finalized and approved MoH Purchasing Service Intention Plan finalized and approved Annual Service Agreement (ASA) guidelines finalized and approved 1st Health Needs Assessment Framework completed National Disease Surveillance 'Pilot' Project ERHA completed	Vision Statement distributed to Stakeholders Approved Policies distributed to Stakeholders MoH Business Plan available to RHAs Purchasing Service Intention Plan available to RHAs Annual Service Agreement guidelines available to RHAs HNA Reports distributed to Stakeholders Disease Surveillance Reports Annual Service Agreements HSRP Annual Reviews (High Level Action Plan)	Director, Policy, Planning and Epidemiology Unit hired Technical Assistance completed in a timely manner, e.g., MoH Change Management, Health Technology Assessment, Risk Management, etc. PAHO Technical Assistance available as required/agreed Financial Resources available Public Servants transferred to RHA employment Adequate numbers of qualified staff available
2. RHA capacity to deliver quality health and wellness services strengthened i. Information Management Strategy approved ii. MoH-RHA Monitoring Framework implemented iii. Quality Management programme implemented	National Information Strategy approved MoH Business Plan finalized RHA Business Plan completed Annual Service Agreement approved Waiting List Management Policy approved Clinical Audit Policy approved Infection Prevention and Control Policy and Procedures Manual approved HN Ward Management Training implemented Accreditation System Legislation drafted Quality Management Legislation drafted	Hardware and software applications delivered to MoH and RHA MoH and RHA Business Plan approved PSI available to RHAs RHA Reports Annual Service Agreements Site Visits HN Training Programme on-going in 5 hospitals Legislation enacted Accreditation Agency established	Financial and Human Resources available to implement plan MoH PSI available Technical Assistance is completed PAHO TA support is available as required Health Professionals support for Policies Legislation passed by GoRTT and promulgated
3. Health Sector Human Resource Strategy Implemented i. Health Sector Human Resource Strategy implemented ii. Managed RHA Pension Plan iii. Public Servants Transferred to RHA employment	Primary Health Care Training Programmes implemented Technical Training Programmes implemented Management Training Programmes implemented Oncology Training Programmes implemented Pension Fund TT$51.5m 2004-5 Pension Fund TT$51.5m 2005-6 3554 perm. employees transferred 431 temp. employees transferred 241 Public Servants Retired	HR 'Bonding' Reports Annual Reviews (High Level Action Plan) Tri-Annual Actuarial Review Minutes of the Pension Committee RHA Pension Records RHA HRIS Reports MoH HR records MoH HRIS reports	MoH HR Training Unit adequately staffed to finalise health sector training plan GoRTT approves the HR Training Plan Adequate financing is available to support training Actuarial valuation of RHA Pension Plan completed and the Plan appropriately financed GoRTT policy decision to transfer staff effected and financial resources available
4. The delivery of quality health and wellness services rationalized i. Primary Health Care Services Strengthened ii. Primary Health Care Facilities Construction	Primary Health Care and Health Promotion Model implemented National Health Promotion Strategy implemented 10 Primary Health Care Chronic Disease 'Pilot' Projects completed 4 new DHF operational 1 DHF operational	MoH-PAHO TA Agreement Deliverables Monitoring Report CCC Deliverables Monitoring Report OPM Deliverables Monitoring Report National Health	MoH and RHA Health Professionals accept new PHC and Health Promotion services delivery model Financial resources are available Sufficient numbers of qualified staff available Construction delays resolved CCC and OPM technical

and Renovation Programme completed	2 new EHC operational 1 EHC renovated 10 new HC operational 2 HC renovated 4 new OC operational 15 OC renovated	Promotion Committee Reports RHA Local Health Promotion Committee Reports PHC 'Pilot' Project Status Reports	assistance Scope of Work Extended NIPDEC Construction Project Management Function regularised SFHG Level 2 and 3 Re- design completed Required Services (27) Upgraded at EWMSC
iii. Hospital Services Strengthened	New Scarborough Hospital operationalised Old Tobago Hospital decommissioned SFGH ICU, Burns Unit, Day Surgery operationalised Pharmacy and Laboratory Services upgraded Phases 1 – 3 EWMSC Upgrade complete	Hospital A& D Reports RHA-Community Home Care contract signed PAU Status Reports RHA Status Reports NCRHA Reports NOP/NOC Status Reports Annual Services Agreement (ASA)	GoRTT approves Community Care Contract as the payment vehicle and community care standards monitoring
iv. Hospital Construction and Upgrade Programme completed	New Scarborough Regional Hospital completed SFGH construction upgrades complete Upgrade PoSGH completed New Point Fortin Hospital completed SGH/EHC integration complete National Oncology Centre	PSIP	
v. National Community Care Policy 'Pilot' Project implemented	78 St James Medical Complex patients placed in Community Care 64 St Ann's Hospital patients placed in Community Care 13 SFGH patients placed in Community Care 9 PoSGH patients placed in Community Care 39 SGH patients placed in Community Care		
5. The financing of quality health and wellness services improved Develop a financing strategy for the health sector	NHI Cross-Functional Steering Committee appointed Technical Secretariat hired	MoH Business Plan NHI Progress Reports PSIP Reports	GoRTT approved NHI Financial Resources are available Adequate numbers of quality staff available
Source: RMC TAP Unit, *VI Report, 1999 – 2005, Appendix 2*, 11 June 2005			

Annex 3
Analysis of Programme Achievements based on Purpose (Draft PCR 2008)

ACHIEVEMENT OF DEVELOPMENT OBJECTIVES (DO)		
Development Objective(s) (Purpose)	**Key Outcome Indicators**	
Goal1. Efficiency Classification: P	**b) Planned Outcomes** Reduced waiting times Increased consumer satisfaction Stabilised costs Medium- and long term financing plans More efficient and rational allocation of resources	**4) Outcomes Achieved** Consumer/patient survey conducted by MoH & RHAs Decentralisation of service delivery facilitated identification of efficiencies, more so than under the previous centralized budgeting process. Such efficiencies are reflected in purchase decisions of supplies and equipment Administration and operations costs reduced, and to be reduced further with deployment of projected IS/IT System Directing specific demand for health care to specific service more efficient: e.g. to primary care away from emergency, secondary or tertiary care Financial and accounting systems designed for RHAs deemed weak and insufficient in 2004. [Work processes are to be re-designed and developed for MoH and RHAs by 1st Qtr 2008]With completion of infrastructure activities, further efficiency gains are likely.
Goal 2. Equity Classification: P	a) **Planned Outcomes** Optimised utilization rates Increased consumer satisfaction Reduced waiting times	**5) Outcomes Achieved** Community care facilities being deployed to minimize unnecessary demand for hospital beds, with care standards developed; more effective direction of patients to primary health care facilities Location of HCFs and range and quality of services offered by the respective RHA ensure comprehensive community reach. Completion of HCFs under construction will increase this reach Health Financing Strategy (and NHI) as yet to be determined and deployed. Activities continue to achieve its development and eventual deployment Emergency Health Services more readily available
Goal 3. Sustainability Classification: P	**a) Planned Outcomes** Stabilised costs Optimised utilization rates More efficient and rational allocation of resources	**6) Outcomes Achieved** GoRTT commitment to sustainability remains firm Some training programmes to strengthen and enhance skills conducted Health Financing Strategy is yet to be completed Activities to develop IS/IT Systems to improve decision making, improve efficiency and facilitate sustainability only recently initiated Health Care Financing strategy yet to be determined and deployed Change Management is to be completed in 2008, and be part of the culture of performance to reinforce the objective of Health Sector Reform
Goal 4. Quality of public and private health service Classification: P	**a) Planned Outcomes** More efficient and rational allocation of resources Medical audits implemented to monitor quality Optimised utilization rates More efficient and rational allocation of resources	**7) Outcomes Achieved** Training programmes reinforce institutional capability Site visits conducted Customer/patient survey implemented. Follow up to be done in April 2008. ASAs permit more directed, improved decision making for PHC delivery For at least one RHA Quality Teams formed and Risk Management Strategies developed by 1st Qtr 2008 Accreditation systems being implemented Activities for development, testing and deployment of IS/IT System for MoH and RHAs only recently (2007) initiated, with projected completion date of 2012.

Annex 4
Retrofitted PPMR Indicators
Last update – March 2010

ACHIEVEMENT OF KEY DEVELOPMENT OBJECTIVES (DO)	
Development Objective/Purpose: To achieve effectiveness, equity, sustainability and quality of healthcare and wellness services in Trinidad and Tobago	
Key Planned Outcome Indicators	**Outcomes Achieved**
1.1 Description: Infant mortality reduced to 15 per 1000 number of deaths **Unit:** Number per 1000 **Baseline Target** 18 (10 June 2005) **Annual/Intermediate Target** **EOP Target** 15 (31 Dec 2010)	16 (31 Mar 2010)
1.2 Description: Implementation of 10 Customer satisfaction surveys by May 2009 **Unit:** Number of surveys **Baseline Target** 0 (21 Jul 1996) **Annual/Intermediate Target** **EOP Target** 10 (12 May 2009)	9 (31 Mar 2010)
1.3 Description: Communicable Diseases Mortality reduced to 60 per 100,000 **Unit:** Number per 100, 000 **Baseline Target** 68 (10 Jun 2005) **Annual/Intermediate Target** **EOP Target** 60 (31 Dec 2010)	65 (31 Mar 2010)

IMPLEMENTATION PROGRESS (IP)	
Components (Outputs)	
Component Title: Reform of the Ministry of Health	
1. Description: Completion of training programmes in Strategic Management and Health Policy **Unit:** Number of training programmes **Baseline Target** 0( ) **Annual/Intermediate Target** **EOP Target** 5 (12 Apr 2010)	5 (31 Mar 2010)
Component Title: Decentralization of service delivery	
1. Description: Full complement of RHA employees **Unit:** Number of full time RHA Employees **Baseline Target** 0( ) **Annual/Intermediate Target** **EOP Target** 5000 (12 Apr 2010)	5200 (31 Mar 2010)
Component Title: Health financing strategy	
1. Description: Complete 3 key studies to establish NHIS framework **Unit:** Number of studies **Baseline Target** 0 ( ) **Annual/Intermediate Target** **EOP Target** 3 (12 Apr 2010)	4 (31 Mar 2010)
Component Title: Human resources strategy	
1. Description: Establish and fund RHA Pension Plan **Unit:** USD$ Millions **Baseline Target** 0 ( ) **Annual/Intermediate Target** **EOP Target** 20 (12 Apr 2010)	3 6 (31 Mar 2010)

Component Title: Rationalization of Infrastructure and Service mix			
1. Description: establish national ambulance service **Unit:** No of ambulances			
Baseline Target 0( )	**Annual/Intermediate Target**	**EOP Target** 100 (28 Nov 2003)	100 (26 Nov 2004)
2. Description: Renovate 22 health centres **Unit:** No of Health Centres			
Baseline Target 0(21 Jul 1996)	**Annual/Intermediate Target**	**EOP Target** 22 (12 Apr 2010)	22 (31 Mar 2010)
3. Description: Completion of district health facilities **Unit:** Number of facilities			
Baseline Target 0(30 Jul 1996)	**Annual/Intermediate Target**	**EOP Target** 4 (12 Apr 2010)	4 (31 Mar 2010)
4. Description: Construction of Tobago Hospital **Unit:** No of hospitals			
Baseline Target 0(30 Jul 1996)	**Annual/Intermediate Target**	**EOP Target** 1 (Apr 2010)	0.25 (31 Mar 2010)

Annex 5
Project Financing

Source of Financing
(Amounts in thousands of US Dollars)

INVESTMENT CATEGORY	Original Budget			Cumulative Investments			Variance as a Percentage of Original Budget		
	IDB	GoRTT	TOTAL	IDB	GoRTT	TOTAL	IDB	GoRTT	TOTAL
1. Administration, Design & Supervision	**5,455**	**986**	**6,441**	**8,852**	**23,351**	**32,205**	**162%**	**2368%**	**500%**
1.1 Administration	1,711	570	2,281	1,120	4,545	5,666	65%	797%	248%
1.2 Design & Supervision	3,744	416	4,160	7,733	18,806	26,539	207%	4521%	638%
							-		-
2. Direct Cost	**105,004**	**17,564**	**122,568**	**122,642**	**58,380**	**181,012**	**117%**	**332%**	**148%**
2.1 Hospitals	33,312	-	33,312	40,879	20,916	61,798	123%		186%
2.2 District Health Facilities	6,991	-	6,991	11,497	4,616	16,114	164%		230%
2.3 Health Centres	11,702	-	11,702	19,332	10,883	30,197	165%		258%
2.4 Ambulance Service Equipment	1,685	-	1,685	-	-	-	0%		0%
2.5 Information Systems Equipment & Software	6,173	-	6,173	2,407	9,616	12,025	39%		195%
2.6 Human Resource Strategy	29,783	17,564	47,347	32,591	5,476	38,067	109%	31%	80%
2.7 Technical Assistance	11,181	-	11,181	12,395	4,139	16,536	111%		148%
2.8 Training	3,657	-	3,657	2,982	2,734	5,718	82%		156%
2.9 Preinvestment Studies	520	-	520	557	-	557	107%		107%
								-	
3. Concurrent Costs	**13,587**	**2,113**	**15,700**	**1,403**	**1,603**	**3,009**	**10%**	**76%**	**19%**
3.1 Initial Operating Expenses: Ambulance Service	11,447	1,931	13,378	2	-	2	0%	0%	0%
3.2 Initial Operating Expenses: Community Care Fund	1,551	182	1,733	425	1,585	2,010	27%	871%	116%
3.3 Early Management Costs: RHA	589	-	589	977	18	997	166%		169%
4. Unallocated	**8,614**	**824**	**9,438**	**-**	**-**	**-**	**0%**	**0%**	**0%**
4.1 Contingencies	4,535	288	4,823	-	-	-	0%	0%	0%
4.2 Cost Escalation	4,079	536	4,615	-	-	-	0%	0%	0%
			-						
5. Financial Costs	**1,340**	**36,513**	**37,853**	**1,103**	**42,777**	**43,880**	**82%**	**117%**	**116%**
5.1 Interest	-	33,641	33,641	-	37,630	37,630		112%	112%
5.2 Credit Commission	-	2,872	2,872	-	5,147	5,147		179%	179%
5.3 Inspection & Supervision	1,340	-	1,340	1,103	-	1,103	82%		82%
				-	-	-			
TOTAL	**134,000**	**58,000**	**192,000**	**134,000**	**126,111**	**260,106**	**100%**	**217%**	**135%**

Source: LMS Executive Financial Summary; Final AFS

ANNEX 6

Inter-American Development Bank
Project Completion Report –2006 PCR
Borrower Evaluation

Project Name:	**Health Sector Reform Program**		
Executing Agency:	**Ministry of Health, Government of the Republic of Trinidad and Tobago**		
Borrower:	**Government of the Republic of Trinidad and Tobago**		
Date of Project Approval:	**July 10, 1996**	Date of Contract Effectiveness:	
Date of Borrower Evaluation:	**June 06, 2011**	Expected Date of Exit Workshop:	**June 09, 2011**

Borrower Project Performance Ratings

Probability on Achieving its Development Objective(s):

[ ] Highly Probable (HP) [P] Probable (P) [ ] Low Probability (LP) [ ] Improbable (I)

Project Implementation:

[ ] Highly Satisfactory (HS) [P] Satisfactory (S) [ ] Unsatisfactory (US) [ ] Very Unsatisfactory (VU)

Sustainability of Project Results:

[ ] Highly Probable (HP) [P] Probable(P) [ ] Low Probability (LP) [ ] Improbable (I)

Comments:

1. Significant progress was made and emphasis placed on the physical infrastructure improvements at the primary care level. This was particularly so given the poor infrastructure conditions that existed prior to the reform initiative at the majority of the health centres. The improved physical environment was a welcomed development for staff and patients.
2. A main concern in achieving the development objective was the lack of the requisite human resource requirement and appropriate staffing levels, including: clinical, nursing, pharmaceutical and administrative, to meet the expanded services needs and public expectations at the various health care facilities. Whilst there have been some improvements, this continues to be a challenge towards meeting the standards of services delivery. As an example, provision of Dental services at these primary care facilities continues to be affected as a result of the inability to attract and retain the dental professionals.
3. The maintenance plans of the new infrastructure also required much attention. This is very important and must be addressed if the Ministry is to ensure that the physical plant and equipment are maintained in a satisfactory condition and continues to meet its intended purpose and useful life in a sustainable manner.
4. Whereas the political will was present, there was moderate strategic management support. Although the relevant structures such as the Inter Ministerial Steering Committee, the Project Execution Team, Project Administration Unit, the Local Counterpart Team and Transition Team were all established for successful implementation; these structures did not always translate to implementation.
5. The absence of a dedicated **Change Management** (CM) program as part of a wider **Organization Development** (OD) strategy was not part of the Project and this compromised Project sustainability. One critical implication is that any positive gains made through the Project cannot be guaranteed by the fact that the positive changes made have not been anchored in new behaviours, practices and organization culture. This is a valuable lesson learnt and is critical to ensuring the Project's sustainability and has to be addressed as a matter of urgency to ensure that the gains made remain.
6. The physical infrastructural component of the Program was not married with a sufficiently robust **organization development** component to anchor the various positive changes.

Bank Performance

Please rate the Bank's overall performance during project preparation and execution. Factors to be considered include the extent to which the Bank facilitated a participatory project design, proposed adequate technical solutions to the problems identified, and responded to the needs of the Borrower (timeliness, selection of instrument type) as well as technical assistance (including informal and formal training) to Executing Agency, timeliness of Bank response and the Bank's flexibility to respond to emergency situations during project implementation. Your comments will be incorporated unedited into the PCR.

[ ] Highly Satisfactory (HS) [S] Satisfactory(S) [ ] Unsatisfactory (US) [ ] Very Unsatisfactory (VU)

Comments:

1. In general the overall performance of the Bank was quite good in particular the technical assistance that was provided.
2. There was a good level of participatory project design at project inception with high participation and involvement of a number of key stakeholders.
3. The Bank appeared at time to be reluctant to change the project design as the project progressed and seemed to be sometime more concerned with keeping the project moving than getting the project right. Whilst momentum, timeline and schedules are important and critical to project efficiency, one has to recognize, particularly given the time span of this project that external conditions change and as such some level of flexibility is not only required, but necessary to ensure the that original solutions remain valid. As an example of this the reluctance of the Bank was noted when it came to changing or updating the original designs of the primary care facilities despite the fact that areas of deficiencies were noted, such as in storage provision, patient waiting, etc.
4. The Bank however did demonstrate flexibility and responsiveness in other areas in responding to some of the other changing needs and realities of the Ministry and appreciated the local factors impacting upon the project's success, for e.g., the reallocation of funding from the pension plan to the VSEP exercise thereby facilitating a critical objective of the Reform Program, namely addressing the dual track employment issue in the newly created Regional Health Authorities (RHA).
5. Technical assistance was satisfactory but could have been a bit more responsive as far as informal (and to a lesser extent) formal training was concerned particularly where new persons were brought into the system at the closing stages of the Programme. Although it is noted that lack of borrower's capacity sometimes impacted on the borrower's ability to benefit from the training components.
6. The Bank's oversight was quite good. There was open, ongoing collaboration throughout the phases of the project.
7. The Local IDB Project Officer (**Mr. Ian Ho-A-Shu**) has been very much a strategic partner and collaborator in the process and assisted the Ministry in staying the course over the extensive and protracted period of the project through vigilant monitoring of the progress of the project and providing sound technical advice with a high degree of professionalism, national social compassion, concern for project success, care and due diligence.

Borrower Performance

Please rate your own overall performance during project preparation and execution.

[ ] Highly Satisfactory (HS) [S] Satisfactory(S) [ ] Unsatisfactory (US) [ ] Very Unsatisfactory (VU)

Comments:

1. Generally there was a strong commitment and willingness on the part of the Ministry of Health's personnel and the Regional Health Authorities' to respond to the demand and challenges of the project.
2. Whereas there was the commitment and willingness, in some instances this commitment and response may have been affected or compromised by the level of skill or capacity to provide relevant inputs as this capacity may not have existed, or available in the required strength and quantity.
3. Also, a lack of awareness of project goals and objectives (the big picture) by some key players may have also contributed to periods of inactivity and timeliness of response.
4. The MOH needed to strengthen its project execution through better documentation and improved information management system, which ideally should have been computerized to allow for the establishment of a comprehensive knowledgebase which should and would have mitigated reliance solely on "institutional memory".
5. There was need to better integrate the 'project execution unit' into the central Ministry's operations and improve the communication and reporting mechanism. This reinforced the need for the borrower to ensure that a robust monitoring and evaluation mechanism was in place. This is an important point to note as the Ministry had taken up the challenge of transforming itself, by itself while continuing to deliver services to the general public of Trinidad and Tobago; under the best circumstances with the best resources this is a difficult challenge. In the Trinidad and Tobago setting it was herculean!
6. There were a number of factors that directly impacted on the implementation rate of the Program by the Ministry that would have also impacted on the achievement of some of the successes anticipated in the timelines dictated by the Project schedule. These included:
   - Consideration to the fact that a large and comprehensive program such as the HSRP with an initial projected life-span of seven (7) years, in the first instance, would cross political electoral periods and therefore would be subject to the expected mandatory reviews and revisions based on new priorities and/or developmental needs. This was not factored in the implementation schedule and programming and it should have been anticipated that this factor would impact on the rate of implementation as well as a review of programming decisions and priorities.
   - The fact that the Ministry did not have the authority and autonomy to implement the Human Resource (HR) Strategy without authorization from other Ministries/Statutory Authorities, such as Ministries of Public Administration and Finance, and the Service Commission and the Chief Personnel Officer (CPO). MOH was not the corporate sole in this regard. Comprehensive legislative reform and a wider modernization of the public sector would have facilitated a more successful health sector reform;
   - Frequent senior executive turnover at the Ministry and at the Regional Health Authorities affected institutional memory loss, weakened managerial and technical system strength, and steepened the learning and progress curve;
   - Lack of the technical and managerial capacity and ability for implementing complex new systems and processes.
7. That being said, in hindsight **the HSRP as defined and designed was ambitious**! More consideration should have been given to the **institutional strengthening** of the Ministry of Health prior to the initiation of the Project to be better able to cope with such a herculean and mammoth undertaking as reforming and transforming an entire health sector. Another critical lesson to inform the way forward.

Additional Suggestions for Improving Bank Performance

Additional comments/suggestions for improving Bank performance in the future.

Comments:

1. Continued support for a participatory approach with all stakeholders is acknowledged as best practice. However, it may be necessary that the Bank ensures a more **sustainable communication strategy** to ensure stakeholders are kept up-to-date of development, progress, problems, new strategies, and more importantly where new persons are introduced during the project execution who may not have been familiar with the original project design and plans at inception.
2. The constant and continuous need for **project renewal** and **project recommitment** as active process.
3. Since structures are absolutely essential for sustainable processes and outcomes, the Bank may wish to ensure that the legal/regulatory framework in the borrower country are appropriate for facilitating reforms and for sustainability; this can be achieved by making this a pre-condition to the loan agreement, or a condition for further disbursements.
4. Introduce a more stringent mechanism to ensure borrower follow-up action following periodic Bank reviews.
5. Large projects such as the Trinidad and Tobago Health Sector Reform Program (HSRP) are not only about improving delivery infrastructure, but more importantly about transforming how services are delivered and improving the lives of a people; it is about how we do business and improving health service delivery and effectiveness. Toward this end the **leadership capacity** of the implementing institution, i.e., the Ministry of Health, must be considered and if necessary strengthened (**institutional strengthening**) at the beginning of the project so as to be able to deal with the requirements and demands of such a massive reform undertaking. This may be an area where the Bank can take the leadership for ensuring that the required skill, technical and managerial competencies are included in the project; not only at the design stage but throughout the project. These would be **consultant professionals** retained by the Bank to **strengthen and support** the country's capacity, capability and effort. They will not be the public servants subject to change, but professionals/consultants serving as internal advisors/resources to be Ministry to assist in **building capacity** and **institution strengthening** at all levels. Both the Bank and the Country would benefit from such an initiative.

(Original signed)
Signature: Date: 10/06/11

Mrs. Sandra Jones
Permanent Secretary
Ministry of Health
Government of the Republic of Trinidad and Tobago

Witness:

(Original signed)
Signature: Date: 10/06/2011

Dr. Anton Cumberbatch
Chief Medical Officer
Ministry of Health
Government of the Republic of Trinidad and Tobago

ANNEX 7

HEALTH SECTOR REFORM PROGRAM (TT-0024)
PROJECT EXIT WORKSHOP MINUTES
9 June, 2011

MEETING AGENDA

Welcome and Introductions	Sr Health Specialist, IDB
Review of Draft PCR	Group Discussion

- Assessment of project results and likelihood for their sustainability
- Lessons Learnt and the way forward
- Borrower evaluation

Closing Remarks	Permanent Secretary, Ministry of Health

Present:

Mrs. Sandra Jones	Permanent Secretary, Ministry of Health (MOH)
Dr. Anton Cumberbatch	Chief Medical Officer, MOH
Mr. Asif Ali	Director, Finance and Accounts, MOH
Dr. Andrea Yearwood	Director, Health Policy, Research and Planning, MOH
Dr. Rohit Doon	Advisor, Health Promotions, Communications and Public Health, MOH
Dr. Andy Thomas	Sr. Health Economist, MOH
Mr. Stewart Smith	Sr. Health Systems Advisor, MOH
Dr. Edison Haqq	Chairman, Northwest Regional Health Authority, MOH
Mrs. Valerie Alleyne-Rawlins	Fr Advisor, Quality, MOH
Mr. Gabriel Castillo	Chief of Operations, IDB
Mr. Ian Ho-a-Shu	Sr. Health Specialist, Team Leader, IDB
Mrs. Denise Salabie	Financial Management Specialist, IDB
Mrs. Neeca Brathwaite	Operations Sr. Analyst, IDB
Ms. Priya Ramsumair	Research Assistant, IDB

Welcome and Introductions: The meeting began with opening remarks from Ian Ho-a-Shu, Team Leader, who outlined the aim of the session which was to review the PCR of the project, with a focus on understanding the factors that affected the implementation of the project, both positively and negatively, as well as lessons learned and the way forward. He noted that the project had in execution for 14 years and as such he wanted to recognize the efforts of several persons throughout the execution period, namely:

Dr. Rawle Edwards, Former Chief Medical Officer
Mr. Errol Pilgrim, Former Permanent Secretary, MOH
Mr. John Eckstein, Former Minister of Health
Mr. Martin Riley, Former PAU Director
Mr. David Rogers, Social Sector Specialist, IDB

The Team Leader presented the historical context for the design of the loan operation, copy of which is attached to the minutes. The following summarizes the discussion following the presentation.

