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JAMAICA

SUPPORT FOR THE HEALTH SYSTEMS STRENGTHENING FOR THE PREVENTION AND CARE MANAGEMENT OF NON-COMMUNICABLE DISEASES PROGRAMME

(JA-L1049, JA-L1080)

LOAN PROPOSAL

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ABBREVIATIONS	
ACR	Ambulatory Care Ratio
AED	Accident and Emergency Department
ALOS	Average Length of Stay
BFHI	Baby-Friendly Hospital Initiative
BOR	Bed Occupancy Rate
CCM	Chronic Care Model
DALY	Disability -Adjusted Life Years of Life Lost
EA	Executing Agency
ECHO	Extension for Community Healthcare Outcomes
ECG	Evaluation Cooperation Group
ESMR	Environmental and Social Management Report
FCTC	Framework Convention on Tobacco Control
FY	Fiscal Year
GDP	Gross Domestic Product
GOJ	Government of Jamaica
HIV	Human Immunodeficiency Virus
IDB	Inter-American Development Bank
IMF	International Monetary Fund
IS4H	Information Systems for Health
JHLS	Jamaica Health and Lifestyle Survey
MND	Mental and Neurological Disorders
MOFPS	Ministry of Finance and Public Service
MOH	Ministry of Health
NCD	Non-Communicable (Chronic) Disease
NHF	National Health Fund
NMHAP	National Mental Health Action Plan
NPAI	National Plan of Action for IS4H
NSAP-NCD	National Strategic and Action Plan for the Prevention and Control of Non-Communicable Disease
OC	Ordinary Capital
OVE	Office of Evaluation and Oversight
PAHO	Pan American Health Organization
PBP	Programmatic Policy-Based Loan
PEU	Programme Executing Unit
PIOJ	Planning Institute of Jamaica
PMR	Project Monitoring Report
POM	Programme Operating Manual
RHA	Regional Health Authority
TCL	Tobacco Control Legislation
THE	Total Health Expenditure
UNOPS	United Nations Office for Project Services
WHO	World Health Organization
YLL	Years of Life Lost

PROJECT SUMMARY
JAMAICA
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<table>
<tr><th colspan="5">Financial Terms and Conditions</th></tr>
<tr><td colspan="3" rowspan="2">Borrower: Jamaica</td><td colspan="2">Flexible Financing Facility [a]</td></tr>
<tr><td>Amortization Period PBP:
Amortization Period Investment Loan:</td><td>20 years
25 years</td></tr>
<tr><td colspan="3" rowspan="2">Executing Agency: Ministry of Finance and the Public Service (MOFPS)-PBP; and
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Original WAL Investment:</td><td>12.75 years
15.25 years</td></tr>
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Disbursement Period Investment:</td><td>1 years
5 years</td></tr>
<tr><td>Source</td><td>Amount (US$)</td><td>%</td><td>Grace Period PBP:
Grace Period Investment:</td><td>5.5 years [b]
5.5 years [b]</td></tr>
<tr><td rowspan="2">IDB Programmatic Policy Based Loan (PBP) (Ordinary Capital-OC):</td><td rowspan="2">50,000,000</td><td rowspan="2">50</td><td>Supervision and Inspection Fee:</td><td>[c]</td></tr>
<tr><td>Interest rate PBP:
Interest rate Investment:</td><td>Libor Based</td></tr>
<tr><td>IDB Investment Loan (OC)</td><td>50,000,000</td><td>50</td><td>Credit Fee:</td><td>[c]</td></tr>
<tr><td>Total:</td><td>100,000,000</td><td>100</td><td>Currency of Approval:</td><td>Dollars of the United States of America</td></tr>
<tr><th colspan="5">Project at a Glance</th></tr>
<tr><td colspan="5">Project Objective/Description: The programme objective is to contribute to the improvement of the health of Jamaica's population by strengthening comprehensive policies for the prevention of Non-Communicable (Chronic) Diseases (NCDs) risk factors and improved access to an upgraded and integrated primary and secondary health network in prioritized areas with an emphasis on chronic disease management, that provide more efficient and higher quality care.
The policy-based operation of this hybrid programme is the first of a programmatic policy-based loan series, which will be made up of two contractually independent and technically linked loans, as per document Policy-based Loans Guidelines for Preparation and Implementation (CS-3633-2).</td></tr>
<tr><td colspan="5">Special Contractual Conditions prior to the first disbursement of the Investment Loan: The Executing Agency will provide evidence to the Bank's satisfaction of: (i) the approval of the Programme Operating Manual (POM) by the Executing Agency in accordance with the terms and conditions previously agreed upon between the MOH and the Bank and (ii) the creation of the Programme Executing Unit (PEU), including the assignment or hiring of its project manager, as well as one procurement management specialist and one financial management specialist (¶3.7).
Special Contractual Conditions of execution for the Investment Loan: See special contractual conditions in the Environmental and Social Management Report (ESMR) (REL#8).
Special Contractual Conditions prior to single loan disbursement of the PBP: The single disbursement of loan resources will be subject to the Borrower's compliance with the policy conditions of the first operation summarized in the Policy Matrix and the Policy Letter (REL#1), as well as the compliance with the conditions contained in the loan contract (¶3.3).</td></tr>
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</table>