Assessment of project results and the likelihood for their sustainability

- **Positive Externalities:** The meeting noted that one positive externality that had been omitted from the PCR was that during the latter part of the programme, the Borrower and the Bank were flexible in using the available loan resources to address the changing current circumstances given the prolonged length of implementation. For example, the increased amount of loan resources allocated for the reimbursement of VSEP, and the nurses oncology programme. In addition, a Readiness Assessment survey is being conducted periodically for the accreditation standards and legislation will be going to Parliament to formalize the accreditation standards. Further, the meeting agreed that another positive externality was that the MOH is now better understands the role of consultants and the types of support they can provide; how to prepare TORs etc. which it didn't have at the commencement of the loan.
- **Negative Externalities:** The meeting agreed that the following sections of the PCR: "Loss of confidence in health sector" and "Lack of wider public sector reform" would be re-worded to more

accurately reflect a lack of confidence in the procurement processes of the government as well as inadequate communication to stakeholders about the reform process and the ensuing changes. It was the lack of communication about the reform that created some of the chaos but the meeting noted that health sector reform creates chaos in any given situation until the process starts to deliver outputs that justify its existence. One of the assumptions of the project was that wider public sector reform would be ongoing at the time of the loan and that process would have prepared the society and the public service for the cultural change that is a critical aspect of reform. Further, there was an inadequate implementation strategy and preparedness to implement the reform by the MOH.

The meeting agreed that "ambitious project design" would be re-worded to reflect that the project design was ambitious for the timeframe set for the loan – 7 years. The Borrower noted that the government's original thinking during the design phase of the loan was that health reform would be a long process possibly 20 years; but when the loan was negotiated, the programme was shortened in time but not scope.
The loan design envisioned all 5 sub-components being implemented at the same time, utilizing the same personnel from the Project Unit. It was thought that in order to undertake the reform initiatives properly, the physical infrastructure needed to be updated as well. In reality during implementation, managing both the physical works and the "soft" components at the same time did not facilitate the timely implementation of all the softer components e.g. change management, since the physical works received priority. This imbalance was addressed to some extent with the assistance of the Technical Assistance Programme Unit but not sufficiently.

- **Project Implementation:** The meeting participants provided comments on some of the challenges experienced during project implementation, as follows: (i) the MOH was not fully aware of the requirements for fulfilling conditions precedent to first disbursement and that caused some delay in implementation; (ii) there was a perception that the Project Administration Unit (PAU) had been vested with a high degree of autonomy and consequently had operated like a separate entity to the MOH, not accountable to anyone but the Bank; (iii) some RHAs felt that they had been starved of resources because of the administrative procedures of the PAU; (iv) at the macro level, the MOH at that time operated without a strategic plan and there was a sense that consultants hired would provide more than technical advice so in many instances the MOH did not fully utilize the consultants or evaluate their deliverables properly. As a corollary, there was an issue of trust in the competencies of the firms that bid for various consultancies because they did not have sufficient background in the health sector and they relied heavily on the Ministry's technical staff in the implementation of their consultancy; (v) at the political level, certain aspects of the programme, like the VSEP, which were viewed as politically sensitive, were not implemented as envisioned and that short circuited the programme; (vi) the project was being implemented during a time of numerous political changes in the country and that affected the implementation of the programme at all levels. As a result, the Ministry was continuously orienting new staff.

Lessons learned and the Way forward. The meeting discussed some initiatives and activities that could be employed in this area in the development of any new projects in the health sector. A summary is presented below.

- **Political insulation for projects.** The government and the Bank need to develop a mechanism to insulate projects from changes in the country's executive in order to facilitate delivery of the objectives of the projects. There must be consensus by the Parliament on the strategy for engagement with donor organizations to reduce politicizing the programmes.
- **Phased program design.** The programme should have been rolled out on a phased basis in order to properly sequence activities and endure that the foundation for reform was properly laid.

- **Change management.** The aims and objectives of reform programs as well as the associated changes – institutional, cultural, human resources, social etc must be managed and communicated to internal and external stakeholders to facilitate buy-in and understanding**.**
- **Borrower Institutional arrangements.** Although one exists presently, at the time of project implementation, the MOH needed to have a corporate strategic plan, which would have provided clear guidance to the staff on what they want to achieve as a ministry; in what specific areas external support is needed; and the role and kind of technical support required. In addition, there should be clarity at the outset on the application of the Bank's policies and procedures.
- **Bank responsibility.** The Bank might wish to consider being more forceful with the Borrower when activities critical to the achievement of developmental objective are not being implemented to the level of effort required or expected.
- **Implementation arrangements.** The Executing Agency driving the implementation of a loan program should be distinct from the technical team employed the Ministry; but the Ministry must provide adequate oversight of the project to foster a sense of ownership and should be the internal driver for the project.
- **Assessment of the Borrower.** An assessment of the Borrower's implementation capacity should be done prior to project implementation to ascertain leadership and change management competencies necessary for a reform program, as well as training for the core technical staff of the Ministry. Further, the political directorate also needs to be oriented on the changes that will be effected by reform programs.
- **IDB Review Mechanisms.** During project implementation there should not be continuous review of the procurement and disbursement processes by the Bank. Having agreed on the policies and procedures, the Borrower should be allowed to proceed with the necessary activities.
- **Wider reform initiatives.** Reform projects must be undertaken in conjunction with wider public sector reform initiatives to ensure that changes made in one sector can be supported by the other agencies in the public service e.g. HR practices, contracting, compensation, IT, personnel management etc.

Borrower's Evaluation. The Borrower's Evaluation was presented at the meeting, which was the output of a collaborative effort by the executive of the Ministry of Health.
Closing Remarks. The meeting was brought to a close with remarks by the Permanent Secretary, Ministry of Health, who noted that the Ministry was continuing the health sector reform thrust that had been established under the project which is firm evidence that the project has contributed significantly to the reform and development of the health sector in Trinidad and Tobago.

---------- ----------
Permanent Secretary, Ministry of Health Date

---------- ----------
Sr. Health Specialist, IDB Date

Annex 8

Persons Interviewed

Reynold Cooper, Permanent Secretary (fmr), Ministry of Health

Anil Gosein, Project Manager, North West Regional Authority

Michael Harris, CEO, North West Regional Health Authority

Ian Ho-A-Shu, Sector Specialist, Inter-American Development Bank

Sean La Mott, Financial Manager, Eastern Regional Health Authority

Wayne L. Nunes, Project Director, Project Administration Unit

Lallan Samaroo, Programme Manager, NIPDEC

Martin Riley, Project Director (fmr), Project Administration Unit

Persons Listed and Identified for Interviews

Agatha Carrington, CEO, North West Regional Health Authority

Lara de Sonpere-Roberts, CEO, North Central Regional Health Authority

Sandra Jones, Permanent Secretary, Ministry of Health

Jerry Narace, Minister of Health

John Rahael, Minister of Health (former)

Project Officer, Ministry of Public Administration

Project Officer, Ministry of Finance

Ronald Tsoi-a-Fatt, CEO, Eastern Regional Health Authority

Annex 9

Documents Reviewed

Corder, David, *Progress on HSRP Components*, 2003-2005

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Project Administration Unit, *Project Status Report*, 10 January 2008

Project Administration Unit, *Health Sector Reform Programme, Extension and Re-Profiling, 2003-2006, Justification and Recommendations*, 3 September 2003

Technical Assistance Procurement (TAP), *TAP Unit Knowledge Transfer V8*, 14 October 2002

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ANNEX 10

KEY PILLARS OF MOH TRANSFORMATION PLAN 2008 – 2013

- The Ministry of Health's Institutional Reform
- Strengthening Vertical Services
- Strengthening of RHAs and other state-owned bodies related to health
- Upgrading Services and Infrastructure
- Skill Development and Availability
- Providing Quality Service
- Developing Information and Communication Technology
- Rationalizing Health Financing
- Continuous improvement on all levels

- **Loan Proposal**
- **PPMR**

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AGENDA

PR-2131
18 June 1996
Original: English

TO: The Board of Executive Directors

FROM: The Secretary

SUBJECT: Trinidad and Tobago. Proposal for a loan for a health sector reform program

Attached for your consideration is a proposal for a loan to the Republic of Trinidad and Tobago of up to US$134 million or the equivalent thereof from the ordinary capital resources, for a health sector reform program.

Any questions concerning this operation may be addressed to Mr. Ernesto Castagnino, Project Team Leader (extension 1894). This matter will be placed before the Committee of the Whole for consideration at a meeting held on or after July 10, 1996.

To expedite consideration of this matter in the Committee of the Whole, those Executive Directors who wish to do so may send the Secretariat, in writing, a list of the points they plan to raise at the meeting. The Secretariat will distribute the observations from Executive Directors that have so requested. If there is agreement on this operation in the Committee of the Whole, it will be placed before the Board of Executive Directors for approval at a forthcoming meeting.

Note is drawn to the fact that, for purposes of the information-disclosure policy, portions of this document are considered confidential.

Other distribution:

Managers and Advisors
Division Chiefs
Representative in Trinidad and Tobago

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TRINIDAD AND TOBAGO

HEALTH SECTOR REFORM PROGRAM

(TT-0024)

LOAN PROPOSAL

This document was prepared by the project team consisting of: Ernesto Castagnino, project team leader (RE3/SO3); Holly Wong (RE3/SO3); Silvia Raw (RE3/SO3); Pablo Adam (RE3/SO3); Gustavo Nevarez (RE3/RE3); Tomás Engler (RE1/SO1); Mario Loterszpil (DPP/MOS); Dana Martin (LEG); Brian McNish (COF/CTT); and Ethel Muhlstein (RE3/SO3).

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LIST OF ANNEXES

APPENDICES

ANNEXES AVAILABLE IN RE3 PROJECT FILES

Annex I-1	Human resources strategy
Annex I-2	Health sector financing strategy
Annex II-1	Information technology/information systems
Annex II-2	Rationalization of physical infrastructure
Annex II-3	Operating Regulations for primary care investments
Annex II-4	Community care program
Annex III-3	Procurement of technical assistance
Annex III-5	Monitoring mechanisms and benchmarks

OTHER REFERENCE MATERIAL AVAILABLE IN RE3 PROJECT FILES

Primary Health Care Design Briefs: Generic Services Facilities
The Community Care Programme
National Emergency Ambulance Services
User Charges Studies
Report on the Mission of Establishing Population Registration System in the Republic of Trinidad and Tobago
Implementation Cost Analysis
From Vision to Reality - A Summary
National Consultation on Health Promotion
Towards a Healthy Nation
Loan Application Document
Health Sector Financing
Human Resources Strategy

CONFIDENTIAL APPENDIX

Annex II-5 Costs by strategic component

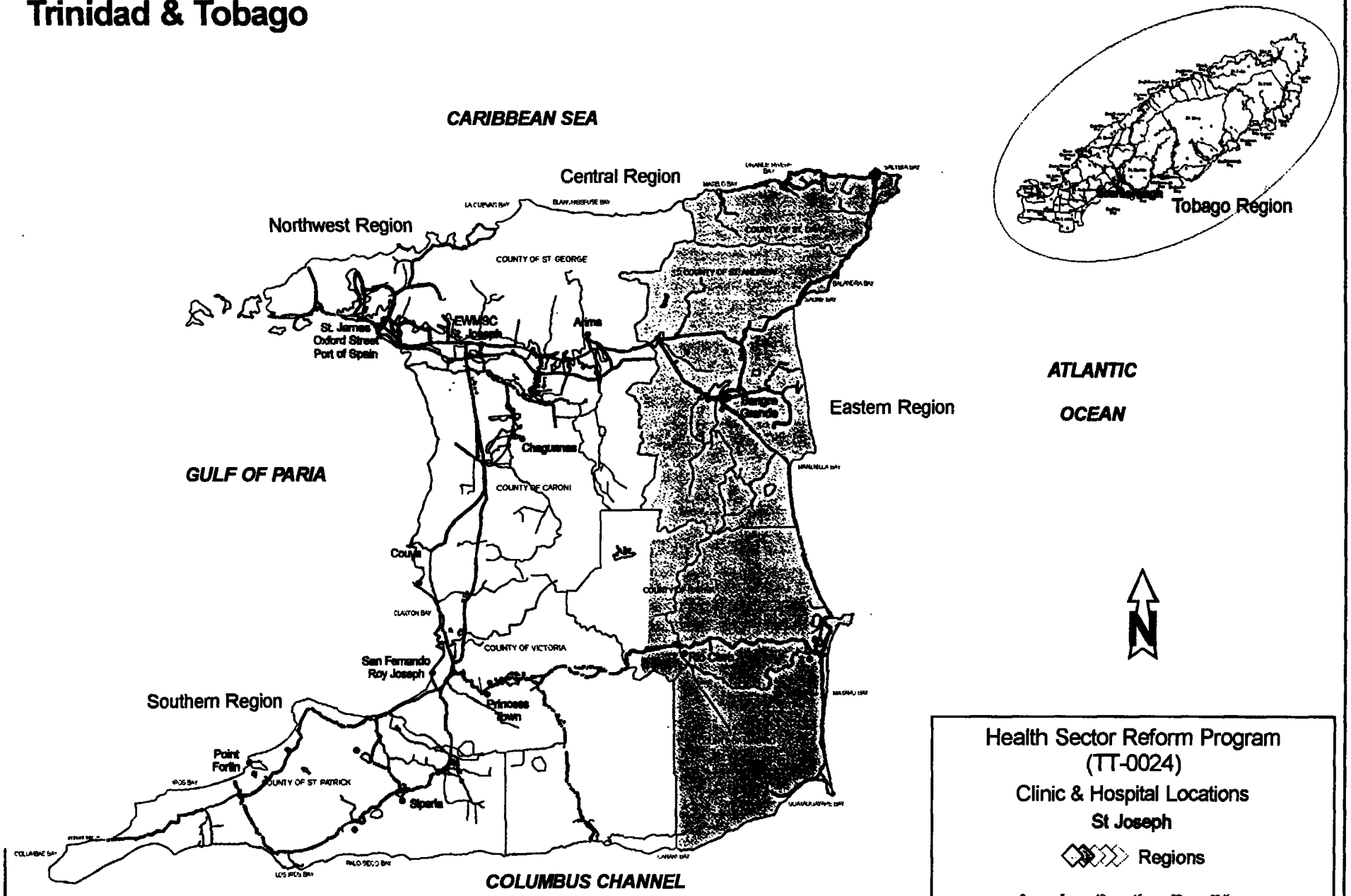
Annex III-2(b) Acquisitions plan

Additional information on the human resources strategy component (paragraph 2.27).

ABBREVIATIONS

ASAs	annual service agreements
CDF	Community Development Fund
DCPs	development control plans
DHFs	district health facilities
EHCs	enhanced health centers
EWMSC	Eric Williams Medical Sciences Complex
GORTT	Government of the Republic of Trinidad and Tobago
HNA	health needs assessment
HSRP	Health Sector Reform Program
ISC	Implementation Steering Committee
MOH	Ministry of Health
MOSD	Ministry of Social Development
MPD	Ministry of Planning and Development
NGO	nongovernmental organization
NHSP	National Health Services Plan
NIPDEC	National Insurance Property Development Company Ltd.
PAU	program administration unit
PET	program execution team
RHAs	Regional Health Authorities
UWI	University of the West Indies

Trinidad & Tobago



This map, prepared by the Inter-American Development Bank, has not been approved by any competent authority and its inclusion in the loan document has the exclusive objective of indicating the area of influence ot the project proposed for financing.

TRINIDAD AND TOBAGO

Basic Socio Economic Data
Statistics and Quantitative Analysis
Integration and Regional Programs Department

Executive Summary

Social Statistics

Land Area (Km2)	1995	5,128
Population (Thousands)	1995	1,306
Population Under 15 (Percent)	1995	32.3
Population 60 and Over (Percent)	1995	8.0
Population (Average Annual Growth Rate)	1986-1995	1.2
Rural (Percent)	1995	33.7
Density (Population per Km2)	1995	254.7
Vital Statistics		
Total Fertility (Rate per Woman)	1993	2.4
Crude Birth (Rate per 1,000 Population)	1993	17.4
Infant Mortality (Rate per 1,000 Live Births)	1993	10.5
Crude Death (Rate per 1,000 Population)	1993	6.5
Life Expectancy at Birth (Years)	1993	71.8
Poverty and Inequality		
Gini Coefficient		...
IDB Poverty Incidence (Percent)		...
Poverty Gap (Percent)		...
Labor Force (Thousands)	1994	506
Participation Rate (Percent)	1994	59.1
Unemployment Rate (Percent)	III-1995	8.3
Real Minimum Wage (Index 1990=100)	1995	81.4
Education		
Gross Enrollment Ratio - Primary	1991	95.0
Gross Enrollment Ratio - Secondary	1990	81.0
Gross Enrollment Ratio - Tertiary		...
Pupil/Teacher Ratio - Primary	1991	26.0
Pupil/Teacher Ratio - Secondary	1991	20.1
Average Years of Schooling (Population >25 Years)	1995	6.8
Illiteracy (Percent)	1985	3.9

TRINIDAD AND TOBAGO

Basic Socio Economic Data
Statistics and Quantitative Analysis
Integration and Regional Programs Department

Executive Summary

Economic Statistics

Exchange Rate (TT Dollars/US$)	3-1996	6.0
GDP per Capita (Average Annual Growth Rate)	1986-1995	-1.7
GDP (Average Annual Growth Rate)	1986-1995	-0.5
Agriculture	1986-1995	3.2
Agriculture Terms of Trade	1985-1994	-7.1
Industry	1986-1995	-1.1
Services	1986-1995	-0.2
Gross Domestic Investment (% of GDP)	1995	13.5
Gross Domestic Saving (% of GDP)	1995	32.7
Consumer Prices (Twelve Month Variation)	1995	5.3
Central Government Deficit or Surplus (% of GDP)	1995	0.4
Domestic Credit (% of GDP)	1995	33.0
Private Sector	1995	25.5
Public Sector	1995	7.5
Balance of Payments (Millions of US$)		
Current Account Balance	1995	174
Trade Balance	1995	690
Capital Account Balance	1995	-67
Change in Reserves (- Increase)	1995	-41
Current Account Balance (% of GDP)	1995	2.8
Capital Account Balance (% of GDP)	1995	-1.1
Total External Debt (Millions of US$)	1995	2,286
Long-Term Debt	1995	1,886
Short-Term Debt	1995	348
Total Debt Service	1995	444
Interest Payments	1995	189
Debt to GDP Ratio (Percent)	1995	36.4
Debt Service Ratio (Percent)	1994	31.2

TRINIDAD AND TOBAGO

Basic Socio Economic Data

1. Poverty and Inequality

	In Percent									
	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995
Gini Coefficient	...	...	...	...	...	...	...	...	...	...
Urban	...	...	...	...	...	...	...	...	...	...
Rural	...	...	...	...	...	...	...	...	...	...
IDB Poverty Incidence	...	...	...	...	...	...	...	...	...	...
Urban	...	...	...	...	...	...	...	...	...	...
Rural	...	...	...	...	...	...	...	...	...	...
Poverty Gap	...	...	...	...	...	...	...	...	...	...
Urban	...	...	...	...	...	...	...	...	...	...
Rural	...	...	...	...	...	...	...	...	...	...

2. Health and Nutrition

	Mortality by cause - in Percent									
	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995
Communicable and Perinatal Diseases	8.2	8.5	8.7	7.3	8.4	7.2	...	...	...	...
Non-Communicable Diseases	53.0	52.8	51.3	51.7	50.2	52.2	...	...	...	...
External and Other Causes	36.4	36.6	37.8	38.7	38.9	38.4	...	...	...	...
Ill Defined Causes	2.5	2.2	2.2	2.3	2.5	2.2	...	...	...	...

	Percent of Central Goverment Expenditure									
	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995
Expenditure on Health	...	...	...	...	...	...	...	...	...	...
Hospitals	...	...	...	...	...	...	...	...	...	...
Clinics and Practitioners	...	...	...	...	...	...	...	...	...	...
Other	...	...	...	...	...	...	...	...	...	...

	Immunization as Percent of Age Group									
	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995
Other Indicators										
Children (< 1 Yr) Immunized DPT3	70.0	79.0	82.0	77.0	82.0	...	...	...	...	...
Children (< 1 Yr) Immunized Measles	45.0	68.0	72.0	59.0	70.0	...	...	...	...	...
Access to Safe Water (% Population)	...	...	95.5	...	...	95.9	...	...	...	...
Doctors per 1000 Inhabitants	...	...	...	0.9	0.6	...	...	0.8	...	...
Hospital Beds per 1000 Inhabitants	...	...	...	3.5	3.2	...	...	...	...	...
Daily Caloric Intake	3052.0	2982.0	2775.0	2685.0	675.0	2633.0	2585.0	...	...	...
Daily Protein Intake (grams)	81.3	75.3	65.3	63.9	63.4	62.5	62.6	...	...	...

3. Education

	In Percent									
	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995
Net Enrollment Ratios										
Primary	...	...	92.0	90.0	90.0	89.0	...	...	...	...
Gross Enrollment Ratios										
Primary	98.0	99.0	97.0	96.0	96.0	95.0	...	...	...	...
Secondary	...	85.0	84.0	85.0	81.0	...	...	...	...	...
Tertiary	...	...	...	...	...	...	...	...	...	...
Primary Survival Rate	...	96.0	89.0	89.0	...	...	...	...	...	...

20 May 1996

TRINIDAD AND TOBAGO

Basic Socio Economic Data

3. Education

Ratios

	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995
Primary	23.0	24.0	25.0	28.0	26.0	26.0	...	...	...	...
Secondary	19.8	20.2	20.0	20.3	19.9	20.1	...	...	...	...

Percent of Central Government Expenditure

	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995
Expenditure on Education	...	...	...	...	...	...	...	...	...	...
Pre-Primary through Secondary	...	...	...	...	...	...	...	...	...	...
Tertiary	...	...	...	...	...	...	...	...	...	...
Other	...	...	...	...	...	...	...	...	...	...

4. Labor Market

In Percent

	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995
Labor Force by Sector										
Agriculture	11.3	11.5	12.9	13.9	12.3	11.7	11.6	11.4	...	...
Industry	29.3	29.1	27.7	27.1	27.2	28.8	27.0	26.4	...	...
Services	59.5	59.3	59.2	59.0	60.5	59.4	61.4	62.2	...	...
Participation Rate	61.2	61.2	59.9	58.2	57.2	59.3	60.0	59.1	59.1	...
Male	83.3	82.6	81.2	79.0	77.0	78.0	...	76.3	...	...
Female	39.9	40.6	39.7	38.3	38.2	41.5	...	42.6	...	...
Unemployment Rate	17.2	22.2	21.1	22.0	20.0	18.5	19.6	19.8	18.6	...
Real Minimum Wage Index	153.3	135.5	126.3	110.1	100.0	99.3	97.7	91.0	84.1	81.4

5. Exchange Rates

TT Dollars/US$, End of Period

	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995
Exchange Rate	3.6	3.6	4.3	4.3	4.3	4.3	4.3	5.8	5.9	6.0
Real Effective Index	87.7	94.7	100.9	102.3	100.0	100.7	98.2	108.8	117.7	117.6

6. Prices

Average Annual Growth Rates in Percent

	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995
Consumer Price Index	7.7	10.8	7.8	11.3	11.1	3.8	6.6	10.7	8.7	5.3
Wholesale Price Index	6.4	4.1	6.0	9.0	1.4	0.2	0.8	5.3	...	...

7. International Liquidity

Millios of US$

	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995
Reserves	476	190	129	249	494	341	174	208	354	360
Reserves minus Gold	474	188	127	247	492	339	172	206	352	358
Special Drawing Rights (SDRs)	137	0	0	9	1	2	0	0	0	0
Reserve Position in the IMF	94	75	...	0	0	0	0	0	0	0
Foreign Exchange	243	113	127	238	491	337	172	206	352	358
Gold (National Valuation)	2	2	2	2	2	2	2	1	1	1

TRINIDAD AND TOBAGO

Basic Socio Economic Data

8. National Accounts

Millions of 1990 US$

	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995
Gross Domestic Product	5781	5486	5261	5210	5265	5436	5357	5274	5514	5707
GDP Per Capita	4918	4607	4362	4266	4259	4347	4236	4127	4267	4369

Annual Growth Rates in Percent-Constant Prices

	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995
GDP Per Capita	-4.6	-5.8	-5.1	-2.1	0.3	1.5	-2.8	-2.7	3.1	2.1
GDP by Type of Expenditure (MP)	-3.3	-4.6	-3.9	-0.8	1.5	2.7	-1.7	-1.6	4.2	3.2
Consumption	2.4	-9.8	-5.8	-3.4	-1.1	1.9	-5.2	-3.9	4.7	3.0
Gross Domestic Investment	-12.5	-20.4	-34.1	18.4	-10.0	30.1	-35.2	0.7	40.2	18.0
Exports of Goods and Services	-1.3	-4.4	10.3	-3.3	10.5	2.7	1.3	0.3	-9.3	18.0
Imports of Goods and Services	8.4	-26.3	-8.1	-5.3	1.9	12.7	-24.6	-4.7	-7.9	47.0
GDP by Sector of Origin (MP)										
Agriculture, Forestry and Fishing	0.8	0.2	-2.8	6.0	17.0	3.0	-1.1	3.5	5.7	0.6
Mining and Quarrying	-4.5	-8.4	-2.6	-1.2	0.6	-3.2	-5.0	-8.9	6.1	-0.6
Manufacturing	4.9	-7.4	0.7	5.1	2.7	8.4	2.2	-3.1	7.9	2.5
Electricity, Gas and Water	9.0	5.3	-0.2	-0.4	4.0	5.0	5.4	-0.6	4.6	2.3
Construction	-21.0	-10.9	-2.5	-8.2	2.2	11.8	-5.0	-4.4	14.6	13.0
Wholesale and Retail Trade	0.0	-0.2	-9.4	-5.8	-8.1	4.3	-0.1	-3.5	1.2	6.2
Transport and Communications	2.6	0.8	-0.8	2.4	0.3	2.8	-1.3	0.2	4.1	5.9
Financial Services	-5.9	-11.1	-12.2	-3.7	11.9	7.8	4.9	2.3	2.7	2.8
Government	0.9	1.1	-4.3	-0.2	4.6	-1.9	-2.9	0.2	-2.0	-1.2
Other Services	-3.4	-5.0	-0.6	5.1	-0.5	2.6	-3.0	12.8	1.6	2.8

Composition in Percent-Current Prices

	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995
GDP by Type of Expenditure (MP)										
Consumption	85.5	79.3	82.1	75.5	70.5	78.3	75.3	76.5	72.0	...
Gross Domestic Investment	21.6	19.3	13.0	16.6	12.6	13.4	13.8	13.6	14.4	18.8
Exports of Goods and Services	33.3	33.9	38.9	42.6	45.4	41.1	39.4	40.5	43.4	...
Imports of Goods and Services	40.4	32.5	34.1	34.7	28.4	32.8	28.5	30.5	29.8	...
GDP by Sector of Origin (MP)										
Agriculture, Forestry and Fishing	3.0	3.0	2.9	2.6	2.5	2.4	2.4	2.2	2.0	2.0
Mining and Quarrying	17.7	19.9	15.7	19.5	21.3	17.1	15.4	14.6	14.4	14.7
Manufacturing	9.6	10.2	12.7	12.7	13.4	13.8	13.2	13.6	16.3	16.1
Electricity, Gas and Water	1.1	1.5	1.7	1.4	1.2	0.9	1.5	1.7	1.7	1.6
Construction	10.6	9.7	10.3	10.0	9.2	9.9	9.6	9.0	9.0	9.6
Wholesale and Retail Trade	16.6	16.6	18.4	18.4	15.4	16.6	17.0	17.4	17.8	18.1
Transport and Communications	9.8	9.7	9.8	9.2	8.1	8.4	9.4	9.2	8.6	8.5
Financial Services	8.1	7.9	7.5	7.6	8.0	9.0	9.2	8.9	8.7	8.8
Government	16.0	14.8	14.1	11.9	10.7	11.1	11.8	11.4	10.3	9.7
Other Services	7.4	6.8	6.9	6.7	10.2	10.7	10.4	11.9	11.0	10.8

TRINIDAD AND TOBAGO

Basic Socio Economic Data

9. Non-Financial Public Sector

As a Percent of GDP

	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995
Current Revenues	31.6	30.7	28.6	26.3	25.7	29.9	26.3	27.4	26.1	26.9
Tax Revenue	24.4	24.5	23.1	21.8	22.3	25.3	22.8	23.2	21.8	22.9
Current Expenditures	32.4	29.3	30.9	28.3	25.8	26.8	27.5	26.1	24.7	24.9
Current Savings	-0.8	1.3	-2.3	-2.0	-0.1	3.1	-1.2	1.4	1.4	2.0
Capital Expenditure	5.1	7.2	3.4	2.4	1.6	3.4	1.6	1.6	1.7	1.8
Deficit or Surplus	-5.9	-5.9	-5.7	-4.2	-1.2	-0.2	-2.8	-0.2	0.0	0.4
Domestic Financing	7.4	6.0	5.8	5.0	3.3	1.9	3.6	-1.9	-1.1	2.6

10. Monetary Survey

As a Percent of GDP

	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995
Domestic Credit	40.6	47.9	53.5	52.2	44.6	43.2	47.8	48.6	38.8	33.0
Public Sector	6.3	14.7	19.0	18.9	15.7	11.7	15.9	16.5	11.8	7.5
Private Sector	34.4	33.3	34.5	33.4	28.9	31.4	31.9	32.1	26.9	25.5
Money (M1)	12.4	12.1	11.0	11.0	10.4	11.2	11.4	12.1	10.9	11.4

11. External Trade

Direction in Percent- Customs Basis

	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995
Exports of Goods (fob)										
Developed Countries	82.0	75.1	69.2	67.3	65.9	62.5	57.6	55.2	62.8	58.8
Developing Countries	18.0	24.9	30.8	32.7	34.1	37.5	42.4	44.8	37.2	41.2
Latin America	9.4	13.4	14.3	15.9	14.9	18.5	20.2	24.1	21.0	23.5
Imports of Goods (cif)										
Developed Countries	84.1	79.5	72.5	77.3	69.3	68.2	72.9	69.9	67.2	71.4
Developing Countries	15.9	20.5	27.5	22.7	30.7	31.8	27.1	30.1	32.8	28.6
Latin America	8.5	12.1	14.2	13.5	20.4	23.9	19.7	24.2	28.1	24.4
Terms of Trade Index	59.6	59.0	68.5	66.5	71.1	71.6	69.6	72.5	88.2	103.4

Millions of US$-Customs Basis

	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995
Exports of Goods (fob)	1385.7	1462.4	1412.0	1578.1	080.4	1985.0	1868.9	662.1	...	...
All Food	4.2	4.5	6.0	6.6	5.5	5.9	6.2	7.8	...	...
Agricultural Raw Materials	0.0	0.0	0.0	0.0	0.1	0.1	0.1	0.1	...	...
Fuels	70.9	71.4	60.6	61.1	67.2	65.3	63.7	57.7	...	...
Ores and Metals	6.2	6.6	7.9	8.9	7.3	6.6	8.0	8.7	...	...
Manufactured Goods	18.7	17.4	25.5	23.4	19.9	22.1	22.0	25.7	...	...
Chemicals	15.4	14.1	21.0	18.3	14.2	16.8	15.8	16.8	...	...
Machinery and Transport Equipment	1.9	1.4	1.4	1.3	2.0	1.0	1.3	2.8	...	...
Other Manufactured Goods	1.4	1.9	3.2	3.8	3.8	4.3	4.9	6.1	...	...
Imports of Goods (cif)	1369.8	1218.7	1127.0	1222.4	261.6	1667.0	1435.6	462.9	135.8	...
Capital Goods	27.7	23.5	21.7	23.4	20.2	...	...	...	...	...
Consumption Goods	38.2	37.9	37.4	32.5	30.1	...	...	...	...	...
Intermediate Goods	29.9	23.5	27.1	34.9	42.6	...	...	...	...	...
Fuels	2.9	4.3	11.9	7.4	11.4	...	...	...	...	...
Other	4.2	15.2	13.7	9.2	7.1	...	...	...	...	...

TRINIDAD AND TOBAGO

Basic Socio Economic Data

12. Balance of Payments

	Millions of US$									
	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995
Current Account Balance	-412	-225	-89	-39	459	-5	139	113	218	174
Trade Balance	169	357	405	506	1013	564	696	547	741	690
Exports of Goods (fob)	1378	1414	1470	1551	1960	1775	1691	1500	1778	2428
Imports of Goods (fob)	1209	1058	1064	1045	948	1210	996	953	1037	1738
Service Balance	-553	-559	-485	-537	-547	-571	-557	-439	-524	-499
Freight and Insurance	-168	-146	-124	-155	-162	-232	-212	-192	-164	-178
Travel	-82	-64	-77	-34	-28	-9	-4	-25	-3	20
Investment Income	-211	-275	-302	-378	-397	-442	-448	-326	-412	-443
Other Services	-156	-54	5	10	-3	60	36	12	-6	1
Unrequited Transfers	-28	-23	-9	-8	-6	2	0	5	0	-17
Private	-10	-4	-3	-2	-2	0	1	5	2	-14
Official	-19	-19	-6	-6	-5	2	-1	0	-2	-3
Capital Account Balance	-218	64	-75	60	-250	-120	-101	87	-39	-67
Non-Monetary Sector	-178	43	1	83	-265	-130	-112	172	81	-143
Private Sector	-112	12	-139	128	-191	-31	-73	153	144	13
Direct Investment	-22	35	63	149	109	169	178	379	516	286
Portfolio Investment	0	0	0	0	0	0	0	0	0	...
Other Long-Term	28	-57	-181	-4	-282	-184	-234	-215	-366	-273
Other Short-Term	-118	34	-20	-17	-19	-16	-17	-12	-6	...
Government Sector	-66	30	140	-45	-73	-98	-39	20	-63	-155
Long-Term	-66	30	140	2	-73	-98	-39	20	-63	-155
Short-Term	0	0	0	-47	0	0	0	0	0	...
Monetary Sector	-40	22	-77	-23	14	10	11	-85	-120	76
Long-Term	0	0	0	0	0	0	0	0	0	...
Short-Term	-40	22	-77	-23	14	10	11	-85	-120	76
Change in Reserves (- Increase)	722	256	143	-67	-97	153	35	-159	-186	-41
Errors and Omissions	-92	-95	21	45	-112	-29	-73	-42	6	-67

13. External Debt

	Millions of US$									
	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995
Long-Term Debt	1582	1636	1816	1785	2052	1963	1894	1849	1800	1886
Public and Publicly Guaranteed	1582	1636	1816	1785	1779	1737	1708	1699	1682	1796
Bilateral	327	312	289	442	557	579	579	532	506	459
Multilateral	66	73	67	69	103	157	208	299	409	529
Bond Holders	207	320	441	366	335	304	304	343	303	400
Banks	671	606	706	664	595	576	519	471	442	407
Suppliers	121	110	100	58	35	25	11	1	0	0
Other Creditors	190	216	215	186	154	97	87	53	23	1
Private Non-Guaranteed	0	0	0	0	273	226	186	150	118	90
Use of IMF Credit	0	0	115	205	329	385	282	155	91	52
Short-Term Debt	273	166	131	127	127	127	198	129	327	348
Interest Arrears on Debt	0	0	4	0	0	0	1	1	4	4
Total Debt Service	328	407	339	247	453	425	572	620	674	444
Public and Publicly Guaranteed	310	388	324	219	344	313	386	420	538	346
Bilateral	90	85	67	28	54	79	101	91	81	99
Multilateral	13	16	15	16	16	21	24	29	32	56

TRINIDAD AND TOBAGO

Basic Socio Economic Data

Private Non-Guaranteed	0	0	0	0	70	69	58	45	41	34
IMF Repurchases and Charges	0	0	0	13	24	29	116	146	79	47
Short-Term Debt (Interest only)	19	20	15	15	15	15	11	10	16	17

TRINIDAD AND TOBAGO

Basic Socio Economic Data

13. External Debt

	Ratios in Percent									
	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995
Debt to GDP Ratio	37	38	45	45	48	45	43	39	36	36
Debt Service Ratio	19	25	19	13	19	19	26	33	31	...

TRINIDAD AND TOBAGO

Basic Socio Economic Data

Sources and Notes

Executive Summary

Social Statistics:

Land Area: Organization of American States (OAS), América en cifras, 1974.

Population: IDB estimates based on data from Latin America Demographic Center (CELADE) and United Nations Population I

Vital Statistics:

World Bank, Social Indicators of Development (WBSID) - 1995 Edition.

Labor Force:

Central Statistical Office of Trinidad and Tobago.

3. Education:

Average Years of Schooling (Population >25 yrs): Number of completed grades of formal education of population older than 25

Illiteracy: Number of adult illiterates as a percentage of that age group. UNESCO Data Base.

Economic Statistics:

Agricultural Terms of Trade: Index of ratio of agricultural GDP deflator to non-agricultural GDP deflator. IDB estimates from

1. Poverty and Inequality:

2. Health and Nutrition:

Mortality Causes: Main causes of death by type of disease. Pan American Health Organization (PAHO) Data Base.

Immunization: Percentage of children under one year who have been immunized for dpt3 and measles. WBSID - 1995 Edition.

Access to Safe Water: Percentage of population with access to safe water. WBSID - 1995 Edition.

Doctors/hospital beds per 1000 inhabitants: Number of doctors/hospital beds per 1000 inhabitants. ECLAC, Statistical Yearboo

Caloric and Protein Daily Intake: Apparent daily per capita average intake. Food and Agriculture Organization of the United N

3. Education:

Net Enrollment Ratio Primary: Enrollment for the age group corresponding to the official age of primary education. UNESCO,

Gross Enrollment Ratio: Total enrollment in primary, secondary or tertiary education, regardless of age, divided by the populati

Primary Survival Rate: Percentage of children of the same cohort starting primary school in a certain year who eventually finish

Pupil/Teacher Ratio: Number of students per teacher in primary and in secondary school. WBSID - 1995 Edition.

4. Labor Market:

Labor Force by Sector: Labor force in that sector as a percentage of total labor force. International Labour Office (ILO) Data Ba

Participation Rate: IDB estimates based on data from the ILO, Year Book of Labour Statistics 1994 Edition, and UNPOP. Econ

Participation Rate: IDB estimates based on data from the ILO, Year Book of Labour Statistics 1994 Edition, and UNPOP. Econ

Unemployment Rate: Programa Regional del Empleo para América Latina y El Caribe (PREALC).

Real Minimum Wage Index: Base year 1990. IDB.

5. Exchange Rates:

IMF, International Financial Statistics (IFS). Market rate.

Real Effective Index: IDB estimates based on data from the IMF, IFS.

6. Prices:

IMF, IFS. Annual figures are expressed as average annual growth rates; monthly figures as a twelve month variation.

7. International Liquidity:

IMF, IFS.

8. National Accounts:

GDP in 1990 US Dollars: IDB estimates.

GDP by Type of Expenditure and Sector of Origin: Central Statistical Office of Trinidad and Tobago.

Central Government:

Central Statistical Office of Trinidad and Tobago, Review of the Economy, and the Ministry of Finance and the Economy.

TRINIDAD AND TOBAGO

Basic Socio Economic Data

Sources and Notes

10. Monetary Survey:

IMF, IFS (mid-year observations).

11. External Trade:

External Trade:

Trade by Direction: IMF, Direction of Trade Statistics (magnetic tapes).

Terms of Trade: IDB estimates based on information from the Central Statistical Office of Trinidad and Tobago, Review of the

Export Composition: United Nations Statistical Division (UNSTAT) Commodity Trade (COMTRADE) Data Base; Exports incl

Import Composition: Central Bank of Trinidad and Tobago, Annual Economic Survey. Fuels include Crude Petroleum.

12. Balance of Payments:

Central Bank of Trinidad and Tobago and IMF, Balance of Payments Statistics (magnetic tapes).

13. External Debt:

World Bank World Debt Tables (magnetic tapes) and estimates.

TRINIDAD AND TOBAGO
REGIONAL SUPPORT SERVICES
RSS/ITC/IRO

IDB LOANS

APPROVED AS OF APRIL 30, 1996

	US$Thousand	Percentage
TOTAL APPROVED *	696.511	100,0%
DISBURSED	441.433	63,4%
CANCELLATIONS	25.143	3,6%
UNDISBURSED BALANCE	255.078	36,6%
PRINCIPAL COLLECTED	35.516	5,1%
PORTFOLIO IN EXECUTION	595.188	
TOTAL DISBURSED FROM PORTFOLIO	340.880	57,3%
APPROVED BY FUND		
ORDINARY CAPITAL	647.024	92,9%
FUND FOR SPECIAL OPERATIONS	31.315	4,5%
OTHER FUNDS	18.172	2,6%
OUSTANDING DEBT BALANCE	405.917	
ORDINARY CAPITAL	390.762	96,3%
FUND FOR SPECIAL OPERATIONS	14.155	3,5%
OTHER FUNDS	1.000	0,2%
APPROVED BY SECTOR		
AGRICULTURE AND FISHERY	104.670	15,0%
INDUSTRY, TOURISM, SCIENCE & TECHNOLOGY	5.000	0,7%
ENERGY	264.301	37,9%
TRANSPORTATION AND COMMUNICATIONS	50.473	7,2%
EDUCATION	43.108	6,2%
HEALTH, SANITATION AND ENVIRONMENT	12.440	1,8%
URBAN DEVELOPMENT	99.360	14,3%
SOCIAL INVESTMENT AND MICROENTERPRISE	0	0,0%
REFORM & PUBLIC SECTOR MODERNIZATION	82.004	11,8%
EXP. FIN., PREINVESMENT & OTHER	35.155	5,0%

* Net of cancellations with monetary adjustments and export financing loan collections.

TRINIDAD AND TOBAGO

REGIONAL SUPPORT SERVICES
ITC/IRO

TENTATIVE LENDING PROGRAM

			US$ Millions
1996			
	TT0043	NATIONAL HIGHWAY PROGRAM	120.0
	TT0024	HEALTH SECTOR REFORM PROGRAM	134.0
		TOTAL A	**254.0**
		TOTAL 1996	**254.0**
1997			
	TT0042	HAZARDOUS AND OILY WASTE MANAGEMENT	30.0
	TT0020	AGRICULTURAL INVESTMENT PROGRAM	30.0
	TT0034	TECNICAL AND VOCATIONAL TRAINING	15.0
	TT0019	SOCIAL SERVICE SUPPORT PROGRAM	35.0
		TOTAL A	**110.0**
	TT0035	TOURISM DEVELOPMENT PROGRAM	30.0
	TT0037	URBAN DEVELOPMENT PROGRAM	30.0
		TOTAL B	**60.0**
		TOTAL 1997	**170.0**

INTER-AMERICAN DEVELOPMENT BANK
REGIONAL OPERATIONS DEPARTMENTS
INFORMATION RESOURCES MGT. UNIT

TRINIDAD & TOBAGO

STATUS OF ACTIVE LOANS AS OF JUNE 11, 1996

(Amounts in US$ thousands)

APPROVAL PERIOD	NUMBER OF PROJECTS	AMOUNT APPROVED	AMOUNT DISBURSED	% DISBURSED
BEFORE 1986				
1986-1989	2	95,709	53,684	56.09%
1990-1993	5	392,479	287,196	73.17%
1994-1995	3	107,000	0	0.00%
1996				
TOTAL	10	$ 595,188	$ 340,880	57.27%

HEALTH SECTOR REFORM PROGRAM

(TT-0024)

EXECUTIVE SUMMARY

BORROWER AND GUARANTOR:	The Government of the Republic of Trinidad and Tobago	
EXECUTING AGENCY:	The Ministry of Health	
AMOUNT AND SOURCE:	IDB:	US$134 million (OC)
	Local counterpart funding:	US$ 58 million
	Total:	US$192 million
FINANCIAL TERMS AND CONDITIONS:	Amortization period:	25 years, including a 7 year grace period
	Disbursement period:	7 years
	Interest rate:	Variable
	Inspection and supervision:	1 percent
	Credit fee:	0.75 percent of loan amount on the undisbursed balance

OBJECTIVES: This program will enable the Government of the Republic of Trinidad and Tobago to improve the health status of the population of Trinidad and Tobago by promoting wellness and providing affordable quality health care in an efficient and equitable manner. To realize this goal, the program focuses on attaining the following key objectives: (a) strengthening the policy-making, planning, and management capacity of the health sector; (b) separating the provision of services from financing and regulatory responsibilities; (c) shifting public expenditures and influencing redirection of private expenditures to high-priority problems and cost-effective solutions; and (d) establishing new administrative and employment structures which encourage accountability, increased autonomy, and appropriate incentives to improve productivity and efficiency.

DESCRIPTION: This operation will be undertaken in a seven-year period constituting the first phase of a sector reform program which is expected to take approximately 10 to 15 years. The main components of the Bank program are: (a) reform of the MOH into a policy, planning, sponsorship and regulatory body; (b) devolution of service delivery and management to five Regional Health Authorities which will contract

with the Ministry of Health to provide a cost effective balance of public and private services within global budgets; (c) development of a human resources strategy, including a new funded pension plan for RHA staff, which will achieve the appropriate skill mix and staffing levels required to support the new organizational structures and institutional and technical emphases, and which will improve productivity and efficiency; (d) rationalization of health services and infrastructure to focus activities on cost-effective and high priority interventions, emphasizing preventive and promotive services and strengthening primary care; and (e) development of a comprehensive financing strategy for the sector, including the evaluation of user charges and a national health insurance system as potential financing mechanisms.

ENVIRONMENTAL CLASSIFICATION: The Environmental Committee, at its meeting of March 1, 1994, classified this as a Category II operation.

BENEFITS: The overall benefit of this program will be better health status for the population, resulting from improvements in the efficiency, equity, and quality of health services, and from the promotion of wellness. These benefits will be achieved through concrete actions which include strengthening policy-making and regulatory capabilities, shifting expenditures toward high-priority problems and cost-effective solutions, and establishing new operational and employment structures which promote accountability and raise productivity.

RISKS: One risk to the program is that implementation of the reforms and specific activities might be slower than anticipated, thereby resulting in delayed development of managerial capacity, inconsistencies among program components, and loss of credibility. Program design has sought to mitigate this risk by developing clear workplans and realistic timetables to guide implementation efforts, and by emphasizing the importance of monitoring efforts throughout the execution period.

Another risk is that political and social pressures might hamper some aspects of the reform program, including the closing of facilities, introduction of user charges, or transfer of labor authority and rightsizing of the work force. While the government has already made important policy decisions on these topics, their successful implementation will require continued commitment during program execution. The

program itself provides for extensive communications and technical assistance efforts to consolidate political as well as popular support for these efforts.

Other risks to the program include: (a) the fact that financial viability depends on the success of cost containment efforts, collection of user charges, and GORTT commitment to maintain real levels of spending; (b) the requirement that strong technical and managerial skills be available to the Ministry of Health and Regional Health Authorities may be endangered by incentives for early retirement inducing the best workers to leave; and (c) the new contracting process involving annual service agreements between the MOH and the RHAs, which is critical to improved incentive structures and better resource allocation, is an untried process. In each of these areas, the risks will be addressed through program activities, including both technical assistance activities and training efforts.

THE BANK'S COUNTRY AND SECTOR STRATEGY: This program is consistent with the Bank's strategy for Trinidad and Tobago, which has among its guiding principles more effective public sector administration and more equitable and efficient resource allocation, as well as reinforcement of the role of the private sector as provider of services.

TARGETING TO LOW-INCOME GROUPS: While not specifically designed as a poverty alleviation program, the HSRP will result in increased accessibility to and quality of health services for the population of Trinidad and Tobago, but particularly for those seeking care in the public sector. This will have a significant impact on low-income groups, who often receive insufficient or unsatisfactory services, and who have no alternative to publicly-provided care. The reform program is therefore expected to have positive equity implications.

PROCUREMENT: The limits over which the purchases of the program will be done by international public bidding are: US$250,000 for goods and services, and US$2 million for works (see para. 3.10).

SPECIAL CONTRACTUAL CONDITIONS: The loan contract will require, inter alia, that the borrower fulfill the following special contractual conditions, to the Bank's satisfaction:

a. prior to the first disbursement of the financing:

i. the establishment of a special account for the resources of the program financing and the procedures for its use (see para. 3.2);

ii. the formalization of arrangements between the Ministry of Health, the Ministry of Finance and the Tobago House of Assembly, for the execution of the program in Tobago (see para. 3.20);

iii. the establishment of the program execution team and the program administration unit, in accordance with their respective composition and functions as previously agreed with the Bank, and the hiring of the program administration unit staff (see para. 3.7 and 3.8);

iv. the signature of the contract between the Ministry of Health and the consulting firm which shall provide technical assistance to the program administration unit in evaluating tender proposals and supervising technical services, in accordance with terms of reference and procedures agreed with the Bank (see para. 3.12);

v. the signature of the contract between the Ministry of Health and the National Insurance Property Development Company Ltd. which shall provide technical assistance to the program administration unit in selecting, contracting and supervising civil works and related goods and services (see para. 3.12);

vi. the approval by Cabinet of the establishment of the Regional Health Authority personnel pension fund and the establishment of the Committee responsible for its implementation (see para. 3.18); and

vii. the contracting of the Health Sector Reform Advisor who shall work with the Minister of Health in support of reform and development efforts (see para. 2.17);

b. prior to the first disbursement of the financing for the health centers global works component, presentation of evidence to the Bank's satisfaction that the operating regulations for

this component, agreed upon between the MOH and the Bank, have been put into effect (see para. 3.22);

c. within the period of three months following the date of first disbursement of the financing, establishment of the monitoring and evaluation program, in accordance with the terms and conditions agreed with the Bank (see para. 3.25);

d. within the period of nine months following the loan contract date, presentation of evidence that the MOH has formalized arrangements with the following entities regarding their respective participation in the program, as previously agreed between the borrower and the Bank:

   i. the Ministry of Social Development and the Ministry of Planning and Development for collaboration in the implementation of the community care program (see para. 3.3);

   ii. the Ministry of Legal Affairs for the implementation of the population registration system (see para. 3.3); and

   iii. the University of the West Indies for development and implementation of courses in primary care and family medicine (see para. 3.3);

e. within the period of 12 months following the loan contract date, evidence that the final plan for the establishment of the RHA personnel pension fund has been fully approved and the firm which shall manage it has been hired (see para. 3.18);

f. within the period of nine months following the loan contract date, conduct a project start-up workshopbased on a plan previously agreed with the Bank (see para. 3.26);

g. prior to the preparation of bidding documents for the hospitals at San Fernando and Scarborough, presentation of satisfactory supporting technical, economic and financial feasibility plans, and environmental protection measures (see para. 2.38);

h. prior to the preparation of bidding documents for technical assistance, hardware and software for the population registration system, presentation

of satisfactory terms of reference and equipment specifications (see para. 2.55);

i. throughout the program execution period, the Borrower shall undertake to ensure that:

   i. all new public investments in health care delivery facilities in Trinidad and Tobago are consistent with the National Health Services Plan (see para. 3.20); and

   ii. existing positions in the MOH staff establishment are abolished if they: (A) are vacant on the loan contract date and not included in the new MOH structure; (B) are or become vacated due to the incumbent's transfer to an RHA or to voluntary separation; or (C) are vacant due to the incumbent's early retirement or resignation and such posts are not included in the new MOH structure (see para. 3.17);

j. the borrower shall conduct, with Bank participation, annual program reviews in June of each year and a mid-term evaluation in June of 2000, to review, inter alia, fixed agenda items (to be included in Annex A of the loan contract), including the investment program and disbursements for the following year. If, as a result of these meetings, it is determined that adjustments are necessary to ensure successful program execution, the borrower shall undertake to carry out the same (see para. 3.27-3.29; and 3.31);

k. the borrower, through the executing agency, shall: (i) undertake to carry out an actuarial valuation one year after the establishment of the RHA pension program to assess and make the necessary adjustments to the financial inputs required by the project, and (ii) carry out actuarial reviews of the RHA pension program every three years (see para. 2.28) ; and

l. up to the amount of US$1.5 million of the resources of the financing may be used to cover eligible expenses incurred during the period of 12 months prior to the loan approval date and up to US$3.5 million may be recognized as counterpart to cover expenses incurred during the period of 18 months prior to the same date (see para. 3.35).

EXCEPTIONS TO BANK POLICY:	The National Insurance Property Development Company Ltd. shall be contracted directly to assist the executing agency in carrying out the procurement of goods and equipment required by the program, in accordance with the Bank's standard procurement procedures (see para. 3.12).
STANDARD PROCEDURE:	Pursuant to Part III, Section 2(a), of the Regulations of the Board of Executive Directors, this operation must be submitted for consideration by the Committee of the Whole.

I. FRAME OF REFERENCE

A. Background

1.1 The proposed program is the outcome of an ongoing dialogue between the Government of the Republic of Trinidad and Tobago (GORTT) and the Bank regarding health sector reform, designed to improve the health status of the population by promoting wellness and increasing the efficiency, effectiveness, quality and equity of health services.

1.2 Discussions between the GORTT and the Bank began in 1988, when the government sought Bank support for the commissioning of the Eric Williams Medical Sciences Complex (EWMSC). At that time many of the problems which affect the organization, financing and delivery of health services were already apparent, and an understanding was reached that the Bank would support a reform effort designed to address these problems in a comprehensive manner. In 1991 the Bank approved the nonreimbursable technical cooperation ATN/SF/CD(PP)/JF-3650-TT for the preparation of studies for health sector reform as well as the commissioning of the EWMSC. The studies carried out under this operation identified key medium- and long-term reform initiatives which have informed the GORTT's approach to health sector reform and the conceptualization of the Bank operation.

1.3 In its Medium Term Policy Framework 1994-96, the GORTT laid out the key elements of health sector reform, including the restructuring of the Ministry of Health (MOH) into a policy-making and regulatory body, the decentralization of service delivery and management, a shift in resources from hospital to primary care and preventive services, and the introduction of a national health insurance system. This program will cover the first phase of the reforms and take place over the period 1996-2002. Its design reflects an integrated approach based on mutually supportive components addressing health sector policies, institutions, financing, human resources and infrastructure.