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

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

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

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

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

I. DESCRIPTION AND RESULTS MONITORING

A. Background, Problem Addressed and Justification

1.1 Jamaica has made significant progress towards achieving a stable macroeconomic environment and debt sustainability since 2013 under two International Monetary Fund Agreements. The country maintained strong economic performance in Fiscal Year (FY) 2017/2018, with macroeconomic stability anchored in prudent fiscal and monetary policies, as well as related institutional reforms.[1] During the first quarter FY 2018/2019, the economy grew by 2.2%, with an expected growth rate of 1.5% to 2.5% for the second quarter. Jamaica's macroeconomic outlook is positive, with economic activity expected to continue to accelerate over the medium term. Inflation remains low, with the outturn for FY 2017/2018 recorded at 3.9%, and a marginal increase in inflation estimated for FY 2018/2019.[2] Net International Reserves increased from US$2.3 billion to approximately US$3.1 billion between March 2015 and March 2018. The Government of Jamaica has also made considerable progress towards its quantitative objectives for fiscal consolidation and debt reduction, as outlined in the country's fiscal rule. A primary fiscal surplus of over 7.0% of GDP was achieved for the fifth consecutive year in 2018. This, along with proactive debt management, has contributed to a substantial reduction of the debt stock. In this context, the debt-to-GDP ratio is expected to continue its downward trajectory, and is estimated to fall below the 96% target by the end of the 2019/2020 FY.

1. Health conditions and Non-Communicable Disease (NCD) risk factors

1.2 The demographic transition in Jamaica has reached an advanced stage, characterised by low mortality and fertility rates. Jamaica has 2.8 million inhabitants, with a median age of 29.1 years, which is expected to increase to 35.6 years in 2030 and to 43.8 years in 2050. The country has a low and declining fertility rate (2.08 births per woman, 2010-2015) and a slowly rising death rate, which is resulting in lower population growth and population aging. The elderly (65 years and over) represented 9.3% of the population in 2015 and will be 22.0% by 2050. In 2011 women accounted for 54% and 60%, respectively, of the population over 65 and 80 years old, due to their greater life expectancy.

1.3 Jamaica has improved the health status of its population. Infant mortality declined from 30.9 deaths per 1,000 live births in 1990 to 16.6 in 2016 [OEL#2, 1]. Birth attendance by trained personnel is nearly universal. Vaccination rates surpass 90% for the common infectious diseases; malaria, yellow fever, Chagas disease, and cutaneous leishmaniosis have been practically eliminated. The country has experienced an epidemiological transition and faces the challenges posed by NCDs that tend to be of long duration and result from genetic, physiological, environmental and behavioural factors. The most common NCDs are

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1 Gross financing needs for FY 2017/2018 are estimated at US$1,772 million, of which US$489 million are for external financing (Third Review of IMF Stand-By Arrangement). The first and second operations of the PBP series (JA-L1080) are expected to contribute US$50 million each in FYs 2018/2019 and 2019/2020, respectively.

2 IMF World Economic Outlook, April 2018.

cardiovascular diseases, cancers, chronic respiratory diseases and diabetes. Mental and Neurological Disorders (MND) —including depression, anxiety disorders, bipolar disorder, schizophrenia and dementia— may be precursors or consequences of NCDs and share several of the same determinants and effects on health and wellbeing, occurring frequently in the same person. Increasingly, MND are considered a chronic disease.