B. Macroeconomic and social context

1.4 Following the collapse of oil prices in 1982, Trinidad and Tobago's economy contracted for seven successive years. Adjustment measures, though adopted slowly at first, have intensified appreciably since 1987. Macroeconomic stability has been achieved through prudent fiscal management and tight monetary policies, accompanied by structural reforms involving trade and exchange rate regime liberalization, divestment of state-owned enterprises, and improvements in the legal and regulatory framework. These reforms and a brief upswing in oil prices facilitated a moderate recovery in 1990 and 1991. Although the growth process faltered slightly in 1992 and 1993, when GDP fell by 1.7 percent and 1.4 percent, respectively, there was a resurgence of economic activity in 1994,

with GDP growth of 4.6 percent. Economic recovery was further consolidated in 1995 with real growth of 3.5%. The continued pursuit of sound macroeconomic policies and structural reforms holds out the prospect that the current recovery will prove sustainable.

1.5 Despite the decline in GDP experienced during the 1980s, Trinidad and Tobago's social indicators still compare favorably with those of other countries in the region. Life expectancy at birth is 71 years, and primary and secondary school enrollment rates are high. Nevertheless, the social consequences of economic contraction and subsequent adjustment measures have been significant. During the period of adjustment the government had some difficulty in maintaining real levels of expenditures in health and education, which resulted in some deterioration in the plant and capacity to provide services. The poverty rate has increased in recent years, from an estimated 18.5 percent in 1988 to 21 percent in 1994At the same time, while there has been some reduction in the unemployment rate, it has remained at a socially unacceptable level, currently 17.3%.

1.6 The government's Medium Term Policy Framework 1994-1996 outlines a strategy designed to continue the country's transformation into a more efficient, market-oriented and internationally competitive economy. The strategy for the social sectors rests on a three-pronged approach: (a) a continued emphasis on sound economic management to lay the foundations for sustained growth; (b) the reform of the public sector, geared to improving the efficiency and effectiveness of public service delivery of social services; and (c) shorter-term measures designed to channel resources to the poor and vulnerable through community-based programs and organizations.

C. Overview of the health sector

1. Health status

1.7 Over the last two decades Trinidad and Tobago has made substantial progress in controlling communicable diseases and reducing infant mortality. The country is now well into the demographic and epidemiological transitions, resulting in a shift in the major causes of morbidity and mortality toward chronic and degenerative conditions including diabetes, hypertension, and certain cancers. Injuries, especially traffic accidents, also represent a major cause of years of life lost and hospital admissions. There are also emerging problems, such as AIDS and substance abuse.

1.8 While the gains to date have resulted in longer life expectancy and improved health status, the sustainability of these successes may be at risk. The changing epidemiological profile has major implications for health provision and financing. Failure to prevent and appropriately manage prevalent conditions in a cost-effective manner will increasingly result in expensive hospital

admissions, and raise the burdens of disability and premature death.

2. Provision and financing of services

1.9 Health sector expenditures represent approximately 4.7 percent of GDP, with public expenditures accounting for approximately 60 percent of the total. Public health services are delivered through a network of 13 hospitals, which provide the vast majority of the country's emergency and elective inpatient care, and 106 health care centers, as well as a variety of special programs and support services. With the exception of the EWMSC, where user fees are in effect, services in the public sector are offered free of charge and financed by general tax revenues, although drugs must sometimes be purchased from private pharmacies.

1.10 The private sector offers mainly walk-in primary and specialist care by independent doctors, over-the-counter drug sales, and some diagnostic services. There are no large private hospitals. Expenditures in private sector services, almost half of it on drugs, are financed primarily by out-of-pocket payments. Private insurance covers less than three percent of total health expenditures.

1.11 While traditionally the government has been the major provider of health services, its ability to finance these services has been sharply curtailed as a result of prolonged economic stagnation. The average annual public expenditure per capita (in constant 1985 dollars) fell from TT$528 in the period 1981-86 to TT$279 in the 1987-92 period, with primary care bearing the brunt of the cuts. The poor state of primary health centers has accentuated the popular perception that while public outpatient services are free, better quality is obtained in the private sector. Thus, a two-tiered system has emerged, with those who cannot afford to pay for private services using the public sector.

1.12 The decline in public resources has been instrumental in focusing attention on how to improve allocation, efficiency, quality and equity in the health sector. There is a general consensus that resolution of these problems requires significant policy reforms, which have already been initiated by government.

3. Main sector problems and constraints

1.13 The MOH has been charged with policy, planning and regulatory functions, as well as the direct management and provision of comprehensive health services. As a consequence, the MOH has been overextended, its resources absorbed by the day-to-day operation of health facilities, resulting in lack of leadership of the health sector. Few resources are directed toward strategic planning, regulation, quality control, and epidemiological surveillance. The analytical basis for policy-making and planning has also been weak,

as critical information on health needs, household demand and utilization of services, and cost of services, has not been systematically collected and utilized. The operation of facilities, which should be subordinated to overall policy and used as one of various instruments to attain health objectives, has been the predominant activity of the MOH.

1.14 The MOH's weak institutional capacity has resulted in an inefficient allocation of resources in the health sector. Expenditure patterns have not reflected changing health care priorities. Despite many years of policy emphasizing primary care, resources in the public sector have been increasingly allocated to hospitals. While in 1980 hospitals received approximately five times the resources granted to community health services, by the end of the decade this ratio had increased to 10. The low level of support for primary care has led to understaffed and ill-equipped primary health centers and a failure to develop cost-effective interventions for the prevention, early detection, and management of the emerging health needs of a population undergoing an epidemiological transition. There is no evidence of better achievement in the private sector, where individual physicians practice without the support of other primary care professionals and undertake little preventive care or health promotion.

1.15 The weaknesses in preventive and curative primary care services result in self-referrals to accident and emergency rooms of the larger city hospitals, as well as expensive and unnecessary hospital admissions. In surgical wards, estimates suggest that up to one-half of patients hospitalized would not need to have been there if quality primary care services had been available. Despite this, acute beds in several of the smaller hospitals remain underutilized, raising costs and providing evidence of the inefficient allocation of resources.

1.16 Problems of internal efficiency and quality exist at all levels. In the case of primary care, the scarcity of human resources and complementary inputs is aggravated by the existence of a large number of centers, a result of the application of planning norms based on travel distance rather than quality of service. In the case of the smaller hospitals, throughput levels are insufficient to maintain skills and meet acceptable clinical standards. Throughout the sector, physical infrastructure, equipment and support services are in poor condition.

1.17 While many of the problems of the health sector have been recognized for some time, resolution of these problems has been constrained by the constitutional structures and centralized administration affecting the entire public sector. Managers at both health centers and hospitals lack authority over critical areas such as personnel, finances, procurement, and maintenance of facilities. While personnel absorbs almost three-quarters of total expenditures, responsibility for appointment, promotion, discipline and dismissal of staff lies with the Public Service Commission,

whose power is enshrined in the Constitution. There is over-staffing in many grades and shortages in others because managers cannot reallocate spending to achieve the right skill mix. The highly centralized and aggregated accounting and procurement systems also provide no incentive to know, or system to measure the costs of services. This overcentralized and difficult to manage structure results in a lack of accountability and responsiveness to changing health needs.

D. Government strategy for the health sector

1. The health sector in the context of public sector reform policies

1.18 The problems discussed above extend to the entire public sector, and have motivated a broad public sector reform effort, designed to increase the administrative capacity, efficiency and effectiveness of the public service. To this end, a ministerial-level office was created in 1993 with the purpose of developing policy options on personnel policies and management.

1.19 Modernization of procurement mechanisms is also taking place, through efforts to develop alternatives to the overcentralized Central Tenders Board system and delegation of authority for purchases and contracts, up to specified amounts, to the Permanent Secretaries.

1.20 The Health Sector Reform Program (HSRP) is at the forefront of the public sector reform effort, encompassing actions and programs aimed at greater efficiency, improved allocation of resources and better organization and management of sector institutions.

2. Main reform strategies for the health sector

1.21 The strategies of the GORTT for the reform of the health sector are based on the outcomes and recommendations of the sector studies conducted with the technical assistance of the Bank and the ensuing policy dialogue. The specific components of the HSRP are defined below.

a. Reform of the Ministry of Health

1.22 The cornerstone of institutional changes within the HSRP is the separation of regulatory and provider functions, which to date have been exercised by the MOH in a centralized manner. By transferring the provider function to the Regional Health Authorities (RHAs), a reorganized and strengthened MOH will be able to assume a leadership role, focusing on policy-making, planning, monitoring, and regulation. It will set national health priorities based on needs assessment, and will influence the provision of care by a combination of sponsorship and regulation of public and private services.

1.23 The MOH has been restructured into five Directorates to reflect the thrust of its new activities: Health Policy, Planning and Health Promotion; Human Resources; Finance and Administration; Quality Management; and Legal Services. Additionally, there is an interim Directorate of Selected Services which will coordinate the activities of programs such as the Vector Control Department and the Trinidad Public Health Laboratory, while analyses are conducted to determine whether to devolve such programs to the RHAs or to maintain them at the central level. The streamlined structure and new responsibilities will result in a dramatic decrease in the size of the MOH headquarters staff complement, from approximately 400 persons to 100, although the positions will increase in responsibility and skill requirements. Changes in structure will be complemented with the adoption of new management strategies. A Management Executive Committee composed of the Directors listed above, the Chief Administrative Officer, and the Chief Medical Officer, chaired by the Permanent Secretary, is already in operation.

b. Decentralization of service delivery and management

1.24 The Regional Health Authorities Act created five autonomous statutory authorities to function as the principal providers of health care services, and vesting them with all public assets of the health care system. As a direct result, authority and responsibility for the delivery of services and for the management of all health care facilities now rests with the RHAs. Promulgation of the Act was followed by the appointment of RHA Boards, with members from commerce, industry, health professions, and the community, which will set policies within national guidelines established by the MOH. Each RHA will have a chief executive officer who, along with a senior management team, will form the RHA management executive.

1.25 The five RHAs will operate under contract to the MOH, which will act as a purchaser of health services on behalf of the population. The services to be provided by the RHAs will be defined in terms of quality and quantity in annual service agreements (ASAs) negotiated with the MOH. Funding will be based on the cost of running the services agreed upon. Within the scope of the ASAs, the RHAs will have significant freedom in the management of their services and in how their budgets are deployed to achieve the results required.

1.26 The RHAs will have responsibility for providing primary care for all residents in their regions. This responsibility can be met through a combination of directly managed primary care services and services purchased from private sector doctors and other health professionals. The RHAs will have to demonstrate the best use of their primary care resources in meeting national goals and targets, and will be encouraged to use their local knowledge to innovate.

1.27 In addition, the RHAs will be responsible for operating secondary services in their areas. Tertiary hospital services will be

delivered from the EWMSC, San Fernando General Hospital, Port of Spain General Hospital, and Scarborough Hospital. Patient access to hospital services will be primarily via primary care referral. Referrals to specialist and tertiary hospital services will be made to the most appropriate service available, regardless of the region in which they are located, and whose RHA will receive funds based on the volume of work agreed upon. In the case of hospital services, the ASAs will include specific targets of changes in bed numbers and specialties, and in day-case to inpatient care ratios, to promote the shift to ambulatory care.

c. Human resources

1.28 A fundamental objective of the reform of the health sector is to improve human resources management by decentralizing authorities, instituting appropriate incentives to increase productivity and efficiency, and improving accountability. Comprehensive policies to guide human resource development and management have been developed to support the restructuring of the MOH, the devolution of operational responsibilities to RHAs, and the shift in resources to primary care. This strategy includes measures to achieve a complete transition from the current public service status of the majority of the nearly 11,000 health sector workers, to RHA employment under new service conditions (see Annex I-1).

1.29 The strategy calls for the use of financial and nonfinancial incentives to entice current staff to transfer, within the parameters set by the RHA Act and as soon as possible, to full employment under the regions. The establishment of a fully funded, contributory pension plan for the RHA employees, the use of discretionary voluntary separation and early retirement "packages", and the abolition of public service positions as soon as they become vacant or as the staff are transferred to the RHAs are meant to be the backbone of the human resources strategy.

d. Rationalization and upgrading of infrastructure and services

1.30 The National Health Services Plan (NHSP) will guide the infrastructure and human resource development required to achieve the shift in resources to primary and preventive care. According to the NHSP, the network of health care facilities and services will be rationalized along two main concepts. First, new models of care and programs to address major health problems in a cost-effective manner will be developed, focusing on behavioral change to reduce morbidity and mortality. Second, redundant, inefficient hospitals and health centers will be closed and certain services consolidated.

1.31 The shift in orientation of services will be achieved through policies emphasizing primary care, ambulatory/day care, family medicine, and strict referrals. An increased focus will be directed toward health education and preventive/promotive

activities, with the goal of encouraging patients to seek care at health centers and district health facilities, rather than at the costly hospital level.

1.32 To support this shift in emphasis, the rationalization strategy calls for the reinforcement of the network of primary care facilities, including the upgrading of selected health centers, and construction of new ambulatory district health facilities, and enhanced health centers with additional diagnostic and emergency treatment capabilities, as well as specialist clinics. The rationalization strategy will result in a reduced number of centers (from 106 to 44), but each will be staffed by a full-time complement of health professionals, including a general practitioner. Many of the remaining facilities will become outreach sites, where regular services will be provided once or twice a week from the appropriate health center, thus maintaining access and equity in a cost-effective manner.

1.33 In the hospital sector, the rationalization foreseen under the NHSP calls for a reduction in the number of public hospitals from 13 to six through the closing of small hospitals (which will be replaced by ambulatory services), and a reduction in planned bed capacity. Achieving the full gains of rationalization, however, requires some physical investments at the remaining hospitals. Unnecessary hospitals cannot be closed nor beds and services in others reduced until the primary care services are in place and some bottlenecks in the remaining hospitals are removed. The plan thus includes the commissioning of EWMSC, a facility with secondary and tertiary level capabilities but from which the country has not yet realized the full benefits, and physical works in the regional acute care hospitals in Port of Spain, San Fernando, Sangre Grande, and Tobago.

1.34 A national ambulance service will be developed to improve access to the reduced number of hospitals, by providing emergency service for accidents and for transfer of the acutely ill to hospitals. In the early stages of the HSRP, an analysis will be made of the feasibility of contracting privately for an ambulance service versus having such services provided directly by the RHAs and MOH, and a pilot program tested in the Southwestern region.

1.35 The NHSP also calls for a shift to community care for the aged, infirm, and handicapped, currently inappropriately placed in hospitals. To this end, the MOH is collaborating with the Ministry of Social Development (MOSD), the Ministry of Planning and Development (MPD), and the Bank-financed Community Development Fund (CDF) to develop and implement plans to contract with the private sector [commercial and nongovernmental organization (NGO)] for the provision of care to priority groups. This will allow the elderly and disabled youths to live in smaller residential facilities and receive more appropriate care, freeing up costly hospital beds which can be reallocated to acute care or eliminated entirely.

e. Health financing strategy

1.36 The strategy for financing the health sector under the reform program is predicated upon achieving efficiencies and cost savings by improving management and delivery systems (see Annex I-2). The HSRP and its program of rationalizing services and infrastructure will enable the overall health sector, including both private and public services, to minimize cost increases and to use existing resources in the most efficient manner possible. In the short-term, there will be no dramatic shifts from the current financing mechanisms of government expenditure and user charges.

1.37 As a result of improvements anticipated as part of the rationalization program, it is expected that recurrent costs for the health sector will rise by approximately one percent per annum (in real terms) over the next five years. This increase is a net figure, resulting from incremental costs in some areas (e.g., hiring of RHA senior managers, hiring and training of ambulance personnel) as well as from cost savings in other areas (closing of smaller hospitals). The projected recurrent costs reflect the new skill mix, reduced hospitalizations and A&E routine visits, utilization rates and drug consumption levels expected to be in place as a result of the totality of efforts under the HSRP.

1.38 In addition to the above changes, the establishment of a fully-funded pension plan for RHA employees will have a significant impact on recurrent costs. Taking into account all impacts envisioned by the HSRP, recurrent costs for the health sector are projected to increase by almost three percent per annum in real terms over the next five years.

1.39 The GORTT has committed itself to maintaining real levels of spending in the health sector, and to allowing for the continued collection of user charges at EWMSC. However, these two actions by themselves may be inadequate to meet recurrent cost increases of the reform program. Thus, a critical effort of the reform program itself will be to examine ways of closing the potential gap between existing sources of revenue and required recurrent costs.

1.40 The MOH has under active consideration the extension of user charges currently in place at EWMSC to other hospitals, and Cabinet has approved a comprehensive review and update of user charges for selected services. Analytical work will be undertaken during the first year of the program to assess the potential revenue to be earned, management and administrative costs, the likely fee structure, and the best means of maintaining equity and protecting the poor.

1.41 In addition, the GORTT has expressed a strong interest in the phased introduction of a national health insurance system. While important initial work on this was done under technical cooperation ATN/SF/CD(PP)/JF-3650-TT, additional studies are required before a

policy decision can be made. It is expected that the required analytical work can be carried out over the next three years.

1.42 As part of the reform program, a comprehensive strategy for financing the health sector will be refined and implemented. This strategy will encompass both the means of generating resources and the expenditure of those resources in an efficient and effective manner. It will be important that this financing approach be consistent with, contribute to, and be supported by the other components of the reform program, including the planned rationalization of services, the restructuring of the MOH, and the decentralization of service delivery and management.

3. Status of implementation of the reforms

1.43 The implementation of the strategy has already been initiated, indicating the GORTT's commitment to address the problems identified. The Regional Health Authorities Act was enacted by Parliament in May 1994 1/, vesting all public assets of the health care system, previously in the hands of the MOH, to five corporate bodies. The Act went into effect in December 1994, at which time responsibility for the management of all public health care facilities in the country was transferred to the RHAs. The five regional boards have been appointed and the process of recruiting chief executive officers and other senior staff started immediately.

1.44 The NHSP was approved 2/ to guide the infrastructure and human resource development required to achieve the shift in resources to primary and preventive care.

1.45 A new organizational structure for the MOH was approved by Cabinet in August 1994 3/, consistent with the goal of transforming the MOH into a policy-making body while devolving operational responsibility to the RHAs; most top positions in the new structure have already been filled.

1.46 On August 24, 1995, 4/ Cabinet agreed to a number of proposals related to both the overall health sector reform effort and the proposed Bank operation. Documents cleared include the sector financing strategy, and the human resource strategy and plan of action. A sector policy letter outlining the GORTT's commitments to the reform programhas been presented to the Bank.

1/ Act number 5, amended by Act number 31 of December 1994.
2/ Cabinet Minute number 1342 of May 26, 1994.
3/ Minute number 2126 of August 18, 1994.
4/ Minute number 2304 of August 24, 1995.

E. The Bank's country strategy and program rationale

1.47 The program is consistent with Bank lending strategy for Trinidad and Tobago, which has among its guiding principles more effective public sector administration and more equitable and efficient resource allocation, as well as reinforcement of the role of the private sector as provider of services. In the social sectors, the Bank's strategy is strongly supportive of the government's efforts to improve the efficiency and effectiveness of public services and increase the participation of the private sector and NGOs in service delivery. With respect to medium- and long-term objectives, priority Bank assistance is being directed to reform of the delivery of social services (Social Service Support Program, TT-0019) and human resource development (Vocational/Technical Education and Training, TT-0034). Bank support is also being directed to short-term transitional needs associated with the process of adjustment, providing a bridge of support while longer-term reforms are being implemented. The recently approved Community Development Fund (loan 872/OC-TT) represents an integral part of this effort.

1.48 From the beginning of the process of reform of the health sector in the country, Bank support through ATN/SF/CD(PP)/JF-3650-TT, PPF resources from ATN/SF-4632-TT and the Multisectoral Preinvestment Fund (764/OC-TT) and an extended policy dialogue have been crucial to the process of raising awareness of the need for reform and developing its technical elements. Financial support from the Bank for the required reforms will thus lend continuity to its commitment. The proposed Bank program will support the initial phase of a long-term, staged effort which will initiate substantive and irreversible change in the health sector of Trinidad and Tobago.

II. THE PROGRAM

A. Goals and objectives

2.1 To respond to the problems and issues identified within the health sector of Trinidad and Tobago, the government has set forth an ambitious, long-term health reform program. The overall goal of the Health Sector Reform Program is to achieve better health status for the population.

2.2 The general objective of the HSRP is to improve the efficiency, equity, and quality of health services provided, in both the public and private sectors. The program expects to achieve these improvements through concrete actions which include strengthening the policy-making, management, and regulatory capacity of the health sector, shifting expenditures to high-priority problems and cost-effective solutions, and promoting lifestyle changes and increasing awareness among the population of the health consequences of behavioral patterns.

B. Program strategy and overview

2.3 This operation will be undertaken in a seven-year period representing the first phase of the long-term HSRP and has been designed with the objective of putting into place a set of critical, irreversible changes that will reorient the provision of services and the allocation of resources within the health sector of Trinidad and Tobago. It will consist of a package of closely integrated and mutually supportive reform activities which will represent profound departures from traditional sector policies, trends and practices. The second phase would be expected to consolidate the improvements made and further them by undertaking reforms in additional areas, including sector financing.

2.4 The program will take place in the context of a favorable policy environment, which creates excellent conditions for success, in which three particular points are worth underlining: first, that health sector reform in Trinidad and Tobago is part of a broader public sector reform effort; second, that the GORTT has adopted a defined strategy for the sector; and third, that implementation of the HSRP has already begun – the Cabinet has made a number of specific policy decisions representing clear shifts in public policy, and new institutions have been created and operational activities begun.

2.5 The program includes activities in each of the five component areas of the overall health sector strategy, thus addressing the sector needs and agreed policy directions in a very comprehensive manner (see paras. 1.21-1.42 for further details):

a. **reform of the Ministry of Health into a policy, planning, sponsorship and regulatory body;**

b. **decentralization of service delivery and management to five autonomous RHAs;**

c. **development of a human resources strategy to increase productivity, efficiency, and equity;**

d. **rationalization and upgrading of infrastructure and services designed to achieve cost savings and a significant shift of resources from inpatient services to primary and ambulatory care; and**

e. **development of a comprehensive health financing strategy.**

The cost of this seven-year program will total US$192 million, of which the Bank would finance up to US$134 million with the remainder to be financed with local counterpart funds.

2.6 The comprehensiveness of the program also creates significant complexities and challenges. First, from the point of view of Bank strategy to provide financial support to the HSRP, this operation is called a sector reform program because the changes which the GORTT is bringing about in the health sector are far-reaching and will establish a health system whose policies, institutional structure and resource allocation mechanisms will be radically different from the existing one. The complexity of the policy and institutional changes, combined with a demonstrated commitment to take the steps necessary to modernize the health sector, have produced the need for a flexible mechanism of financial support. This has been addressed through a loan operation in which funds are to be disbursed according to a detailed but flexible timetable matched to the priority of key program components and the country's absorptive capacity, and in line with normal Bank disbursement procedures. Thus, loan disbursements will be against advance of works and services. The execution/disbursement targets in the timetable are final for the first year and tentative for the rest of the loan period.

2.7 A joint annual review meeting will be a key operational feature of the program and will evaluate progress achieved in the previous year, based on the targets and benchmarks which have been established in the monitoring tables for the program (see paras. 3.27-3.30 and Annexes III-4 and III-5 for more details). These expected outcomes include both institutional and financial changes which are required to achieve program goals, as well as the attainment of better health status per se. Based on the conclusions of the annual review, the execution and disbursement timetable for each forthcoming year will be finalized, and corrective actions agreed upon when needed.

2.8 There is also the challenge of implementing a complex program comprising large technical assistance and training components, significant physical investments, and an innovative human resources component involving massive transfers of staff to the RHAs and the creation of a new pension scheme. To address this issue, a number of complementary steps have been taken. The execution mechanisms, presented in detail in chapter III, have been designed having in mind the above needs; over one fourth of the technical assistance effort (in terms of person-months) will in fact support execution capacity at the MOH, including specific support to manage the procurement of goods and services, which has been recognized as a chronic bottleneck to execution of other Bank programs. Also, all program components have been reviewed to ensure readiness for execution; for example, terms of reference and design briefs are already available for all consultancies and civil works to be contracted during the first year. Also, preparatory studies for the first phase have been already completed; therefore, consultant services will be devoted to provide hands-on support to the MOH and RHA managers for implementation of agreed upon and clearly defined activities.

2.9 Finally, the lessons learned during the preparation of the program have resulted in some of its specific features. For example, special attention will be paid to the need to retain in the health sector the staff acquiring needed skills through program training. The new salary scales and other incentives and service conditions to be offered by the RHAs outside the constraints of the civil service will be systematically used to address this issue. In the case of the staff to be sent abroad for training, individual agreements will specify the obligation to remain in the employment of the sponsoring health institution for at least twice the length of the training.

C. Program components and activities

1. Reform of the Ministry of Health
(US$8.451 million, 764 person-months of technical assistance)

2.10 In order to establish the MOH as a policy-making and regulatory institution, a number of technical assistance and training activities will be required. First, the MOH will require **management systems development.** Technical assistance (52 person-months) will be provided to the MOH to develop and gradually improve its essential management operating systems, including the annual contracting process, purchasing plans, business plans, and financial systems. In addition, training programs will be developed on-site, and will be complemented by overseas work experience opportunities for approximately eight MOH managers.

2.11 To develop the MOH's planning and policy-making capabilities, technical assistance and training will be required in these areas. Twenty-four months of technical assistance will be provided to

develop decision-making and policy analysis skills, including development of the health needs assessment (HNA) function. This practical planning tool will be used to guide the annual services purchasing plans and service agreements, as well as to carry out required research and surveys. The program will provide for periodic updates to the NHSP, beginning with the establishment of an updating methodology during the first year of the program. Additionally, short-term overseas training in health economics and finance will be provided to approximately four persons.

2.12 As part of the restructuring of the MOH, a Directorate of Quality Management has been established, with responsibility for quality assurance and auditing throughout the sector. However, as no formal quality assurance or medical audit programs are as yet in place, technical assistance will be required to develop these areas. This program will provide approximately 24 person-months of consultant services for this purpose. Training will also be required for the staff of this new directorate, as well as for RHA staff responsible for annual service agreements and the contracting process. Overseas placements (hands-on training opportunities or internships within relevant institutions) will be provided for approximately six individuals.

2.13 The MOH's Directorate of Quality Management will also require development of its technology assessment capabilities. Four person-months of technical assistance will be provided to help establish a regulatory approach focused on both equipment and procedures. Such an approach will allow for the management of the planning and utilization of technology, in both public and private sectors.

2.14 Training and staff development will be provided to upgrade the skills of administrative staff of the MOH. A local training institute will be contracted for 12 person-months of assistance over a four-year period, to conduct required workshops, seminars, and other training sessions.

2.15 As part of the restructuring of the MOH, a Directorate of Selected Services has been created with the expectation that it will last for approximately three years. During this period, a rapid audit of the costs and output of the national programs and laboratories will be conducted, to assess whether they should be transferred to RHAs or remain within the MOH, and how best to organize the provision of services across regions. Six person-months of technical assistance will be provided during the first two years of the program, and a laboratories centralization project coordinator will be hired for a one-year period.

2.16 In the area of information systems and technology, an IS/IT unit will be established to develop and implement the IS/IT strategy. This area will be primarily concerned with establishing consistency between regions and with the MOH, and integrating information

related to health services, operations, financing, human resources, and medical records. In total, 520 person-months of technical services will be provided through this program, including the establishment of the unit which will serve all RHAs and the MOH. The equipment and software costs for the first phase of the HSRP IS/IT component are expected to total US$4.67 million. This component is described in further detail in Annex II-1.

2.17 A **Health Sector Reform Advisor** will be contracted to work with the MOH in the support of reform and development efforts during the first three years of the program. The advisor will address health policy matters during the implementation of the reforms, provide advice in overseeing the fulfillment of reform objectives, identify issues for consideration by the reform execution and oversight bodies, and provide guidance monitoring and review activities and indicators. The advisor will ensure that the required technical documentation is produced including documents needed for the annual reviews and the mid-term evaluation. The advisor will provide the secretariat functions of the ISC and the PET, including coordinating reports and information for each group. Finally, he or she will advise the directors of the MOH and the management of the RHAs during the execution of the reforms supported by this program as required. Hiring of the Health Sector Reform Advisor is a condition prior to first disbursement.

2.18 In order to clearly communicate the objectives and activities of the HSRP, a **communications program** will be established to focus on public relations and information dissemination during the early years of the program. A total of 36 person-months of technical assistance will be provided by a communications coordinator. The program will also finance local public relations and media costs, a newsletter, and selected publicity events.

2. Decentralization of service delivery and management
(US$1.926 million, 172 person-months of technical assistance)

2.19 The second major component of the HSRP is the separation of operational activities from financing, policy-making, and regulatory activities. The establishment of RHAs has created a clear separation of functions, but has also created new responsibilities, structures, and a need for training and technical assistance.

2.20 Each of the RHAs will be run by a board and headed by a chairperson. Senior managers will carry out day-to-day management of operational activities. The program will provide resources to support half of the costs of the new senior management for the RHAs, for a period of two years. It is anticipated that after that time, performance savings will have been achieved, and that the full costs of RHA management can be borne by the RHAs themselves.

2.21 In parallel with the MOH, the RHAs will require management systems development. Technical assistance will be provided to the RHAs to

develop their essential management operating systems, including the annual contracting process, purchasing plans, business plans, and financial systems. In addition, training programs will be developed on-site, and will be complemented by overseas work experience opportunities for approximately 20 RHA managers. Similarly, training and staff development to upgrade the skills of administrative staff will be provided to the RHAs through contracting of a local training institute. Subsequent to this program, activities for continuous staff development will be incorporated into RHA operations. In these two areas, a total of 36 person-months of technical assistance will be provided.

2.22 Infrastructure maintenance will become a function of the RHAs, as they take over responsibility for individual facilities and equipment. Although the MOH will retain authority for the assessment of technology, RHAs will be responsible for operating within policy guidelines set by the MOH, and will carry out needed maintenance themselves. Training will be required to restructure and develop maintenance services in a decentralized manner. Approximately nine overseas placements will be provided by the program for this purpose.

3. Human resources strategy
(US$47.894 million, 238 person-months of technical assistance)

2.23 A critical component of the HSRP is the human resources strategy. With the establishment of new organizational structures and institutional and technical emphases, it will be essential to achieve an appropriate skill mix and new staffing levels. The program will support the implementation of the health sector's human resources strategy through a combination of technical assistance and incentives to achieve the effective transfer of MOH staff.

2.24 A senior Human Resources Advisor will be contracted to work as a counterpart to the Director of Human Resources within the MOH, for a period of 18 months. The advisor will assist in restructuring the MOH and defining positions, leading the move of staff to RHAs, and supporting the growth of effective human resources systems in both the MOH and the RHAs.

2.25 In addition to the senior Human Resources Advisor, short-term consultant support to the MOH and the RHAs will be required to develop human resources systems and to assist with human resources functions during the first several years of the program. Specific terms of reference will be developed by the human resources advisor on an as-needed basis, but are likely to cover industrial relations, legislation, and staff structures. Program resources will also be used to finance a temporary (18-month) human resources implementation unit working directly under the MOH's Human

Resources Director, to process the administrative matters of staff transfer and employment. A total of 214 person-months of technical assistance will be provided through the program.

2.26 An integral part of the human resources strategy consists of incentives for staff to transfer their employment from the MOH to RHAs under the RHA Act. The incentive provided is in the form of a fully-funded contributory pension plan that will include a "top up" payment which will guarantee that MOH employees transferring to RHAs do not lose any of their accrued pension benefits. Current estimates are that approximately $25 million will be required over a 15-year period to cover the transfer of 80 percent of all pensionable staff to RHA employment. The program will finance five years of the "top up" contribution to establish the pension plan. After this five years, the GORTT will assume responsibility for these contributions. Additionally, the program will finance the first two years (1996-1997) of the pension contributions on the part of both employee and employer, during which period staff who have transferred will have a contribution holiday. Beginning in 1998, the RHAs will start to cover the corresponding employer contributions to the plan, and employee contributions will be deducted directly from wages.

2.27 The program will finance a series of activities in order to achieve the required skill mix within the MOH and the RHAs. Based on an assumption of 15% of the total staff receiving voluntary separations or abolition payments, a total of approximately $16 million will be required, spread over the program's lifetime.

2.28 The pension scheme for the RHAs will be initiated in 1997. While preliminary work has been completed, further design and development will be required through the end of 1996. Technical assistance will be provided by a local pensions consultant. An actuarial review will be required one year after establishment of the program, and thereafter once every three years, to adjust financial inputs depending on the pace of staff transfers. A total of six person-months of technical assistance will be available through this program.

4. <u>Rationalization and upgrading of infrastructure and services</u> (US$80.303 million, 346 person-months of technical assistance)

2.29 The rationalization of infrastructure and services is critical to the implementation of the health services strategy laid out in the NHSP, and therefore, to the shift in resources from traditional hospitals to ambulatory and primary care and prevention. Activities included in the program are those recommended in the NHSP based on the detailed analysis of the current situation, options, required changes, and resulting priorities.

a. Rationalization of services

2.30 One of the objectives of the HSRP is to focus health sector activities on cost-effective and high priority interventions. To that end, a central tenet of the program is to strengthen primary care services in both the public and private sectors. This strengthening is expected to achieve a reorientation toward current health needs, and to emphasize preventive and promotive services.

2.31 Technical assistance will be required to develop high quality primary care services in the public sector, including the implementation of new prevention and maintenance programs focused on priority chronic diseases. This will include consultant support to the commissioning of new district health facilities and health centers, and the transfer of staff from hospital closures. Assistance will be required to involve the commercial and NGO sectors in service delivery, and to develop pilot projects for building primary care teams within the private sector. A total of 36 person-months of technical assistance will be provided for these purposes. In addition, a development fund of $500,000 will be established to fund pilot projects aimed at building primary care teams and establishing contracting mechanisms between the RHAs and private sector entities. A clear set of criteria and guidelines for operation of this development fund will be established during the first year of program execution.

2.32 In addition to the technical assistance described above, the program will support training activities as part of the efforts to establish the RHAs and to develop a reorientation in service provision. Technical training will be required in the areas of primary care, ambulatory/day care, and family medicine.

2.33 In primary care, a consultant will be hired to oversee a national training program. This will involve 20 person-months of technical assistance. The training program will include short-term training and retraining of hospital staff transferring to primary care, and in-service training related to chronic disease prevention and maintenance. In conjunction with the University of the West Indies (UWI), training programs will be developed and implemented for health visitors, district and school nurses, and allied professionals. It is anticipated that approximately 345 individuals will be trained in the five years of this program, as follows: 150 health visitors, 150 district and school nurses, and 45 allied professionals.

2.34 In ambulatory/day care, 12 person-months of technical assistance will be required to develop skills in day surgery and ambulatory care. The development of this capacity will make possible decreases in hospital admissions and concomitant cost reductions. Based on priorities set by the MOH's Directorate of Policy, Planning and Promotion, consultants will be contracted to provide

training sessions, consisting of both one-on-one and small group seminars. In addition, the program will fund overseas placements for approximately 12 individuals.

2.35 The HSRP calls for the establishment of a postgraduate course in family medicine (general practice) as a means of emphasizing family health and primary curative care. For this purpose, the program will support approximately three person-months of technical assistance to prepare specifications for the functions of the general practitioner and the knowledge base required. To this end, the MOH will hold a workshop in 1996 to identify what is required from general practitioners, prepare a specification for teaching and accreditation, and plan the introduction of the program, which will be done in conjunction with UWI. The program will also provide approximately $600,000 for start-up costs for the course.

b. Infrastructure changes to support service rationalization

(i) Hospitals

2.36 Hospital investments were selected and prioritized based on their contribution to the overall services rationalization goals, i.e. those investments required to close smaller hospitals, consolidate specialized services or free staff required elsewhere have been given higher priority in time.

2.37 Hospital investments are incorporated into the HSRP as a means of concentrating skills and equipment to raise the quality of care and contribute to overall cost containment and efficiency. The physical works are intended to adjust capacity and to achieve the shift from inpatient to ambulatory care. Among the six hospitals to remain operational as part of the HSRP, all but one (St. Ann's) will require modifications during this initial phase, which has physical works planned only for the second phase of the HSRP.

2.38 For each of the hospitals requiring physical works, development control plans (DCPs) were prepared to group the required improvements into discrete and sequential packages. The DCPs are based on functional priorities in allowing the hospitals to fulfill their roles within the overall NHSP, and will allow for construction to be carried out while the hospitals remain fully operational. Prior to the preparation of bidding documents for the hospitals at San Fernando and Scarborough, satisfactory supporting technical, economic and financial plans, and the environmental protection measures, will be presented to the Bank. The program includes 12 person-months of technical assistance for the completion of these plans for Scarborough Hospital.

2.39 In parallel with the physical works at hospitals, consultants will be required to assist with the transfers of staff from hospitals that are closing, reorganization of hospitals that are decreasing

in size, rationalization of services between hospitals, and the commissioning of new services at relevant facilities. A total of 30 person-months of technical assistance are required.

2.40 The infrastructure changes at hospitals planned for the first seven-year period of the HSRP are as follows: transfers of services to EWMSC to allow closure of Caura Hospital; transfers of radiotherapy services to EWMSC and transfer from long-term to community care to allow the closure of St. James Hospital; transfers of certain services to EWMSC and reduction in capacity of Port of Spain Hospital; commissioning additional services at EWMSC, including selected specialist services; capacity increases at San Fernando; incremental replacement program for Sangre Grande Hospital; replacement program for Scarborough Hospital; and closure of Couva, Pt. Fortin, Mayaro and Princess Town Hospitals.

2.41 The physical works to be carried out at hospitals during the first phase of the HSRP will total approximately US$33 million, which will cover the costs of architectural designs, construction, and purchase of equipment. To complement these activities, 24 person-months of technical assistance will be provided in commissioning hospitals. A more detailed description of the development control plans and the process utilized to define needed infrastructure improvements is included in Annex II-2.

(ii) <u>District health facilities and enhanced health centers</u>

2.42 A total of eight district health facilities (DHFs) will be established as part of the HSRP. The DHFs are primary care centers providing not only primary clinical care to a local population, but also after-hours care, access to therapies and consultations on-site with hospital specialists for a wider population. The precise range and volume of services will be dictated by local health needs and MOH/RHA policies set to effect changes in health status and/or behavior. Attention at such facilities will be dependent on referral from health centers, except in emergencies.

2.43 Five enhanced health centers (EHCs) will also be established, and will be similar to DHFs in that they will provide additional primary care services such as dental and school health services. As they will be located in close proximity to hospitals, they will not duplicate the emergency care, diagnostic services, or specialist outpatient clinics available nearby.

2.44 These 13 facilities will involve a combination of rebuilding, adaptation, and new construction as part of the HSRP. Detailed functional briefs have been prepared, as have suggested operational policies, staffing levels, and equipment lists. The costs of physical infrastructure for DHFs and EHCs during the first phase of the HSRP total US$7 million, which covers design, construction, and equipment. Further details on these facilities and the works to be carried out are included in Annex II-2.

(iii) Health centers

2.45 Health centers will remain the cornerstone of primary care services for the local population choosing to seek care in the public sector. Physical works for the health centers and outreach sites are planned over the course of the five years of the HSRP, as a global multiple works component. Actual work to be undertaken ranges from minor renovations to complete reconstruction, depending on physical condition, space allotment, and site adequacy. Selection of works to be carried out in each of the five years will be done as part of the annual review process, with coordination between the MOH and RHAs, and with approval by the Bank. A further description of the process of selecting and approving individual works is included in the draft Operating Regulations (Annex II-3). Detailed functional briefs have been prepared, as have suggested operational policies, staffing levels, and equipment lists. The costs of physical infrastructure for health centers during the first phase of the HSRP total US$11.7 million, which cover design, construction, and equipment.

(iv) Ambulance service

2.46 To maintain access to health services despite the closure of selected hospitals, a national emergency ambulance service will be developed as part of the HSRP. The development will take the form of a pilot project, under the direction of an Ambulance Service Manager within the HSRP's program administration unit (PAU). The Southwest Region has been selected as the pilot site, in view of the opening of San Fernando General Hospital's Accident and Emergency Department, and the need for a service to support the rationalization program at Couva, Princess Town, and Point Fortin Hospitals.

2.47 The ambulance pilot project will involve the development of standards and protocols, training of ambulance technicians and paramedics, establishment of specifications for, and tendering of ambulances, technical and communications equipment. Given the current lack of capacity to manage such a service within other government agencies (e.g., the Fire Department) or the private sector, the pilot project will involve direct provision of services by the MOH. Nevertheless, an essential element of the pilot will be to assess the viability of alternative options as part of the decision-making process prior to nationwide implementation.

2.48 The program will finance a combination of investment costs (purchase of ambulances and equipment, contracting of consultants) and recurrent costs (salaries of staff, maintenance, transport). Beginning in the fifth year of this first phase, the MOH will shoulder responsibility for the approximately $2 million in recurrent costs of this service.

(v) Community care program

2.49 As part of the HSRP, a community care program has been developed by the MOH in consultation with the MOSD and the MPD, designed to transfer the elderly, the handicapped, and those with significant physical or sensory disabilities from inappropriate and costly hospital beds to smaller, community-based facilities. Alternative models of community care will be developed in collaboration with NGOs and the commercial private sector, piloted, and evaluated in order to establish a longer-term strategy to be followed by GORTT.

2.50 Two priority subprojects will be undertaken: one for the elderly poor institutionalized at the St. James Complex and one for youths with multiple disabilities, currently abandoned at St. Ann's and other large hospitals. Implementation of these subprojects will support the HSRP's rationalization program, through the closure of St. James and the reallocation of acute pediatric beds at other hospitals for more appropriate use (see Annex II-4).

2.51 Under both subprojects, the MOH will develop patient classification systems to determine the needs and requirements of the institutionalized clients and develop community care standards and protocols to be followed by NGOs and the commercial private sector. The program will finance 30 person-months of technical assistance, training, and recurrent costs over a three-year period, until cost savings from the closure of St. James and the reallocation of acute care beds in the other hospitals can be realized.

2.52 Implementation of these two subprojects will also draw on resources available in the Bank-supported CDF for strengthening the institutional capacity of participating NGOs and community-based organizations and for the provision of community infrastructure, such as small nursing homes and day care centers. Infrastructure projects will be subject to the CDF's operating guidelines, which ensure that projects are targeted to the poor and involve the community as a major stakeholder. They are to be executed by the National Commission for Self-Help which has experience, as well as a lean and efficient administrative structure.

5. Health financing strategy
(US$3.855 million, 113 person-months of technical assistance)

2.53 A number of sector financing issues will need to be monitored and further studied over the early program years. Technical assistance will be required in the areas of user charges, role of the private sector, costs of services, cost containment and cost-effectiveness, and development of an overall financing strategy. Consultant support may also be required to assist with the implementation of new systems or procedures. A total of 67 person-months of technical assistance will be financed by the program.

2.54 The GORTT has indicated its interest in considering a national health insurance system (NHIS) in the next several years. While initial work was done under ATN/SF/CD(PP)/JF-3650-TT, additional work is required before a policy decision can be made. Under this program, the required analytical work will be carried out in order to fill in gaps in information regarding the viability and technical feasibility of NHIS. The studies will focus on defining the institutional structures required, identifying legislative implications, and evaluating financial viability. These studies will require a total of 46 person-months of technical assistance.

2.55 In parallel with the assessment of the feasibility of a national health insurance system, the HSRP will develop a population registration system based in the Registrar General's office. Such a system would be required by the NHIS, but would also support the operation of a primary care system based on capitation and providing access to the private sector through the RHAs. Technical assistance will be required to develop this system and carry out needed survey work. Specific terms of reference for this work, and specifications for hardware and software needs, will be defined to the Bank's satisfaction prior to preparation of bidding documents.

6. Program execution
(US$2.281 million, 792 person-months of technical assistance)

2.56 A program administration unit (PAU) will be established to manage the program. It will comprise a director and a small professional and administrative staff, as well as external consulting firms or agencies under subcontract to provide specific services. The PAU will manage the physical investment and technical assistance aspects of the HSRP, complete tender documentation and specifications for construction, plant, and equipment, prequalify contractors, evaluate bids, and oversee the awarding of contracts, procure consultants for the full range of technical support, arrange overseas work experience for MOH and RHA staff, and oversee all management development and training activities. The program will finance the staffing of the PAU, operating costs, and equipment (computers and vehicles).

2.57 The PAU staff will be assisted in the procurement of goods and services by a consulting firm and by the National Insurance Property Development Company Ltd. (NIPDEC). The firm will help to manage technical assistance contracts as part of the HSRP, for both companies or institutions and individual consultants. NIPDEC will assist in the management of contracts for construction and equipment. These responsibilities are described in further detail in chapter III.

D. Cost and financing

2.58 Table II-1 presents the costs for this program, by line item, with breakdowns by funding source. Table II-2 shows the breakdown of

costs and person-months of technical assistance by strategic component. (The figures in the latter table are exclusive of unallocated and financial costs.) Annex II-5 presents detailed costs by strategic component. Annex II-6 presents the summary and timing of technical assistance.

Cost and Financing (in thousands of US$)					
		IDB	GORTT	TOTAL	%
1	ADMINISTRATION, DESIGN & SUPERVISION	5,455	986	6,442	3.4
1.1	Administration	1,711	570	2,281	1.2
1.2	Design and supervision	3,744	416	4,160	2.2
2	DIRECT COSTS	105,004	17,564	122,568	63.8
2.1	Hospitals	33,312	0	33,312	17.3
2.2	District health facilities	6,991	0	6,991	3.6
2.3	Health centers	11,702	0	11,702	6.1
2.4	Ambulance services equipment	1,685	0	1,685	0.9
2.5	Information systems equipment & software	6,173	0	6,173	3.2
2.6	Human resources strategy	29,783	17,564	47,347	24.7
2.7	Technical assistance	11,181	0	11,181	5.8
2.8	Training	3,657	0	3,657	1.9
2.9	Preinvestment studies	520	0	520	0.3
3	CONCURRENT COSTS	13,587	2,113	15,701	8.2
3.1	Initial operating expenses: ambulance services	11,447	1,931	13,378	7.0
3.2	Initial operating expenses: Community Care Fund	1,551	182	1,733	0.9
3.3	Early management costs: RHAs	589	0	589	0.3
	SUBTOTAL	124,047	20,664	144,710	75.4
4	UNALLOCATED	8,613	823	9,437	4.9
4.1	Contingencies	4,535	288	4,822	2.5
4.2	Cost escalation	4,079	536	4,614	2.4
5	FINANCIAL COSTS	1,340	36,513	37,853	19.7
5.1	Interest	0	33,641	33,641	17.5
5.2	Credit commission	0	2,872	2,872	1.5
5.3	Inspection & supervision	1,340	0	1,340	0.7
	TOTAL	134,000	58,000	192,000	100.0
	% / Fund	70.0	30.0	100.0	

TABLE II-2
TRINIDAD & TOBAGO HEALTH SECTOR REFORM PROGRAM
COSTS BY STRATEGIC COMPONENTS
(US$000)

COMPONENT	COST	%	TECHNICAL ASSISTANCE PM 1/
COMPONENT 1: REFORM OF THE MINISTRY OF HEALTH	8,451	5.8	764 2/
COMPONENT 2: DECENTRALIZATION OF THE RHAs	1,926	1.3	172
COMPONENT 3: HUMAN RESOURCES STRATEGY	47,894	33.1	238
COMPONENT 4: RATIONALIZATION AND UPGRADING OF INFRA-STRUCTURE AND SERVICES	80,303	55.5	346
4A: Rationalization of services	3,892	2.7	
4B: Rationalization of infrastructure	76,411	52.8	
COMPONENT 5: HEALTH FINANCING STRATEGY	3,855	2.7	113
PROGRAM ADMINISTRATION	2,281	1.6	792 3/
TOTAL	144,710	100.0	2,425

1/ Person-months
2/ Includes technical assistance for information systems and technology which apply to both MOH and RHAs
3/ Costs of technical assistance provided by NIPDEC are included in component 4B, rationalization of infrastructure

III. INSTITUTIONAL FRAMEWORK AND PROGRAM EXECUTION

A. Institutional framework

1. Borrower and executing agency

3.1 The borrower is the Government of the Republic of Trinidad and Tobago and the executing agency is the Ministry of Health. Policy-related responsibilities and overall monitoring of qualitative and quantitative objectives and targets of the HSRP and the program will be undertaken by the Cabinet-appointed HSRP Implementation Steering Committee (ISC), chaired by the Minister of Health. The program's activities will be executed by the relevant units of the MOH and the RHAs and coordinated by a program execution team (PET).

3.2 Bank resources and counterpart funds will be transferred to the MOH as the program is executed. The transferred funds will be deposited into a special account that will be established in the Central Bank for this purpose. The establishment of this special account and the procedures for its use will be a condition prior to first disbursement of the loan.

2. Other participating agencies

3.3 Other agencies will participate in the implementation of the program. The MOH will collaborate with the MOSD and with the MPD, through the CDF, in the implementation of the community care program. The Ministry of Legal Affairs will undertake the population registration system. The University of the West Indies will be requested to assist in the development and implementation of courses in primary care and family medicine. Presentation of agreements between the MOH and all other participating agencies will be done within nine months of the loan contract date.

3. Program execution strategy

3.4 The program execution strategy is based on a flexible approach that relies on a combination of: (a) the MOH's and RHAs' own capabilities; (b) specific temporary reform implementation support and advisory structures; and (c) consultant services, under the leadership of the Minister of Health and day-to-day guidance and coordination of the PET. This strategy avoids the creation of a parallel structure for program execution, and moreover, aims at taking maximum advantage of the execution of the program as a means of consolidating and strengthening the new MOH and RHA structures.

3.5 To this end, execution of the program activities will be among the main tasks to be carried out by the new MOH Directorates and the RHAs, and in order to be able to discharge these tasks in an effective and timely way they will have full support from the

program resources for technical assistance, training, information systems, etc. Moreover, the MOH and RHA senior managers will have joint responsibility for program management as described below.

4. Program management

3.6 Direct responsibility for execution of program activities will lie with a PET to be formed on the basis of the MOH Management Executive Committee (see para. 1.23), expanded to include the CEOs of the five RHAs, the Health Sector Reform Advisor and the Director of the PAU. The PET will be chaired by the Permanent Secretary and report to the Minister of Health. Its role will be to ensure that all technical work is well directed and coordinated. All senior managers are currently functioning as such, and most RHA managers have already assumed their positions. Program administration will be undertaken by a PAU, to be established, which will contract all technical support and infrastructure procurement. Technical support will be provided by a combination of individual consultants and consulting firms. Graphic representation of the program administration scheme can be seen in Annex III-1.

3.7 The PET will meet weekly to execute the implementation of the program in the context of the HSRP. The PET will review implementation progress, make medium- and long-term plans for needed action, ensure coordination in the use of technical support and systems development between the RHAs and with the MOH, monitor the performance of health services and of the PAU, ensure the provision of relevant information from the MOH and RHAs and its transmission to the PAU, and maximize the amount of technical skills imparted to local health sector personnel and institutions. The PET must be established as a condition prior to first disbursement.

3.8 The management of program implementation will be done by the PAU. It will arrange the procurement and management of the physical investment and technical support procurement components, arrange overseas placements for MOH and RHA staff, oversee all management development and training activities, and communicate the objectives and activities of the HSRP. The PAU will organize, coordinate, manage, and administer finances, procurement, and disbursement. The PAU will be staffed by a director and a small professional and administrative staff, as well as external consulting firms or agencies under subcontract. Establishment and staffing of the PAU is a condition for first disbursement of the loan.

3.9 The ISC will be responsible for monitoring progress against the agreed-upon targets and benchmarks, assessing the continued viability of the program, facilitating inter-institutional coordination, and channelling policy and organizational issues requiring government decisions or international involvement. The ISC will meet monthly and will comprise the Minister of Health, the Permanent Secretary, the Chief Medical Officer and the Chief Administrative Officer of the MOH, senior officials from the Office of the Prime Minister, the Ministry of Finance, the Ministry of

Planning and Development, and the Chief Personnel Officer, the Secretary for Health of the Tobago House of Assembly, the Chairpersons of the RHAs, the Director of the PAU, the Health Sector Reform Advisor, the local representatives of the Bank and the Pan-American Health Organization, and the representatives of other Ministries as needed. This committee was established February 2, 1995 by Cabinet Note number 274 and is in the process of consolidating.

B. Program procurement procedures

3.10 Acquisition of goods and services and contracting of civil works will be subject to the procedures stated in Annex B of the loan contract. International public bidding will be mandatory for acquisition of goods and related services that exceed US$250,000, and US$2 million for civil works. These limits are justified considering that in similar projects in the country, international participation is attracted when amounts exceed these limits. Also, on account of the technical complexity of the work to be done, acquisition packages were established to facilitate procurement. Civil works for district health facilities and health centers consist of several small units which have been grouped according to type of work and geographical location. All bidding under the set limits will be done following national legislation that requires public bidding for amounts that exceed US$100,000 and shopping below those amounts (see Annex III-2).

3.11 To facilitate the process of contracting technical assistance, the specific consultant activities have been grouped into five packages, as appropriate based on the technical skills required. Work of each package will be carried out by consulting firms. Individual consultants will be contracted as such. Procurement of these consulting services will be done according to regular Bank procedures (see Annex III-3).