1.4 NCDs are caused by four modifiable risk factors: (i) the use of tobacco; (ii) excessive consumption of alcohol; (iii) a sedentary lifestyle; and (iv) unhealthy dietary habits, as well as by population ageing. In 2016, NCDs accounted for 8 of the 10 leading causes of death and represented 85% of all deaths (22,034), compared to 78.6% in 1990. The toll from NCDs has existed longer in Jamaica than in other countries of the region.[3] Moreover, NCDs have been the leading cause of premature death since 1990, when they represented 55.6% of Years of Life Lost (YLLs)[4] (68.8% in 2016). The leading causes for morbidity measured with Disability Adjusted Life Years (DALYs) are also NCDs, followed by interpersonal violence. Jamaica has a higher life expectancy (74.6 years) than Guyana (67.7 years), Suriname (71.3 years), and Trinidad and Tobago (73.0 years). However, life expectancy at birth and at age 65 has increased minimally since 1990, which is consistent with the country's advanced position in the epidemiological and demographic transitions. Hence, the main challenges for the Jamaican health sector are: (i) to prevent early onset of NCDs by addressing the four preventable risk factors [2]; and (ii) for people with NCDs, to improve the quality of care[5] and life and prevent premature NCD-related deaths, which the evidence shows is possible with Chronic Care Models (CCM)[6] based on strong primary health care services [3].

1.5 Tobacco is one of the leading causes of preventable deaths, resulting in six million global deaths annually. Tobacco consumption causes high blood glucose levels, hypertension and abnormal lung function, leading to all major NCDs. In Jamaica, according to the 2015 Survey of Living Conditions, men smoke at much higher rates than women (22% and 3%). This reflects in the higher levels of respiratory afflictions affecting men, with lung, larynx and trachea cancers and respiratory diseases as the seventh and eighth leading causes of death, respectively. In 2003, the Framework Convention on Tobacco Control (FCTC) was adopted as the first international health treaty negotiated under the World Health Organization (WHO). The treaty includes evidence-based actions to reduce consumption and the harmful effects of tobacco. Jamaica ratified the FCTC in July 2005.

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[3] Mortality due to NCDs in Jamaica in 1990 was similar to that for 2016 in the rest of the region: in 2016 NCDs caused 76% of deaths in Latin America and the Caribbean, up from 58% in 1990 [39].

[4] YLLs give more weight to younger deaths than older deaths. For each death, YLL is the difference between the life expectancy and the age of the person. Deaths that occur when a person lives longer than the life expectancy will generate zero years of life lost.

[5] Jamaica has problems with the quality of some health care services. For example, maternal mortality is still quite high (over 100 deaths per 100,000 live births) despite almost universal coverage of birth attendance by skilled personnel. For this reason, Jamaica is implementing the €$22 million European Union Programme for the Reduction of Maternal and Child Mortality (PROMAC), which finances health facility infrastructure and equipment upgrades, research, and training/capacity building.

[6] The CCM is an organizational framework for improving the care and management of chronic illnesses through interventions in six areas: organizational support, clinical information systems, delivery system design, decision support, self-management support, and community resources. https://www.paho.org/hq/index.php?option=com_content&view=article&id=8502&Itemid=39959

1.6 The harmful use of alcohol results in a large number of diseases and is a social and economic burden in societies. Alcohol consumption increases the risk of developing NCDs, MNDs and is a causal factor in more than 200 disease and injury conditions. Worldwide, 3.3 million deaths every year result from harmful use of alcohol (5.9% of all deaths). Overall, 5.1% of the global burden of disease and injury is attributable to alcohol, more than half of which were the result of NCDs, including cardiovascular disease and diabetes (33.4%), gastrointestinal diseases (16.2%), and cancers (12.5%).[7] According to the 2007-8 Jamaica Health and Lifestyle Survey (JHLS), 65% of the population aged 15 to 74 currently used alcohol and 83.2% of the 25 to 34-year-old age group did so [4]. The alcohol-attributable death rates in 2012 were 23.7 and 9.1 per 100,000 population, for men and women, respectively [5]. In May 2010 the World Health Assembly endorsed the Global Strategy to Reduce the Harmful Use of Alcohol[8] that focuses on key policy options and interventions, including: drunk-driving countermeasures; limits to the availability and marketing of alcoholic beverages; and pricing policies.