3.12 Due to the substantial resource demands associated with meeting short-term needs to the reform, the project team recommends that the Bank allow the MOH to contract assistance for procurement purposes on the two most relevant areas. For the first one, civil works and related goods and services, the team recommends that a waiver be given to enable the direct contracting of the National Insurance Property Development Company Ltd. (NIPDEC), who will act only as procurement agency for works. NIPDEC has been authorized by the Central Tenders Board, which is the government procurement agency, to act as agent for public institutions. The services of NIPDEC were engaged by the MOH, with the nonobjection of the Bank to carry out related activities during 1995. NIPDEC is an institution with over 15 years of proven experience in activities of this nature. The second area that requires assistance is the one related to consulting services for technical assistance. For this, the team recommends that a firm be contracted, using a short procedure method, for overseeing all related procurement activities

and supervision of consulting works. Both NIPDEC and the consulting firm will be supervised by the PAU. Detailed terms of reference and draft contracts for each agency will be presented to the Bank prior to negotiations with them. Presentation of the signed contracts will be a condition prior to first disbursement.

C. Program execution

3.13 The five components of the HSRP can be grouped in three areas into which investments will be made, as follows: (a) **institution building**, which covers the MOH reform, decentralization of service delivery and management, and the human resources strategy; (b) **rationalization and upgrading of services and infrastructure**; and (c) **preinvestment studies** for the definition of anticipated additional reforms, which relates to the financing of health services. Detailed timetables specifying the required timing for contracting and execution of program activities are available, as well as terms of reference and draft designs. It is expected that implementation will start as soon as the Bank loan is approved; preparatory work for prequalification of consultants and contractors according to Bank procedures is already taking place.

1. Institution building

3.14 Consolidating the newly created institutional structures is of utmost importance. To accomplish this, the first three components of the program will establish new operational systems and procedures and provide necessary training. As of the date of analysis, the RHA boards and most new directors of the MOH had been appointed and initial steps taken to transfer responsibilities from the MOH to the regions.

3.15 Due to the number of consultancies involved and also to the fact that during the first year, both the MOH and the RHAs will be firming up their new organizational structure, the PAU will retain the services of a specialized firm to assist in the contracting, supervision and management of the consultancies. With the exception of this firm, which must be contracted before program initiation, the contracting of the necessary consultants, individual and/or firms, will commence immediately after the loan has been declared eligible for disbursements. The PAU and the firm will finalize the terms of reference and estimated budgets, prepare bidding documents, identify and prequalify consultants and conduct the bidding process.

3.16 Most training will be done mostly by private local training organizations. Special training studies required for learning the operation of the new management systems will be done by international consultants and some training requiring studies or placements in specialized institutions will be done overseas. These

training services will be contracted by the PAU and supervised by the corresponding units of the MOH and RHAs who, as receptors of the products of the consultancies, will participate in the implementation.

3.17 The human resources strategy, which must be approved as a condition to first disbursement, will be implemented in stages. Preparatory activities, now in execution and expected to be completed by December 1996, will set the stage for the transfer of staff and attainment of the required skill mix. As part of the human resources strategy, existing positions in the MOH will be abolished if they: (a) are vacant on the loan contract date and not included in the new MOH structure; (b) are or become vacated due to the incumbent's transfer to an RHAor to voluntary separation; or (c) are vacant due to the incumbent's early retirement or resignation and such posts are not included in the new MOH structure.

3.18 An actuarial consulting firm has been engaged to complete the design of the new pension plan and to develop a pension management scheme and the corresponding procedures and manuals. A firm will be contracted to manage the pension fund. Prior to the first disbursement of the financing, the GORTT will secure Cabinet approval of the establishment of the RHA personnel pension fund and the establishment of a committee responsible for its implementation. Within 12 months of the loan signature date, a firm will be contracted to manage the pension fund. GORTT contributions for the "top-up" of the pension plan will be financed with counterpart resources and will be done in an ascending basis because the financial requirements for the payments of benefits will be lower in the first years.

3.19 Execution of the human resources strategy will be a joint responsibility of the Director of Human Resources of the MOH and the Human Resources Directors of the RHAs. To assist them in the process, a team of short term advisors and administrative support will be provided through the technical assistance resources.

2. Rationalization and upgrading of services and infrastructure

3.20 Physical works and equipment acquisitions related to the rationalization of services have been divided into two groups: (a) hospitals and district health facilities; and (b) health centers and outreach facilities. The first group represents specific projects according to designs which have already been drafted. The second group will be executed under the modality of global works; basic designs have been finalized and implementation parameters have been established. All works planned for Tobago will require an agreement between the Tobago House of Assembly, the Tobago RHA, and GORTT prior to first disbursement of the loan. The GORTT will ensure that all new public investments in health care delivery facilities in Trinidad and Tobago are consistent with the NHSP.

3.21 For both groups of projects, the PAU will retain the services of NIPDEC who will assist in the contracting and supervision of works. The executing agency and NIPDEC will formalize a contract, a draft of which will be presented for Bank approval before negotiations.

3.22 Selection of works to be done under the global works group will be done following the criteria established in the Operating Regulations, which will be presented prior to first disbursement of the financing for this component. A draft of these Operating Regulations is presented in Annex II-3. The following are among the most relevant and indicative criteria for health centers: (a) cost of construction must not exceed US$800 per square meter; (b) total cost of construction of any individual center must not exceed US$450,000; (c) cost of equipment for each center shall not exceed US$165,000; and (d) the effective catchment population must be at least 10,000 inhabitants, except where there is no other health service within five miles of the terrain. For outreach facilities, the most relevant and indicative criteria are: (a) population to be served should be no less than 1,000; (b) there should be no health center within a radius of 10 miles or 30 minutes of travel time by public transport; (c) the health center from which services are outreached must be operating and fully staffed; (d) there should be no suitable building in the area that could be used to accommodate outreach service delivery; and (e) cost of rehabilitation should not exceed US$320 per square meter, and the total cost should not exceed US$90,000. All exceptions to the above-mentioned limits will be submitted, prior to commitment of funds, for Bank approval.

3.23 The MOH, with the technical support of the PAU, will supervise works. All works will be done according to annual programs prepared by the executing agency and the RHAs and reviewed with the Bank. As works are finished, infrastructure and equipment will become the property of the corresponding RHA who will assume responsibility for operation and maintenance.

3. Preinvestment studies

3.24 The Director of Planning and Health Promotion of the MOH will have responsibility for the execution of studies defining the future financing strategy. The studies for sector financing and for the feasibility of a national health insurance program will be carried out by a specialized consulting firm. Basic terms of reference have been prepared and contracting will start as soon as the loan has been declared eligible for disbursements. The studies are expected to be completed in the first three years of program execution.

D. Program monitoring and evaluation

3.25 Program monitoring and evaluation will be used to identify problems and needed changes in program implementation and/or targets.

Program supervision will be performed by the Bank's Country Office, with the support of the project team. The monitoring and evaluation program, which will be established in accordance with the terms and conditions agreed with the Bank within the period of three months following the date of first disbursement of the financing, is described below:

1. Start-up

3.26 The borrower, through the executing agency, shall within the period of nine months following the date of the loan contract, conduct a project start-up workshop based on a plan previously agreed with the Bank. The purpose of the workshop is to review the strategies, main goals, and the steps needed to assure a smooth program start-up. The plan for the workshop, including dates, contents, and other logistic matters will be presented by the executing agency within six months of subscription of the loan contract.

2. Annual review and programming

3.27 Annual reviews will be conducted by the GORTT and the Bank, in June of each year of the program starting in 1997. Annual reviews will be used in the annual planning cycle so the MOH can submit its business plan to the Ministry of Finance in July.

3.28 During the first year of program execution, the Bank and the executing agency will agree on the details of the annual reviews, including their scope and agenda, based on the items identified below. The referred agreement will define the documents to be prepared by the executing agency and other institutions taking part in the program, as well as deadlines for the completion of these documents before the date of each annual review. Tentatively, the terms of reference for the annual reviews will include:

a. evaluation of progress in implementation of the overall health sector reform, including compliance with policy directions reflected in the sector policy letter, the NHSP and any other relevant policy documents, as well as related conditions in the loan contract;

b. review of program implementation during the previous year, including execution and expenditure;

c. monitoring of specific program achievements against the detailed benchmarks specified in the monitoring tables;

d. review of the sector financial strategy, including an assessment of: (i) the financial requirements for the forthcoming fiscal year, (ii) available funding sources, and (iii) required decisions on user charges or other revenue generating measures as appropriate.

e. Review of the budgeting process and proposals for the forthcoming year for both the MOH and the RHAs, with a view towards their full and effective integration within the annual planning cycle and incorporation into the ASAs;

f. review of the performance of the health institutions in rationalizing services and shifting expenditures within and between RHAs as described in the HSRP, and in introducing cost-effective practices and quality assessment programs;

g. review of the effectiveness of the program execution mechanisms. Special consideration will be given to the evaluation of consulting services effectiveness;

h. evaluation of studies and proposals related to the creation of the NHIS completed during the previous year;

i. evaluation of new information from HNA studies in the light of the NHSP; identification of the need to update the NHSP when relevant;

j. Evaluation of policy and implementation efforts to improve equity in the delivery of health care services;

k. agreement on the detailed action plan for execution of the program in the forthcoming calendar year, which will direct the projected disbursements of loan and counterpart resources; and

l. agreement on any corrective actions and deadlines for their implementation, including decisions to postpone new commitments of program resources for lower priority components, when needed to improve program effectiveness.

3.29 The annual reviews will in part be based on internal monitoring coordinated by the PAU and undertaken by the PAU, MOH, and RHAs. The three monitoring areas are: (a) program achievements and expenditures; (b) annual services activity levels and recurrent expenditures; and (c) revision of plans for services configuration.

3. Benchmarks and reports

3.30 In order to contain recurrent expenditure and maintain sustainability of the reforms, it is important that all activities of the program, aimed at the improvement of management and to make operation more efficient, are implemented in a timely way. To guarantee that interdependent parts of the reform proceed at the right pace, a list of benchmarks is included in Annex III-4. The targets will be incorporated into the appropriate year's annual service agreement for the RHAs concerned, along with adequate resources corresponding to the agreed-upon service levels, to ensure that they can be achieved. In addition, the PAU will inform the PET and/or the ISC of pending benchmarks so coordination among groups will occur when needed.

4. Mid-term evaluation

3.31 A mid-term evaluation will be undertaken jointly by the GORTT represented by the HSRP Implementation Steering Committee and by the Bank. This will take place in June 2000 and will replace the annual review for that year. The mid-term evaluation will supplement the topics covered in the annual reviews with evaluation of the progress being made in achieving the broader objectives of the HSRP and specific targets for each component. In addition, the review will examine the coverage, quality, and efficiency of services delivery; the functioning of the RHAs and the reformed MOH; and, more generally, ways to adjust the HSRP to better achieve the stated objectives. Also to be covered during the mid-term evaluation will be: (a) the results of the studies on the feasibility of the NHIS and related recommendations; and (b) the progress in implementing decentralization and an evaluation of the need and feasibility of further decentralization to the level of individual hospitals.

5. Ex post evaluation

3.32 An ex post evaluation of the program will be undertaken jointly by the GORTT and the Bank to assess the program's success in obtaining the objectives of the first phase of the HSRP and derive lessons to guide the design and implementation of further reforms. Since data collection and monitoring of the program will be done on an ongoing basis, the baseline and comparative data needed for ex post evaluation will be available through regular information systems. It will be the responsibility of the MOH to assemble the necessary data and prepare an ex post evaluation document, the scope and methodology of which will be agreed upon during the first annual review meeting. This document will be available within one year after final disbursement of the loan and related costs will be split between the borrower and the Bank. A joint ex post evaluation meeting to review the above document and finalize its conclusions and recommendations will take place in Port of Spain within 18 months after final disbursement of the loan.

3.33 Tentatively it is anticipated that among its main topics the evaluation will focus on the degree to which the following targets are achieved: (a) target indicators for coverage, accessibility, equity, and the population's health status; (b) economic and financial targets based on indicators for growth, relative share of allocations to the various service categories, efficient use of allocations, service productivity, health care costs, and service financing; and (c) institutional targets based on service organization and implementation of new management and financing systems, with special emphasis on the impact of institutional strengthening activities and decentralization.

E. Disbursement schedule

3.34 The disbursement schedule for the program, by source of funds, is presented in the following table:

TABLE III-1
DISBURSEMENT SCHEDULE
(in 000's of US$ equivalent)

Source	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Total	%
IDB Loan	22,103	25,543	23,757	20,910	16,843	14,726	10,118	134,000	70.0
Counterpart	2,588	4,401	5,620	9,004	11,054	12,215	13,118	58,000	30.0
Total	24,691	29,944	29,377	29,914	27,897	26,941	23,235	192,000	100.0
% / year	12.9	15.6	15.3	15.6	14.5	14.0	12.1	100.0	

F. Recognition of expenditures and advance of funds

3.35 The borrower has requested that the Bank recognize expenses to be incurred prior to consideration of the proposal by the Bank's Board of Directors. The project team has reviewed the expenses which will have been incurred by the executing agency before loan approval and considers that up to US$5 million could be recognized, US$3.5 million as counterpart and US$1.5 million as retroactive financing.

3.36 A revolving fund will be established with resources from the Bank's loan to pay for projected expenditures. Because of the types of activities planned and the pace of execution, an advance of 15 percent of the financing, or US$16 million, is recommended.

G. Maintenance

3.37 Each participating agency will commit to operate and maintain the works and equipment financed with program resources in accordance with generally accepted technical standards and that the resources necessary for their efficient operation will be made available. During the ten years following the completion of the first of the works of the project, the Bank will be allowed to visit and inspect all projects and programs, and, if unacceptable levels of maintenance and upkeep are found, it will be the obligation of the agency involved to take all necessary steps to correct the shortcomings.

H. Environmental impact

3.38 At its meeting of March 1, 1994, the Environmental Committee classified this as a Category II program. The design of the effluent control systems for the hospitals to be rehabilitated will conform to international standards. If the Environmental Management Authority of the GORTT develops comparable standards during

the execution of this program, at the request of the GORTT, the Bank could consider the use of such standards for project purposes. Also, as part of the restructuring and institutional strengthening of the Ministry of Health, the program will address the monitoring and control of certain public health problems resulting from the use of agrochemicals.

I. External audits

3.39 During the execution period of the loan, the executing agency will present to the Bank financial statements for the loan. These statements should be submitted annually within 120 days of the close of the fiscal year and should be certified by a firm of independent public accountants acceptable to the Bank.

IV. VIABILITY, BENEFITS AND RISKS

A. Lessons learned during the preparation of the reform program

4.1 The reform of the health sector is at the forefront of current GORTT efforts to implement broad reforms in the public sector and is also a pioneering effort to address health sector issues in the English speaking Caribbean; the Trinidad and Tobago experience is being looked at with great interest by most Bank member countries in that region as well as by Eastern Caribbean countries. Among the many lessons learned, three can be highlighted.

4.2 First, while the concept of health sector reform and its basic tenets enjoyed full political support from very early on, the development of the actual reform components required strong participation of and close collaboration among many government institutions and officials, due to various policy matters that cut across the responsibilities of specific ministries and had far-reaching implications. Development of the reform of the health sector has therefore evolved into a government-wide effort, thus contributing to full ownership and institutional sustainability of the program.

4.3 Second, considerable effort was devoted to addressing the complex issues related to new personnel policies and the transfer of staff from public service to RHA employment. This is, of course, one of the areas that required close collaboration among government agencies. While sectoral human resources issues had not been initially identified as one of the main reform components, in the end there was consensus that this was indeed one of the pillars of the reform. A substantial amount of technical work and discussions on policy options were devoted to this area, and as a result, a significant component of the Bank loan was allocated to cover costs of the agreed upon policies.

4.4 Third, while the program was prepared with the assistance of a Bank technical cooperation that included significant funding for counterpart teams, with the objective of training them in various policy analysis areas during program development, in practice very few of the local counterpart staff were retained by the government after the technical cooperation was completed. Thus, the "technology transfer" effects expected from the technical cooperation were achieved only partially, which presents a challenge to the sustainability of the reform efforts over time. Additional consultant support will therefore be required and is included as part of the program, but will emphasize the necessity of close collaboration between consultants and MOH/RHA staff and of adequate measures to retain the newly created technical capacity, that will be taken into account when designing the new service conditions for the staff of the sector.

B. Benefits expected from the reforms

4.5 This program will enable the GORTT to achieve better health status for the population. Specifically, benefits of the program will include strengthened policy-making and regulatory capacity of the health sector, a shift in public and private expenditures to high-priority and cost-effective problems and solutions, the establishment of new operational and employment structures which will promote accountability, increased decision-making autonomy, and appropriate incentives to improve productivity and efficiency. Taken as a whole, these benefits will result in increased efficiency, greater equity, improved quality, and sustainability of the health system.

4.6 Beneficiaries of this program will include the GORTT and the MOH, who will benefit from a more efficiently managed health system with clearly defined roles, new operating structures, and plans for long-term sustainability. Health sector personnel will benefit from training opportunities, improved management, and new employment structures. The private sector may benefit through increased opportunities to expand involvement in the health sector. The ultimate beneficiaries will be health care consumers, who will have greater access to better quality services.

C. Technical viability

4.7 As a result of the reform program, the health care system of Trinidad and Tobago will shift from the current, inadequate pattern of services and programs towards one more responsive to the health needs of the population, with increased emphasis on promotion of health and prevention of diseases. Health services delivery will be rationalized and reorganized around a smaller number of modern hospital facilities and a strengthened network of health centers and district health facilities. Priority will be given to modern, effective treatment techniques that minimize hospitalization.

4.8 Community care schemes will also be developed for the elderly and the multiply-disabled currently institutionalized in MOH facilities, providing them with alternative sites for the provision of care when hospital confinement is not required by health conditions, while easing pressure on limited and expensive hospital resources.

4.9 Through decentralized management of health facilities and periodic assessment of the health needs of the population, the health system will also become more responsive to changing demographic and epidemiological conditions in the country. Selection of specific interventions will be based on a consistent NHSP, to be updated approximately every three years.

D. Socioeconomic viability

4.10 The program is fully consistent with the modernization approach adopted and implemented by the GORTT since 1991 and has been designed to maximize its contribution both to the economic and social policies of the country. In economic terms, the strengths of the program include 5/:

a. **Higher allocative efficiency**: new policies and resource allocation criteria will systematically favor selection of the most cost-effective interventions and technologies available for addressing the health needs of the population.

b. **Increased technical efficiency**: the decentralization of management of health facilities, the gradual transfer of personnel out of the public service and budgeting procedures based on outcomes and agreed levels of service delivery, rather than on inputs and bureaucratic inertia, will create incentives for cost containment and result in greater efficiency in the use of resources.

c. **Rationalization of health infrastructure**: this will allow for better achievement of economies of scale in some cases and optimum use of highly skilled personnel and specialized equipment. Moreover, all investment decisions in the health sector will be based on the priorities set in the NHSP.

d. **Cost containment and selection of least cost investment solutions**: the program components related to facilities to be built or refurbished and equipment to be purchased have been selected and designed so as to contribute to the overall cost containment policies in the sector. Systematic investment selection techniques to minimize investment and operating costs will also be introduced.

4.11 The analysis has verified that the methodologies utilized for selecting and prioritizing physical investments included in the program are conducive to the attainment of greater economic efficiency and cost containment in the terms discussed above.

4.12 In the case of the hospitals and DHFs, physical investments become difficult to appraise in traditional economic terms because they are merely one of the elements of rationalization, given the potential to increase both the effectiveness, quality and efficiency of health services. This rationalization is normally achieved through a combination of investments and qualitative changes of different types affecting several facilities simultaneously, such as redefinition of the role and scope of services to be delivered out of specific facilities, consolidation

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5/ Social impacts are discussed in section G.

of some types of services across facilities, added emphasis on certain types of services (health promotion and prevention, primary care) and technologies (ambulatory care), etc., and therefore it is not possible to attribute benefits to the physical investments in one facility per se. An alternative analysis, based on cost of services with and without rationalization, was not possible ex ante because of information gaps, but will be implemented during program execution.

4.13 For health centers, the selection criteria specified in the Operating Regulations regarding demonstrated demand, use of standard cost and design parameters and rationalized services and staffing programs are in line with Bank methodology for similar types of projects and are sufficient to ensure ex ante economic efficiency.

E. Institutional viability

4.14 The development of new sector institutions (the reorganized MOH and the newly created RHAs) is in fact the cornerstone of the current phase of the reform of the health sector. Implementation of institutional development actions began in 1994 and substantial program resources will be allocated to this end.

4.15 The implementation strategy is based on a flexible approach relying on a combination of the MOH's and RHAs' own growing capabilities, specific temporary reform implementation support and advisory structures, and consulting services, under the leadership of the Minister of Health and a reform execution team composed of senior MOH and RHA managers. This approach is designed to take maximum advantage of the reform execution process as a tool to consolidate the new sector institutions; it also depends on successful recruitment and training of staff with the required skills, and close coordination among various institutions.

4.16 The development of sector policy analysis and management capacities to strategically monitor and evaluate health needs and institutional performance, and plan future sector activities accordingly, is also a critical requirement of the reform process.

F. Financial viability

4.17 While the HSRP does not call for a fundamental shift in the financing of health services, it does result in a strategic shift in the organization and provision of services which should have a significant impact on financing requirements. Therefore, the financing strategy anticipated for the near term focuses on maintaining real levels of government budget allocations, with increases in out-of-pocket expenditures by patients seeking care through hospital user charges. The latter is expected to generate revenue for the sector, but more importantly, to reinforce appropriate patterns of utilization of care.

4.18 However, a fundamental component of the HSRP will be to establish a comprehensive financing strategy for the sector, for the medium- and long-term. This will require a number of analytical efforts, many of which are part and parcel of the ongoing monitoring and operation of health services. It will also require that increased attention be paid to the private sector and its potential role in the provision and financing of services.

G. Impact on priority population groups

1. Women

4.19 While the program is intended to improve the health status of the whole population of Trinidad and Tobago, its design and specific features will have a positive impact on the living conditions of women in a number of different ways:

4.20 First, health care services targeted to women (e.g. prenatal, ob/gyn care) will be improved in terms of quality and accessibility. They will be delivered from facilities located in the community (district health facilities and health centers) rather than hospitals whenever possible. In addition, new health promotion programs will include modules to benefit women, such as education to reduce the incidence of teenage pregnancy.

4.21 Second, the improvement of health promotion and primary care programs targeted to young children and the elderly (as well as the community based programs for geriatric care) will result in a reduced burden for women, who are generally responsible for the health and welfare of dependent family members. This is particularly important given the increased labor force participation of women in Trinidad and Tobago, and the rapid growth in the percentage of female-headed households.

4.22 Third, new personnel policies for the health sector will result in increased training and career advancement opportunities for nurses and health technicians, positions overwhelmingly held by women.

4.23 Finally, it is worth noting that roughly half of the senior management positions in the restructured MOH are currently occupied by women. In the context of the sectoral reform taking place, this high level of women's participation in decision making should result in increased consideration of health issues affecting women in Trinidad and Tobago.

2. Low-income groups

4.24 While not a poverty alleviation program, and therefore not specifically eligible under para. 2.15 of the Eight Replenishment, the reform of the health sector in Trinidad and Tobago will result in increased quality of and accessibility to health services for the entire population of Trinidad and Tobago. Current gaps result in insufficient and/or less than satisfactory services and programs

for rural and urban-marginal populations, which depend largely on publicly provided health care. Therefore, closing such gaps will directly benefit those populations.

4.25 Based on data collected during program preparation, it is estimated that between 25 percent and 40 percent of the users of public hospitals and other facilities belong to low-income groups (using the Bank's poverty line for Trinidad and Tobago). This is significantly above the proportion of low-income persons in the overall population, estimated at 20 percent. In sum, it is determined that the reform of the health sector will have significant (positive) equity implications.

H. Risks

4.26 The following risks have been identified:

a. Implementation of the reforms and specific activities included in the Bank program could be slower than anticipated. This could lead to problems such as: (i) sluggish development of the RHAs, resulting in managerial vacuums; (ii) lack of synchronization between complementary program activities; or (iii) loss of credibility in the public's eyes. To manage this risk, clear workplans and timetables have been developed to guide implementation efforts, which will be the focus of systematic monitoring during the execution period.

b. Political and social pressures could hamper some aspects of the reform program such as: (i) the closing of smaller hospitals, the consolidation of certain services, or the transformation of small hospitals into district health facilities if perceived as "downgrading"; (ii) the introduction of user charges; or (iii) the introduction of a new pension plan for health workers who leave the public service for RHA employment. The government has already made important decisions on the above topics, which will require continued commitment during the execution of the program, as well as extensive communications efforts to gain the support of all relevant actors.

c. During the execution period of this program, financial viability will depend on the success of cost-containment efforts, collection of user charges, and GORTT commitment to maintain real levels of spending. In the short term, the program will provide technical assistance in a number of health financing areas, including user charges and cost-containment efforts. As a longer-term approach, the program will develop a comprehensive health financing strategy that will include an evaluation of the feasibility of introducing a national health insurance system.

d. Execution of the reform program relies on strong technical and managerial skills within both the MOH and the RHAs; incentives for early retirement and voluntary separation might induce the

best workers to leave. Better service conditions at the RHAs and training efforts are expected to contribute to development of the necessary skills and retention of qualified staff.

e. Efficiency gains depend largely on improved incentive structures and specifically on better resource allocation through a contracting process involving ASAs between the government and the RHAs, which will replace traditional budget financing. However, the characteristics of the new contracting process have not yet been defined. Specific preparatory activities will be carried out as part of the program to strengthen such efforts, including both technical assistance and training for the MOH and RHAs. Full implementation of the ASAs as a contracting mechanism is expected by 1998.

f. The implementation of the human resources strategy could be hampered by delays in negotiations with the various unions and associations. The main issues, specially the transferring of authority and the rationalization of the workforce, have been the subject of informal comments by the different stakeholders. The strategy includes a communications program that will address all related issues. In anticipation to negotiations, the MOH has begun a series of workshops with the main employee groups and associations. Professional assistance in industrial relations and communications will be provided throughout the program.

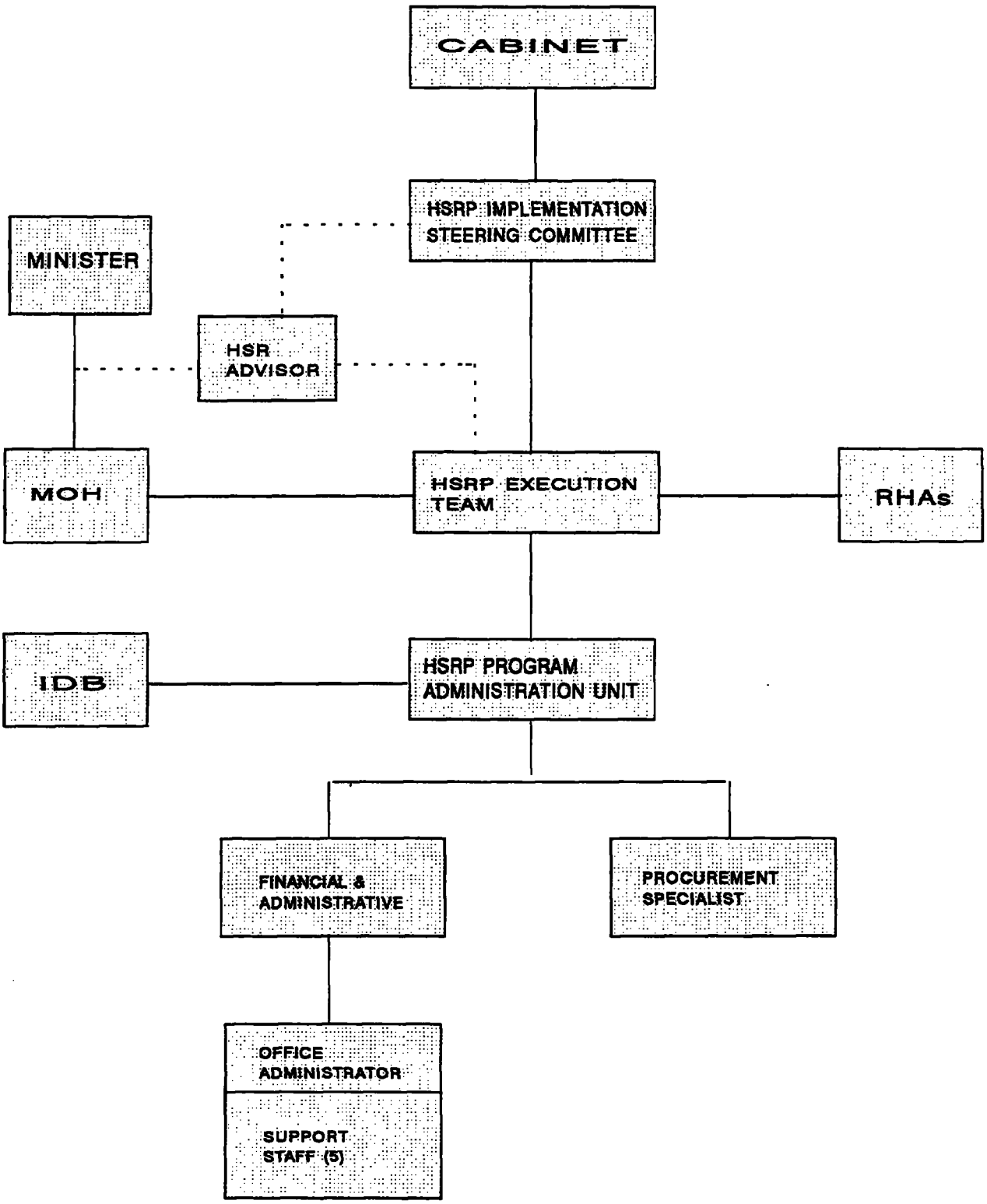
TECHNICAL ASSISTANCE: TIMING AND SUMMARY BY COMPONENTS

	PM *	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7
COMPONENT 1: REFORM OF THE MOH	**764**							
Management systems development	22							
Management development training	32							
Health planning/policy analysis	24							
Quality assurance and auditing	24							
Technology assessment	4							
Training and staff development	12							
Audit of vertical programs	18							
Information systems **	520							
Health sector reform advisor	36							
Communications coordinator	36							
PR/media support	36							
COMPONENT 2: DECENTRALIZATION	**172**							
Management systems development	22							
Management development training	114							
Training and staff development	36							
COMPONENT 3: HUMAN RESOURCES STRATEGY	**238**							
HR advisor	18							
HR implementation support	214							
Pension consultant	6							
COMPONENT 4: RATIONALIZATION	**346**							
PHC development	36							
PHC training	20							
Ambulatory/day care	12							
Family medicine	3							
Hospital commissioning	24							
Ambulance services	126							
Community care	113							
Feasibility study - Scarborough	12							

	PM *	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7
COMPONENT 5: HEALTH FINANCING STRATEGY	113							
Health financing	67							
National health insurance	46							
Population registration system	TBA							
ADMINISTRATION	792							
PAU Director	84							
Health infrastructure procurement	48							
Finance controller	84							
Office manager/administrator	84							
Administrative staff	420							
Technical assistance management	36							
Technical assistance administration	36							
TOTAL:	2,425							

* Person-months
** Technical assistance covers both MOH and RHAs

PROGRAM ADMINISTRATION SCHEME



This chart is not intended to show the reporting relationship of between the entities listed.

ACQUISITIONS PLAN
(TENTATIVE PROCUREMENT PLAN)

PROGRAM PROCUREMENT MAIN ACQUISITIONS 1/		FINANCING	METHOD		PREQUALIFI-CATION	DATES
CIVIL WORKS: 2/		**IDB 100%**	**NCB**	**ICB**	**NO**	
1.	Port of Spain Hospital			X		II/97
2.	Mount Hope Complex			X		II/97
3.	San Fernando G. Hospital			X		I/98
4.	S.Grande Regional Hosp.			X		II/97
5.	Scarborough Regional Hosp.			X		II/98
6.	District Health Fac. NW RHA		X			II/97
7.	District Health Fac. CT RHA		X			I/98
8.	District Health Fac. SW RHA		X			II/98
9.	District Health Fac. East/Scar.		X			I/99
10.	Health Centers NW RHA			X		II/97
11.	Health Centers Central RHA			X		I/96
12.	Health Centers SW RHA			X		II/98
13.	Health Centers East/Scarb RHA		X			I/99
HOSPITAL AND MEDICAL EQUIPMENT:		**IDB 100%**	**NCB**	**ICB**	**NO**	
1.	Port of Spain Hospital			X		II/97
2.	Mount Hope Complex			X		II/97
3.	San Fernando G. Hospital			X		I/98
4.	S.Grande Regional Hosp.			X		II/97
5.	Scarborough Regional Hosp.			X		II/98
6.	1 Bidding, 2 lots			X		II/97
7.	1 Bidding, 2 lots			X		II/97
PURCHASE OF DATA PROCESSING EQUIPMENT, SOFTWARE AND RELATED TRAINING:		**IDB 100%**	**NCB**	**ICB**	**NO**	
1.	Bidding of lot 1			X		I/97
2.	Bidding of lot 2			X		II/97
PURCHASE OF AMBULANCE EQUIPMENT:		**IDB 100%**	**NCB**	**ICB**		
-	1 lot			X	NO	I/97

PROGRAM PROCUREMENT MAIN ACQUISITIONS 1/	FINANCING	METHOD		PREQUALIFICATION	DATES
CONTRACTING OF CONSULTING SERVICES FOR THE PROVISION OF TECHNICAL ASSISTANCE, STUDIES, AND TRAINING, 6 LOTS	IDB 100%	NCB	ICB	YES	
1. ONE BIDDING WITH 2 LOTS:					I/97
1.1 Health policy/financing organization			X		
1.2 Health care organization			X		
2. ONE BIDDING WITH 3 LOTS:					
2.1 Accounting firm			X		
2.2 Information systems/technology firm			X		I/97
2.3 Training/management development firm.			X		

ICB = International Competitive Bidding NCB = National Competitive Bidding
DATES = Refer to semester of year

1/ Does not include contracting of individual consultants (local and international) of which 558 person/months are planned. Regular Bank procedures will be applied.

2/ Works for district health facilities and health centers consist of several small units which have been grouped according to type of work and geographic location.

TRINIDAD AND TOBAGO
HEALTH SECTOR REFORM PROGRAM (TT-0024)

PROCUREMENT OF TECHNICAL ASSISTANCE

	LEVEL OF EFFORT (person-months)
(1) HEALTH SYSTEMS ORGANIZATION	
Primary care specialist	24
Quality Assurance specialist	24
Technology assessment specialist	4
Primary care training specialist	20
Hospital ambulatory care specialist	12
Family medicine specialist	3
A&E services specialist	10
Community care specialist	53
Vertical programs specialist	6
Technical assistance management	36 (*)
Technical assistance administration	36 (*)
SUBTOTAL:	**228**
(2) HEALTH POLICY/FINANCING ORGANIZATION	
Health planner/policy-analysis specialist	24
Health financing specialist	67
Health insurance specialist	46
SUBTOTAL:	**137**
(3) ACCOUNTING FIRM	
Contracting and purchasing specialist	12
Financial systems/accounting specialist	32
SUBTOTAL:	**44**
(4) INFORMATION SYSTEMS/TECHNOLOGY FIRM	
IS/IT project director	24
IS/IT project director, counterpart	36
IS/IT specialist	28
IS/IT program managers (6)	144
IS/IT system development assistants (12)	288
SUBTOTAL:	**520**
(5) TRAINING/MANAGEMENT DEVELOPMENT FIRM	
Management development specialists	146
General training specialists	48
SUBTOTAL	**194**

	LEVEL OF EFFORT (person-months)
(6) INDIVIDUAL CONSULTANCIES	
Health sector reform advisor	36 (*)
Human resources advisor	18
Hospital commissioning specialist	24
Primary care commissioning specialist	12
Ambulance service manager	30
Ambulance service manager, counterpart	30
Ambulance service trainer	32
A&E services specialist	24
HR systems support	24
HR Implementation unit manager	18
HR Implementation unit coordinators (2)	36
HY Implementation unit clerical (8)	136
Communications coordinator	36
PR/media support specialist	36
Pensions consultant	6
Laboratories project coordinator	12
Community care project manager (2)	60
Hospital specialist - Scarborough feasibility study	12
SUBTOTAL:	**582**
(7) PROGRAM ADMINISTRATION UNIT	
Director	84 (*)
Health infrastructure procurement counterpart	48 (*)
Finance controller	84 (*)
Office manager/administrator	84 (*)
Administrative staff (5)	420 (*)
SUBTOTAL:	**720**
TOTAL:	**2,425**

(*) Consultants/staff who will provide direct support for program execution.

TRINIDAD AND TOBAGO

HEALTH SECTOR REFORM PROGRAM (TT-0024)

PERFORMANCE BENCHMARKS

OBJECTIVES	INDICATORS	MEANS OF VERIFICATION	ASSUMPTIONS
GOAL To improve the health status of the population of Trinidad and Tobago.	Health status indicators (e.g., infant mortality, life expectancy) remain stable or improve.	Vital statistics.	Health status gains will result from improved efficiency, equity, and quality of health services.
PURPOSE To achieve greater efficiency, equity, sustainability, and quality of public and private health services.	Stabilized costs, optimized utilization rates, increased accessibility, defined medium- and long-term financial plans, medical audits implemented to monitor quality of services, increased consumer satisfaction, reduced waiting times, more efficient and rational allocation of resources	Annual service agreements, MOH and RHA management information systems, budgets, personnel databases, annual reviews, patient surveys, household surveys, site visits	Reform of MOH, decentralization of service delivery, implementation of human resource strategy, infrastructure rationalization and development of financing strategy are sufficient to achieve greater efficiency, equity, sustainability and quality through better allocation of resources, cost containment, increased accessibility and greater consumer satisfaction

OBJECTIVES	INDICATORS	MEANS OF VERIFICATION	ASSUMPTIONS
SPECIFIC OBJECTIVES			
• Strengthen leadership capabilities of the Ministry of Health;	• Full complement of MOH staff with strategic planning, regulatory, policy-making skills by 1998	As indicated in boxes below for each one of the program's components	Government efforts to avoid or control risks identified (e.g. slow implementation, political and social pressures against specific policy changes) are successful
• Decentralize service delivery and management to autonomous statutory authorities;	• Functioning of RHAs, operating under service agreements with MOH by 1998		
• Achieve the appropriate skill mix and new staffing levels required, while providing appropriate incentives and developmental activities;	• Employment of staff by RHAs in numbers and mix laid out in NHSP (50% by 2000, 100% by end of the project), establishment of pension plan by 1997 and full funding by 2002		Outcomes of program activities are appropriate and sufficient to achieve specific objectives
• Rationalize and upgrade services and infrastructure to support the emphasis on cost-effective care;	• New/rehabilitated infrastructure and availability of new and more services in line with NHSP (ongoing)		
• Achieve efficiencies and cost savings while developing a long-term financing strategy for the sector which promotes equity and efficiency	• No significant increases in sector financing requirements (ongoing), existence of long-term financing strategy (by 1999)		
OUTPUTS AND ACTIVITIES			
<u>Component #1: Reform of the Ministry of Health</u>			
• Define new structure and responsibilities of MOH	• 97 full definition	Annual reviews, annual service agreements, personnel database, status reports on training activities	MOH is able to retain or recruit high quality staff capable of exercising new functions. ASA's are systematically used as budgeting and resource allocation tool
• Reduce headquarters staff in line with National Health Services Plan, abolish vacant posts	• 98 full staff complement • 99 vacant posts abolished		
• Provide training to develop needed planning and policy-making capabilities	• 98 short- and medium-term training completed		
• Develop information systems for use by both MOH and RHAs	• 96 full definition of strategy • 98 systems fully in place		
• Institute Annual Service Agreements in place of historic budgeting process	• 96 methodology established • 98 process fully in place		

OBJECTIVES	INDICATORS	MEANS OF VERIFICATION	ASSUMPTIONS
Component #2: Decentralization			
• Create RHAs, devolve decision-making responsibilities, incorporate staff	• 96 RHAs created and functioning	Annual service agreements, annual reviews, status reports on training activities, RHA contracts with providers	Human resources strategy is adequate to induce staff to transfer to RHA posts. RHAs are capable of recruiting and retaining highly qualified managers. Decentralization of service delivery and management will insure greater responsiveness to local health needs
• Provide training to develop management capacity	• 98short- and medium-term training completed		
• Institute Annual Service Agreements to encourage focus on cost-effective activities	• 96 methodology established • 98 process fully in place		
• Increase role of private providers to supplement RHA-provided services	• 96 baseline data on private sector • 97 plans developed to facilitate private sector participation • 98 RHA-provider contracts established, as appropriate		
Component #3: Human Resources Strategy			
• Establish pension plan for RHAs	• 97 fund of US$1 million 98 fund of US$2.5 million 99 fimd pf US$5 million 00 fund of US$8 million	RHA records, annual reports, supervision visits	Human resources strategy is accepted by staff and trade unions, and adequate to induce staff to transfer to RHA posts. Staff close to retirement age will choose to retire early, while younger staff will choose to transfer out of civil service positions, in order to attain proper skill mix
• Employ all RHA staff directly or through contracts	• 97 employed in RHAs reaches 1000 98 employed in RHAs reaches 2000 99 employed in RHAs reaches 3500 00 employed in RHAs reaches 5500 01 all employed in RHAs MOH staff reaches 100		
• Achieve desired skill mix	• 02 target mix achieved		
• Abolish vacant posts not required in new MOH structure	• 97 100 posts have been abolished • 98 posts abolished reach 200 • 99 posts abolished reach 350 • 00 posts abolished reach 560 • 01 posts abolished reach 800		

OBJECTIVES	INDICATORS	MEANS OF VERIFICATION	ASSUMPTIONS
Component #4: Rationalization			
• Renovate, construct, and close selected health centers, district health facilities, and outreach centers	• 96-02 execution of works in line with National Health Services Plan	Annual service agreements, annual reviews, status reports (on investment, training), site visits, evidence of bed reductions and facility closures	Rationalization strategy accepted by communities, especially with regards to closing of facilities. Existence of NGOs and other groups interested in providing community-based services to elderly and disabled
• Provide technical training in PHC and relevant clinical specialties	• 98 short- and medium term training completed		
• Develop community care program for elderly, disabled, mentally ill	• 96-02 patients deinstitutionalized in line with NHSP		
• Consolidate secondary and tertiary services	• 96-02 consolidation of services in line with NHSP		
• Renovate, construct, and close hospitals in accordance with National Health Services Plan	• 96-02 execution of works in line with NHSP		
• Establish national ambulance service	• 98 pilot test completed • 00 national system implemented		
Component #5: Health Financing Strategy			
• GORTT to seek to ensure adquate resources available to meet operating expenses	• 96-02 Revenues available increase at the level required to meet projected recurrent costs	Annual reviews, annual service agreements, GORTT budget presentations, consultant and/or MOH reports, Cabinet notes	Macroeconomic conditions allow for maintenance of expenditure levels in real terms. Revenues generated by user charges at EWMSC do not decrease in real terms. Acceptance of user charges at public hospitals, if warranted
• GORTT to permit continued collection of user charges at EWMSC, and to consider establishing user charges at other regional hospitals	• 96 user charges at EWMSC • 97 policy decision on use at other hospitals		
• Undertake analytical studies to assess costs, cost containment mechanisms, cost-effective interventions, targets for rationalized spending, and role of private sector	• 97 initial studies completed • 98 ongoing data collection, monitoring continue		
• Develop comprehensive strategy for medium- and long-term financing of the health sector, including evaluation of merits of a national health insurance system	• 97 initial strategy prepared • 98 completion of NHIS studies • 99 final strategy completed		

OBJECTIVES	INDICATORS	MEANS OF VERIFICATION	ASSUMPTIONS
INPUTS			
• Technical assistance	$11.701 million (2,425 person months)	Disbursement records, annual reviews	Inputs are available on a timely basis
• Training	$ 3.657 million		
• Design, construction, supervision	$56.166 million		
• Equipment	$ 7.858 million		
• Concurrent costs	$15.700 million		
• Administration	$2.281 million		
• Human resources strategy	$47.347 million		
(excludes unallocated and financial costs)	Total: $144.710 million		

PROPOSED RESOLUTION

TRINIDAD AND TOBAGO. LOAN ___/OC-TT TO THE REPUBLIC OF TRINIDAD AND TOBAGO

(Health Sector Reform Program)

The Board of Executive Directors

RESOLVES:

That the President of the Bank, or such representative as he shall designate, is authorized, in the name and on behalf of the Bank, to enter into such contract or contracts as may be necessary with the Republic of Trinidad and Tobago, as Borrower, for the purpose of granting it a financing to cooperate in the execution of a health sector reform program. Such financing will be for the amount of up to US$134,000,000, or its equivalent in other currencies, except that of Trinidad and Tobago, which are part of the Ordinary Capital resources of the Bank, and will be subject to the "Special Contractual Conditions" and the "Terms and Financial Conditions" of the Executive Summary of the Loan Proposal.

PROJECT PERFORMANCE MONITORING REPORT (PPMR)

I. BASIC DATA (AMOUNTS IN US$)

PROJECT NUMBER: TT0024
TITLE: Health Sector Reform Program

LOAN NUMBER(S): 937/OC-TT ;937A/OC-TT (Closed)
Lending Instrument: Investment / Specific Investment Operation
Borrower: TRINIDAD AND TOBAGO
Executing Agency (EA): MINISTRY OF HEALTH

Sector: HEALTH

Date of Board Approval: 10 Jul 1996
Date of Contract Effectiveness: 12 Jul 1996
Date of Eligibility for First Disbursement: 23 Dec 1997

Contacts:
Executing Agency:
Team Leader: HO-A-SHU, IAN

Date of Current Update: 29 Jun 2009
Date Validated by Representative or Division Chief: 30 Jun 2009

PTI: [ ] Yes [X] No
SEQ: [X] Yes [ ] No
Environmental Classification:

Months in Execution:
* from approval: 158
* from contract effectiveness: 157

Loan Proposal, as approved by the Board: PR-2131

Disbursement Periods
Original Disbursement Expiration Date: 12 Jul 2003
Current Disbursement Expiration Date: 12 Nov 2009
Cummulative Extension (months): 76
Special Extension (months): 0

Loan Amount(s):
* Original amount: 134,000,000
* Current amount: 134,000,000
* Pari Passu: 62.91%

Disbursements:
* Amount to date: 122,063,516
* Percent: 91.09%

Total Project Cost:
* Original estimate: 192,000,000

Redirecting Of Resources:
* Has this project:
  [ ] Received funds from another Project?
  [ ] Sent funds to another Project?
  [X] N/A

To Project Number	Via Sub-Loan Number	Amount
From Project Number	Via Sub-Loan Number	Amount

On Alert Status:
Is project currently designated "on alert": [ ] Yes [X] No

HISTORICAL AND CURRENT PPMR RATINGS:

Month Year	Dec 2007	Jun 2008	Dec 2008	Jun 2009	Current
Implementation Progress	S	S	S	S	S
Risk	M	M	M	M	M
Development Objectives	P	P	P	P	P

II. ACHIEVEMENT OF DEVELOPMENT OBJECTIVES (DO)

If the operation has multiple purposes (DOs) then enter each one in a separate field. In such a case, each DO must have individual DO ratings. *Progress towards achieving each DO should be rated individually based on the corresponding outcomes achieved. The relative weight of each individual DO in the summary DO classification should be discussed with the Executing Agency.*

Development Objective(s)/Purpose(s)

1. 1. To achieve effectiveness, equity, sustainability and quality of healthcare and wellness services in Trinidad and Tobago
Classification: Probable

Key Planned Outcome Indicators	Outcomes Achieved
1.1. Description: Implementation of 10 Customer satisfaction surveys by May 2009 **Unit:** Number of surveys **Baseline Target** 0 (31 Jul 1996) **Annual/Intermediate Target** **EOP Target** 10 (12 May 2009)	7 (30 Jun 2009)
1.2. Description: Communicable Diseases Mortality reduced to 60 per 100,000 population **Unit:** Number per 100,000 **Baseline Target** 68 (10 Jun 2005) **Annual/Intermediate Target** **EOP Target** 60 (31 Dec 2010)	67.10 (30 Jun 2009)
1.3. Description: Infant mortality reduced to 15 per 1000 number of deaths **Unit:** Number per 1000 deaths **Baseline Target** 18 (10 Jun 2005) **Annual/Intermediate Target** **EOP Target** 15 (31 Dec 2010)	16.50 (30 Jun 2009)

Reformulation: Was the objective(s) of this project reformulated? [ ] Yes [X] No

If yes, indicate date of Board Approval: _____

Briefly describe the consequences of these changes. (If any changes were made to the outcome indicators/targets, describe it under the next section.):

Hyperlink: _____ (Hyperlink through IDBDOCS to documentation approved by the Board.)

Were there any changes to the outcome indicators or targets? [ ] Yes [X] No

If yes, indicate most recent date _____ and who approved these changes: _____.

Briefly explain any changes that were made. (If this was part of a retrofitting exercise, see below.)

Hyperlink: _____ (Hyperlink through IDBDOCS to documentation approved by the Representative.)

Retrofitting: Was this PPMR retrofitted? [X] Yes [ ] No

If yes, indicate most recent date 03 Dec 2003

Briefly explain any changes resulting from this exercise.

The PPMR was retrofitted in 2003 as part of the project's reprofiling process. The project's objectives were NOT REFORMULATED as part of the re-profiling exercise, but rather the implementation sequencing of the components was revised and adjusted to suit the government priorities at the time. (Please see lessons learnt for further expansion on this point.) The original logframe was not updated at the time of the reprofiling with respect to the insertion of outomce indicators due mainly to the fact that Government did not have the systems at the time, to capture the data in a meaningful and structured way. However, the lograme was revised in 2005 (CTTDOCS# 52960) and baselines and 2 outcome indicators inserted (as presented above in the PPMR). This logframe revision was done in 2005 given that the MOH had at that time begun to staff its Health Policy and Planning Unit and as such was now in a position to collect and measure data. (Please see Section VII for more details on this point.) To this end, the PPMR's DO is rated against one output indicator and two outcome indicators as presented above.

In addition, the final PCR will provide an update on the achievement of the original output indicators with additional comments on outocme indicators added in 2005. In addition, the PCR will include an update of risks identified in the risk profile section of the PPMR. A final PCR report is due in Feb 2010

Summary Development Objective(s) Classification (DO):

[ ]Highly Probable (HP) [X]Probable (P) [ ]Low Probability (LP) [ ]Improbable (I)

Briefly justify the Summary DO Classification based on the degree planned targets were met, explaining the difference between planned and actual outcomes, as well as any other relevant factors. Cite reference for evidence that supports these results.

Based on the progress to date on the indicators for the achievement of the DO, the PPMR is given a DO rating of : Probable. As a footnote and it is important to note that the following activities were significant contributing factors:

1) There has been significant progress in the area of reform of the Ministry of Health and a MOH Business Plan was developed and approved by Cabinet in August 2008.

2. The VSEP is essentially complete and the dual track employment issue which significantly challenged project implementation from 1998 to 2007, has finally been resolved.

3. The MoH has strengthened its area of health planning, policy development and health economics which began with the installation of the Director, Deputy Director Health Planning and technical analyst who are working to operationalize its data collection and analysis systems. This system should be fully operational by 2010.

4. The MOH is presssing ahead with hiring key senior management positions in accordance with the priorities set out in its 2009 -2013 Business Plan

Country Strategy: **At the time of approval this project was expected to contribute to the following Country Strategy objective(s):**

AT THE TIME THE PROJECT WAS APPROVED, the project was consistent with the Country Strategy with respect to more effective public sector administration, more equitable and efficient resource allocation as well as the reinforcement of the role of the private sector as providers of service.

Given the results described above, briefly discuss how the project has contributed or will contribute to the Bank's strategy in this country:

The HSRP provided the foundation for advancing the sustainable reform agenda in the sector, In this regard, the reform has already taken root, particularly in the area of primary health care. In terms of contributing to the Country strategy over the next 4 year horizon, the gains from the project proved that reform is slow and there is need to continue with the reform efforts. In addition and taking into account the increasing levels of consumerism among the TT population, the Ministry of Health (MOH) as part of its Health Transformation Plan has agreed upon to focus on 9 Strategy Pillars for the overall development of the Health Sector. These strategic pillars form part of Government's Vision 2020 and include institutional strengthening of the Regional Health Authorities (RHAs), transformation of Ministry of Health, Human Resources Development and capacity strengthening of Vertical Programs. Within this context, the proposed country strategy for the health sector(to be finalised by 1st quarter 2009) will focus on developing the Governance and Institutional capacity of the MOH and RHAs (service providers). The strategy will also focus on assisting Government to establish the building blocks for (1) a health financing system and (2) a Human Resources Development for the sector, especially in terms of Retention Strategies, an issue that has challenged the sector over the last 20 years.

Hyperlink to Country Strategy: _____

Sustainability Analysis:

Building on the successes of the program, which is under a Special Extension, Government has since Nov 2007, been using its own resources to continue with the implementation of the institutional activities of the project. In particular, reform of MOH and the institutional strengthening of the RHAs. The Government and the Bank are in dialogue with respect to developing a Phase 2 of the program. As agreed in a Special Mission of 3 to 4 December 2008, the Government and Bank agreed that the phase 2 of the program which would consolidate and build on the reform foundation set in place under the HSRP, focusing on two critical areas: governance and institutional development and health financing systems, two key elements to complete the reforms initiated under the HSRP.

Sustainability Classification:

[ ]Highly Probable (HP) [X]Probable (P) [ ]Low Probability (LP) [ ]Improbable (I)

Externalities:

As captured in the Country Strategy 2004 - 2007, the project was significantly delayed because the Bank was too optimistic in the design, in particular by promoting decentralizing central Government services without the benefit of the enabling conditions provided by wider public sector reform. Periods of political uncertainty and wavering political momentum for the project over the last 7 years also significantly contributed to the delays in project implementation. Moreover, the absence of wider public sector reform is making it extremely difficult for the MoH to drive the reform agenda in the health sector given that the existing machinery of government is not set up to deal with the robust and ambitious institutional changes now being presented by the project. Against this background, the borrower has sought to address these concerns by adopting several innovative "work around" strategies and tactics, which provided the basis for the Bank to re-profile the project and grant 2 general extensions and 1 special extension to the program. As the project approaches its final disbursement date, the MOH recognizes the importance of having a clear development results framework for future projects, whether funded by the Bank or its own resources which throught its risk matrix, the MOH can anticipate and re-allign the project to mitigate against any potential negative externality.

III. IMPLEMENTATION PROGRESS (IP)

Components (Outputs):

Component Title: Reform of the Ministry of Health

Description: The Ministry to become a purchaser of health services and will monitor and regulate the health policy for the country.

Total cost of Component	0	Counterpart:	0	IDB:	0	Co-financing:	0
IDB Disbursement:	0	Total amount committed:	0				

Classification: Satisfactory

Key Indicators for Planned Outputs	Actual Outputs
1. Description: Completion of training programmes in Strategic management and Health Policy **Unit:** Training Programmes	

Baseline Target	Annual / Intermediate Target	EOP Target	
0 (_____)		5 (29 May 2009)	3 (30 Jun 2009)

In the case of unsatisfactory or very unsatisfactory ratings for this component, provide comments on its status focusing on the problems identified in attaining planned outputs. Other pertinent information may also be entered here:
The MOH has laid down the groundwork for full transformation of its head office. In particular, the MOH conducted an in-depth situation analysis, identified strategies for change, defined its core processes, revised its organization structure and developed a change and transition plan to guide the seamless roll-out of the reform activities at the MOH. In addition and as set out in its 2009-2013 Business Plan, a key deliverable under this project component, the MOH has identified the following challenges that delayed initial implementation of reform activities under the HSRP: (i) lack of key senior staff at the MOH; (ii) lack of focused dedication to the implementation; (iii) operational activities that were not part of the reform agenda but continued to dilute implementation focus and absorb resources; and (iv) the lack of stakeholder buy-in . To this end, the MOH has developed and commenced implementation of the attendant strategies to address these challenges. It is expected that the full reform of the MOH will be completed by 2013.

Restructuring: Indicate if this component was restructured (approved by Operational Department): [ ] Yes [X] No

If yes, date: _____

Briefly describe the consequences of these changes:

Hyperlink to documentation approving restructuring, if relevant: _____

Component Title: Decentralization of service delivery.

Description: Authority and responsibiity for the delivery of services and management of all public healthcare faciilties to rest with 5 RHAs

Total cost of Component	0	Counterpart:	0	IDB:	0	Co-financing:	0
IDB Disbursement:	0	Total amount committed:	0				

Classification: Satisfactory

Key Indicators for Planned Outputs			Actual Outputs
1. Description: Full complement of RHA employess **Unit:** Full time RHA Employees			
Baseline Target	**Annual / Intermediate Target**	**EOP Target**	
0 (_____)		5000 (29 May 2009)	4500 (30 Jun 2009)

In the case of unsatisfactory or very unsatisfactory ratings for this component, provide comments on its status focusing on the problems identified in attaining planned outputs. Other pertinent information may also be entered here:
Complementing the completion of physical works, the respective regional health authorities have implemented a number of management systems improvements which are the beginnings of the decentralization process, including: the introduction of appointment systems and patient satisfaction surveys at all primary care centres and the introduction of improved human resource improvements to the physical infrastructure and the implementation of the reform activities have laid a solid foundation to achieving the program's development objectives. In addition and in accordance with the Public/Private Partnership strategy of the program, the Ministry and the RHAs are contracting private sector providers for specific medical services which is being made available to the public at Government's expense. In particular, the MOH is currently negotiating a PPP contract for the provision of dialysis services. Contract negotiations are expected to be completed by August 2009. While the decentralization process is still ongoing but the RHAs have recognized the need for institutional strengthening support which is presently under discussion as a likely component for a new Bank funded program.

Restructuring: Indicate if this component was restructured (approved by Operational Department): [ ] Yes [X] No

If yes, date: _____

Briefly describe the consequences of these changes:

Hyperlink to documentation approving restructuring, if relevant: _____

Component Title: Health financing strategy

Description: Develop the health financing model for the country which will result in efficiences and cost savings

Total cost of Component	0	Counterpart:	0	IDB:	0	Co-financing:	0
IDB Disbursement:	0	Total amount committed:	0				

Classification: Satisfactory

Key Indicators for Planned Outputs			Actual Outputs
1. Description: Complete 3 key studies to establish NHIS framework **Unit:** Studies			
Baseline Target	**Annual / Intermediate Target**	**EOP Target**	
0 (_____)		3 (29 May 2009)	2 (30 Jun 2009)

In the case of unsatisfactory or very unsatisfactory ratings for this component, provide comments on its status focusing on the problems identified in attaining planned outputs. Other pertinent information may also be entered here:
Following the setting up of a NHI Task Force in December 2004 , a draft NHIS model was developed in Feb 2006, which was not approved by Cabinet. As part of the Health Transformation Plan which Cabinet approved in Aug 2008, the MOH has hired the Health Economics Unit of UWI who is undertaking the costing exercise to inform the final basket of services to be covered under the NHS. UWI is expected to complete its initial work by December 2009. A number of pre-requisite studies for the costing exercise have been completed and the Health Policy Unit of the MOH is collecting further data to feed into the costing exercise

Restructuring: Indicate if this component was restructured (approved by Operational Department): [ ] Yes [X] No

If yes, date: _____

Briefly describe the consequences of these changes:

Hyperlink to documentation approving restructuring, if relevant: _____

Component Title: Human resources strategy

Description: The strategy calls for the use of financial and non-financial incentives to encourage staff from the Public Service to transfer to the RHAs, namely :

1- The use of VSEP packages

2.- The establishment of RHA pension plan

Total cost of Component	0	Counterpart:	0	IDB:	0	Co-financing:	0
IDB Disbursement:	0	Total amount committed:	0				

Classification: Satisfactory

Key Indicators for Planned Outputs	Actual Outputs
1. Description: Establish and fund RHA Pension Plan	

Unit: USD$ Millions			
Baseline Target	**Annual / Intermediate Target**	**EOP Target**	
0 (_____)		20 (29 May 2009)	35 (30 Jun 2009)

In the case of unsatisfactory or very unsatisfactory ratings for this component, provide comments on its status focusing on the problems identified in attaining planned outputs. Other pertinent information may also be entered here:
The MOH has made significant progress in implementing the HR Strategy. While the action was long in coming, due to strong resistance by the Trade Union, the tenacity of the MOH is now paying off and it is clear that the implementation of reform actions such as these, require a substantial learning curve. This is outlined in the Lessons Learnt section of the PPMR but essentially, implementing the transfer of staff requires 2 key ingredients: strong political commitment and stakeholder support, especially from the Trade Unions.

With respect to advancing the Human Resources strategy , the Borrower topped- up the RHA Pension Plan, (the Pension Plan now stands at $35M) engaged with the Trade Unions on the Staff Transfer process and held public consultations and information sharing sessions with staff on specific details on the staff transfer issue.

The VSEP process is completed. The Trade Unions fully supported the VSEP process.

The MOH as oultined in their Business Plan expects to have its core staff by 2010. However the RHAs are having difficulties in finding and retaining suitable persons which speaks to the need to develop a staff retention policy and competitive salaries. As the HSRP is winding down, discussions are ongoing between tje Bank and Government for a new program which will include a the development of a comprehensive HR plan. Discussions should be concluded by last quater 2009.

Restructuring: Indicate if this component was restructured (approved by Operational Department): [ ] Yes [X] No

If yes, date: _____

Briefly describe the consequences of these changes:

Hyperlink to documentation approving restructuring, if relevant: _____

Component Title: Rationalization of infrastructure and service mix.

Description: Physical Upgrades to primary care facilties, the construction of district ehalth facilities and the construction of the Tobago hospital

Total cost of Component	0	Counterpart:	0	IDB:	0	Co-financing:	0
IDB Disbursement:	0	Total amount committed:	0				

Classification: Highly Satisfactory

Key Indicators for Planned Outputs			Actual Outputs
1. Description: Establish national ambulance service **Unit:** No of ambulances			
Baseline Target	**Annual / Intermediate Target**	**EOP Target**	
0 (_____)		100 (28 Nov 2003)	100 (26 Nov 2004)

In the case of unsatisfactory or very unsatisfactory ratings for this component, provide comments on its status focusing on the problems identified in attaining planned outputs. Other pertinent information may also be entered here:
1) Under the program, loan resources in the sum of $63M funded the renovation of 22 health centers , completion of 4 new District Health Facilities, renovations to 3 hospitals and procurement of modern biomdecical equipment and hospital plant equipment installed throughout the public health sector facilities. In addition, the Scarborough hospital foundation was constructed.

2) Given that the loan resources for the physical infrastructure component are essentially expended, the Borrower is funding new infrastructure works from counterpart resources . In particular, Government intends to spend US$79 M to complete and outfit the Scarborough Hospital by last quarter 2009

3) With respect to the Scarborough Hospital construction works, work resumed in November 2008 following a a lengthy arbitration process which commenced in December 2005. There are a number of lessons learnt for both the Bank and the Borrower from this Scarborough Hospital Construction which has been recorded in the "Lessons Learned" section of the PPMR.

4) The Borrower finalised a private financing arrangement in the sum of US$24 M to fund the construction of the National Oncology Center (NOC). While this is not being financed by loan resources, Bank resources funded the feasibility study. Construction work on the NOC which started in April 2007 was suspended in April 2008 based on a contract dispute which has now gone to arbitration. It is expected that the arbitration process will conclude by end of 2009. No loan resources funded this contract.

5) A ntaional ambulance serive with its full compliment of 100 ambulances was established in 2004

Restructuring: Indicate if this component was restructured (approved by Operational Department): [ ] Yes [X] No

If yes, date: _____

Briefly describe the consequences of these changes:

Hyperlink to documentation approving restructuring, if relevant: _____

Implementation Progress Summary Classification (IP):

[ ] Highly Satisfactory (HS) [X] Satisfactory (S) [ ] Unsatisfactory (U) [ ] Very Unsatisfactory (VU)

Briefly justify the Summary IP Classification based on the degree planned targets were met , explaining the difference between planned and actual outputs as well as any other relevant factors. Cite reference to evidence that support these results.

The project is rated satisfactory based on the following factors:

1.The present dual track employment which has been a major factor in the poor implementation of the project has now been resolved.

2. Significant progress has been made in the physical infrastructure rationalisation focused on primary health care. Complementing these physical works, the respective regional health authorities have implemented a number of management systems improvements including: the introduction of appointment systems and patient satisfaction surveys at all primary care centres and the introduction of improved human resource management systems. What is required now is standardization of systems and protocols across the RHAs.

3. There is now a wider availability of a wider range of services, longer service hours and a fuller complement of staff at the primary healthcare level. This is currently occurring at several primary health care centers financed by the programme throughout the country including Caanan (Tobago), Rio Claro and Couva. Other important achievements of the primary health care initiatives supported by the program to date include: maintenance of 100% immunization rates for diphtheria tetanus/yellow fever/measles, mumps, rubella; a 52% increase in cervical cancer screening for women; reduction in transfer time for patients referred to the secondary care system; reduction in waiting times at Accident and Emergency Centers and the maintenance of dental outreach attendance at approximately 60% of the total primary school population. In addition, new levels of efficiency are being achieved as the Ministry is contracting private sector providers for some specific medical services that are being made publicly available at government's expense. What needs need to be done now is a proper assessment of the quality of the heathcare being delivered. The funding of this assessment can be done through the Bank's' Social Fund and is being discussed presently.

4. In general the output targets of the project are being met albeit in a longer time frame as expected. The reasons for this are set out in the lessons learnt section of the PPMR.

Check off critical factors / reasons for Unsatisfactory / Very Unsatisfactory IP Classification or Low Probability / Improbable DO classification, and reflect in section IV (Risk Profile), as needed:

[ ] Legislative approvals
[ ] Borrower/executing agency commitement
[ ] Counterpart funding shortfall/fiscal ceilings
[ ] Executing agency institutional capacity
[ ] Community/politial opposition
[ ] Consultant services performance
[ ] Inter-agency coordination
[ ] Supplier/contractor performance
[ ] Project/component design
[ ] Bank efficiency (response delays)
[ ] Environmental issues
[ ] Cost overrun
[ ] National policy changes
[ ] Executing agency policy changes
[ ] Bank policy changes
[ ] Lack of monitoring/evaluation system
[ ] Other:

FIDUCIARY ISSUES PROFILE

[X] **Contractual Condition Compliance Delays.** List any delay and/or other problems in compliance with other important contractual conditions:
[X] Article 7.03(a)(iii) Audited Financial Statements (AFS) for the Fiscal year ended September 30, 2008 has been outstanding since January 30, 2009. Despite many reminders and grace periods given, the Borrower/Executing Unit has not submitted the AFS to date (June 8, 2009). As a result of this state of affairs, the CCB/CTT has sent a recommendation to the CCB General Manager to suspend dibursements to the project.

[X] **Audited Financial Statements (AFS).** List any important qualified options of the auditor presented in the AFS:
External Auditors' opinion of the most recent financial statement (as at Sept. 30, 2007), received by the Bank, was unqualified.

Observations of Financial Specialist, including comments on AFS and/or factors affecting the development objectives:
As a result of the significant delay in the submission of the AFS for the Fiscal Year ended September 30, 2009, the project faces the huge possibility of having disbursements suspended. This event will impede the disbursement of current available balances, before the current expiration date of November 12, 2009.

Relevant Hyperlinks:

Qualified opinions given by external auditors (AFS): _____

Project AFS Review Guide(AF320): _____

Timeliness of AFP Submission(LMS40): http://ops/lms/lms40.asp?UDRCode=CTT&LoanType=LON&AuditYear=2008

Documents/correspondence to and from the EA regarding non-compliance, if applicable: _____

[X] **Procurement difficulties, if applicable.** Briefly list any major procurement issues affecting implementation progress:
There are no major procurement issues at this time. The arbitration on the contract dispute for the construction of Scarborough Hopsital has ended and the Borrower is moving ahead to fund the completion of the works using is own resources in the sum of USD$79 M. Work is expected to completed by Dec 2009.

Any additional observations of Financial, Sector and/or Procurement Specialist(s):
As the project approaches the last disbursement date there is a concern regarding the financial administration of the project as key staff have demitted office thus leaving a void in the management of the project. While interim arrangements have been put in place by the Ministry, the Bank has encouraged the Borrower to install more permament arrangements to oversee the project up to the final disbursement date. As a result of this issue, the PEU has been submitting financial reports. including the AFS, of the Project extremely late.

The PEU has been facing difficulty in sourcing adequate supporting documenation for several items which form part of the commited amounts which the Bank agreed to disburse against during the special extension period. As a result of this, the amounts related to these items face the high possibility of being cancelled.

_____

IV. RISK PROFILE

Key Risk:	Category	(a) Severity of Impact	(b) Likelihood of Ocurrence	(a x b) Classification
1. On conclusion of the project, the Ministry of Health will not have the sustained capacity to perform its new role as regulator	Fiduciary and operational	1	70	70
2. At the end of the project, the Regional Health Authorities will not have the sustained capacity to continue with its institutional strengthening activities to effectively deliver healthcare services.	Fiduciary and operational	3	40	120
3. At the conclusion of the project, there will be no stakeholder engagement mechanisms in place to build on the reform gains achieved during the life of the project	Environmental, social, cultural and natural disaster	3	45	135

Summary Risk Classification (RI):

[ ]Very High [ ]High [X]Moderate [ ]Low

ALERT STATUS PROJECTS

Comments on relevance of "on alert" status for this project (if applicable):

V.PLAN OF ACTION FOR RISK MANAGEMENT AND TO ADDRESS IMPLEMENTATION PROBLEMS

RISKS

Risk:	Response:
0	Finalize a detailed impementation for the health transformation agenda for 2009 to 2013 which will outline the key activities and steps required by the MOH to take in order to preserve and build its policy and regulatory role **Responsible unit:** MOH **Date Action to be completed:** 30 Oct 2009 **Date Action Completed:** _____
0	As part of its health transformation agenda for 2009- 2013, the MOH to complete and kick-off implementation of a comprehensive communication plan which is to include a mechanism for on-going social marketing and stakeholder engagement for the next 6 years **Responsible unit:** MOH **Date Action to be completed:** 27 Nov 2009

Date Action Completed: _____

IMPLEMENTATION PROBLEMS	
Implementation Problem:	**Action Plan:**
1. Complete final PCR for the project. The PCR will include an assessment of EA with respect to its capacity to monitor the project, a stakeholder analysis, lessons learnt.	**Responsible unit:** MOH **Date action to be completed:** 28 Aug 2009 **Date action completed:** _____

VI. LESSONS LEARNED

Add or fine-tune lessons learned that can be used to improve the programming, design, execution, as well as the monitoring and evaluation of other operations in the sector or country, as needed.

1. Problem Description:

The logframe for the project was general and output oriented as opposed to outcome oriented. And without proper baselines and intermediate targets to measure performance.

What happended:

It was difficult to measure performance and success. Even after a re-profiling exercise of the project, it was difficult to measure progress.

What should be done in the future:

Based on the HSRP implementation experience, it is recommended that for future projects and to ensure that projects can deliver on the client's expectations, it is important that the new operations have in place the following: (1) An appropriate Development Results Framework with measurable output and outcome indicators (baseline, intermediate and final) (2) An appropriate Results Based Project Management Framework, so that planning and implementation capacity are addressed early on from the design phase. This includes identifying EU personnel to participate in the design with Project Management training and competencies (3) Performance based Contracts, if possible, for EU staff.

In these respects, we are trying to ensure that the Bank can deliver technical assistance and financing in a timely manner, so that the client has a greater likelihood of success with reforms that enhance service delivery.

2. Problem Description:

There was little stakeholder engagement throughout the life of the project. Little effort was made to engage primary stakeholders on a consistent basis, namely, doctors, nurses, trade unions.

What happened as a result:

There was resistance to the institutional aspects in particular given miscommunication and lack of understanding of the reform process. This resulted with slow implementation of the reform agenda. The project required strong and even substantial change to the status quo. The establishment of RHAs to provide health services directly to their respective communities and for the MOH to assume the role of policy maker, policy planner, manager and regulator, while promising to deliver greater equity, efficiency and effectiveness in health service delivery, required a transformation of culture. Some significant stakeholders had little interest in or apparent incentive to `buy into' any drastic change that would affect employment status and responsibilities. Such interest groups included the trade unions, many professionals and health service employees. This was even more difficult without an effective promotion campaign and negotiating strategy on the part of Government.

What should have been done:

1. Given its multi-dimensional context and its political economy, the Bank and the Borrower have recognized that the success of the HSRP, especially where there are no clear technical solutions, depends to a large extent on the continuous social participation by key stakeholders that take part in the process and are also affected by its on going developments.

2. To achieve success in the health sector reform process, there needs to be an integration of all health sector functions, namely, financing, insurance, service provision which should be steered by a strong capable MOH. In addition, this integration should continue to promote and advance the institutional capacity of the MOH to run the entire health sector system.

3. The project should have had some sort of flexible mechanism built in its design which would facilitate quick project responsiveness to the re-difinition of components to match changing stakeholder needs.

4. If there was ongoing stakeholder consultations, a strategy to address the issue of Human Resources, a bargaining authority for potential transferees could have been established earlier, perhaps in 1996, when the HSRP loan agreement was signed in order to lay the groundwork for more timely implementation of the VSEP and employee transfer process.

3. Problem Description:

Project components were not implemented in an integrated and cohesive manner. The technical components lagged behind the physical infrastructure components. As a result, the program implementation was frontloaded with a focus on physical infrastructure which distracted efforts on addressing the institutional aspects of the project.

What should have been done:

There could have been better sequencing design for implementing the HSRP components. The lack of integrated implementation slowed the momentum for initiating and completing other projects. Greater effort might have been made to redress the imbalance away from emphasis on physical infrastructure/civil works. As such, significant benefits deriving from the mutually reinforcing impact of implementing the `soft' and `hard' projects were lost. In particular:

a. Efforts to initiate implementation of Change Management, which started in May 2003, only gained momentum in 2007.

b. IS/IT System, fundamental to the programme, is now being implemented. Efficiency gains were lost. Also, measurable indicators to guide improvement performance in targeting and providing service are now being developed.

c. The Human Resource Strategy Implementation Plan was only kicked off in earnest in 2007. To drive the reform agenda, the design of the project should have built in, as the first priority, the development of the appropriate human resource base throughout the public sector to support the reform. As a second priority, there should have been the incremental introduction of regional health authorities informed by the a-priori development of appropriate robust management support systems, business plan, operational manuals, and protocols.

4. Problem Description:

Several co-entities charged with executing the various aspects of the HSRP varied in strengths, capabilities and commitment to the goals and objectives of the project.

What happened:

The overall implementation of the project was delayed especially in the first 6 years of execution because of the following:

a. The Project Administration Unit (PAU), most directly involved in the implementation process, suffered from insufficient staff. In particular, the Project Director's strengths in infrastructure and civil works could have been complemented and strengthened by an Associate/Deputy/Co-Director with similar strengths in the institutional areas. In addition, the PAU's schedule for implementation would be affected by the performance of the entities responsible for infrastructure and technical cooperation.

b. NIPDEC, responsible for Project Management of Civil Works/Infrastructure lacked, inter alia, strengths in health facility construction and in large projects. Moreover, NIPDEC's technical strengths have been considered uneven, even as its more professional employees were being induced away by more lucrative opportunities in a booming construction industry. Another weakness admitted by NIPDEC is the relative slowness of its procurement process, a weakness that would have significant feedback effect on achieving project timelines.

c. The Implementation Steering Committee performed sporadically and inconsistently.

d. The Project Execution Team, though comprising senior officials of the RHAs and the MoH, there was belated implementation of the critical Annual Service Agreement between the MoH and the RHAs.

What should have been done:

A complete institutional assessment of all the entities involved in the execution of the project.

5. Problem Description:

The traditional method of procurement was used to hire the architect and contractor for the design and construction of the Scarborough Hospital. Due to contractor and architect differences, the construction was halted for over 2 years.

What happened:

The contract for the contractor went into arbitration resulting with a 2 year delay and Government being forced to hire a new contractor to continue the construction.

What should have happened:

Based on the Scarborough Hospital construction experience and from a procurement perspective, there are a number of lessons learned as follows:

1) For complex and specialized construction of this nature, the Bank and the Borrower should explore alterative procurement methods. Given the sophistication of building a modern hospital, it would be value-added to adopt the Construction Management Approach in which an experienced Construction Manager with hospital construction experience would have the overall responsibility to manage the design and construction of the facility. Taking this approach should be implemented at the start of any pre-planning and continue through completion of project as best practice. This is an alternative approach to the traditional procurement method of hiring a design firm and a construction contractor under separate contracts. The Construction Management approach for highly complex works would result with minimal construction disruption, effective cost management and avoid some of the project coordination issues that are being experienced on the Scarborough job.

2) There is a need to clearly define the framework for engagement of contracts which are being funded with Bank resources and the responsibility of the Bank with respect to the administration of these contracts by the Borrower(s). Present arrangements call for a watching brief during contract administration given that the Borrower has full responsibility to manage the contract. However from a development effectiveness perspective, there is a need to work with DEV/PRM in addressing this area of how our partnership relationship with the Borrowers can be improved during contract administration.

3) In terms of practical application, this experience has proven that there is need to revise the Project Administration Function and Project Unit configuration in Bank funded investment projects. The recommendation is that there should be 2 Project Units set up, where one totally dedicated to physical infrastructure works and the other to reform/technical components.

6. Problem Description:

Two different procurement procedures, IDB and Government were followed in the execution of the project.

This resulted in:

Unnecessary scrutiny and misunderstanding.

What should have been done:

A single procurement process, e.g., an integrated approach using the IDB `model', can give greater appearance of accountability and transparency, and dispel unwarranted disquiet. This is being explored at present under a separate project.

VII.MONITORING AND EVALUATION

When was the baseline information gathered for at least one outcome indicator?

[ ] Before Board Approval [X] Other Date: 03 Dec 2003

When was the baseline information gathered for at least one output indicator, if applicable?

[ ] Before Board Approval [X] Other Date: 03 Dec 2003

Does the borrower have a defined data gathering system in place?

[ ] Yes [X] No

Is the borrower maintaining performance data on agreed outcome indicators?

[X] Yes [ ] No

Is the borrower maintaining performance data on agreed output indicators?

[X] Yes [ ] No

Are there any *issues* or problems related to the quality, validity and timeliness of the data gathering system?

[ ] Yes [X] No

Start-up Mission:

[X] Yes [ ] No If yes, date: 10 Mar 1998

Hyperlink(s) to relevant Aides Memoire(s): _____

Administration or Other Relevant Missions:

[X] Yes [ ] No If yes, date: 05 Dec 2004

Hyperlink(s) to relevant Aides Memoire(s): _____

Mid-Term Evaluation (MTE):

[ ]N/A [ ]Planned [ ]Completed Date: 25 Jul 2000

Briefly describe the main findings and results, as well as the principal conclusions/recommendatios of this evaluation:
Update:

Following the MTE which was held in July 2000, the MOH by the end of 2007, implemented all 5 recommendations of the MTE. In particular, the MOH strengthened its M & E capacity by staffing its Health Policy and Planning Unit at the close of 2006. The Unit has put systems in place to collect and analyse data and has also competed 6 Customer surveys to date and 2 Annual reports which contain health outcomes data. The Unit commenced a comprehensive country wide health needs assessment in March 2009 in order to update the country's disease profile which will inform health service provision from an evidence-based approach. This exercise is to be completed by December 2009.

In addition and in order to strengthen and integrate the M&E capacity of the Executing Agency, a decision was taken in 2007 to integrate the PAU in the Ministry of Health which created a robust MOH projects office. This portends well for the sustained success of the project noting that the Bank's involvement comes to an end in May 2009

The following recommendations were made at the MTE:

1. Strengthen the operations of the ISC and Project Execution Team

2. Strengthen the administration and execution of the PAU

3. Move forward in the staffing of the new directorates of the MoH

4. Transfer public sector staff to RHAs

5. Contract a change management consultant to assist in implementing the new MoH organizational structure and to assume its new role and responsibilities.

General Note:

All these recommendations were done by the MOH and completed by November 2007.

Hyperlink(s) to MTE: _____

Final Evaluation: Is a final evaluation for this project foreseen?

[X] Yes [ ] No If yes, date: 26 Feb 2010

Hyperlink(s) to relevant Aides Memoire(s)and/or report: _____

Ex-Post Evaluation: Is an ex-post evaluation for this project foreseen?

[X] Yes [ ] No If yes, date: 26 Feb 2010