1.7 Unhealthy eating habits and lack of exercise are key risk factors leading to obesity, hypertension, high blood glucose and abnormal blood lipids, proximate causes of NCDs. Healthy dietary practices begin during pregnancy. Breastfeeding and the proper introduction of complementary foods in the baby's first two years foster healthy growth and improve cognitive development, and may have longer-term health benefits, like reducing the risk of becoming overweight or obese and developing NCDs later in life. Furthermore, exercise contributes to the prevention of hypertension, overweight, and obesity, and is associated with delay in the onset of dementia and improved mental health. According to the JHLS, over 70% of men engage in moderate to high levels of physical activity, compared to only 38% of women. Approximately 40% of Jamaicans consider their work sedentary, and 90%, ages 15 to 74 reported being either sedentary or participating in light physical activity during their leisure time. Over 75% of Jamaicans ages 15-74 consumed one or more bottle or glass of sweetened beverage per day, and less than 2% of individuals were meeting the recommended daily intake of fruits and/or vegetables [4].

1.8 Sedentary behaviour, unhealthy diets and harmful use of alcohol, are also risk factors for MNDs. One risk factor in particular –exposure to childhood adversity (such as physical and sexual abuse, neglect, family violence or the death of a parent)– is related to later-life MNDs and to a range of adult-onset NCDs. Additionally, both groups of conditions disproportionally affect people from the most disadvantaged socioeconomic groups. Globally, over 300,000,000 people suffer from depression and close to 800,000 people die annually by suicide (the second highest cause of death among young people) [6]. MNDs are responsible for about a fifth of all years lived with disability, and major depression and anxiety disorders are among the leading causes. In Jamaica, depression is the most prevalent MND, and affects 20.3% of the population (14.8% of males and 25.6% of females). Twenty-three percent of people with primary education or less suffer from depression, in contrast to 15% of those with postsecondary education.

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[7] Alcohol consumption differs from other preventable NCD risk factors because it also causes acute health problems, such as injuries and disability, and death, resulting from violence and road collisions. Approximately 25% of deaths within 20-39-year-old persons are alcohol-attributable [38].

[8] http://www.who.int/substance_abuse/activities/gsrhua/en/

Additionally, the prevalence of depression among Jamaicans with heart disease is up to three times higher than in the general population [4].

2. Health services delivery challenges

1.9 Jamaica's public national health system strives to provide universal coverage free of charge, but several factors limit its ability to deliver effective financial protection and quality services. The Ministry of Health (MOH) is responsible for policy, planning, regulation, and purchasing, while four Regional Health Authorities (RHA)[9] manage health service delivery. In the 1980's the country established a strong primary care platform with over 300 health centres. The MOH operates 24 hospitals, including 9 multispecialty and referral hospitals. The government established the National Health Fund (NHF)[10] in 2003, which subsidizes drug costs for the elderly and NCD patients. It also ended user fees in 2008, which resulted in a 10% increase in public health facility use by the poorest 20% of the population from 2008-2009, but the increased demand aggravated long wait times, supply shortages, inadequate human resource levels and poor quality of services [7]. As a result, the population, including the poor, often pay for services in the private sector, especially for ambulatory care and diagnostics.[11] Private insurance coverage reaches only 19% of the population and accounts for 12% of Total Health Expenditure (THE), and much of the cost of private services is paid out-of-pocket (24% of THE) [8].

1.10 Although Jamaica could improve its health system efficiency, its main challenge is meeting growing demand for services related to NCDs with limited expenditure and investment. Jamaica performed well in a recent health sector efficiency study using the data envelopment analysis methodology [9]. It ranked consistently as a frontrunner for population health outcomes and access indicators given its level of inputs, with some areas of possible improvement such as DALYs lost. THE has remained relatively low and stagnant at 4%-6% of GDP, with the government portion never exceeding 56% in any given year. Recurrent costs consume most of the MOH annual budget, and capital projects, only around 3%, between US$15-18 million. Although the NHF finances around half the MOH investment in equipment and infrastructure, this funding source has become restricted by the growth of the individual benefit plans (drugs for the elderly and NCD patients), which now account for 50%-70% of total NHF expenditure. Sustaining the proper functionality of existing equipment and infrastructure should be a priority, but the MOH assigns few resources for corrective and preventive maintenance.[12] The lack of investment and maintenance has resulted in accumulated needs that require strategic planning, priority setting and institutional strengthening to be properly addressed.

1.11 Primary care in Jamaica currently appears unable to fulfil its role in properly screening and referring to higher levels of care and managing less complex conditions. Physical accessibility to primary care is not a significant issue, since

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9 The 1997 National Health Services Act decentralized service provision to the RHA to increase the efficiency and responsiveness of the health sector to local needs.

10 The NHF is financed by a combination of earmarked taxes on tobacco, a special consumption tax, and a 1% payroll tax.

11 The private sector provides only around 6% of total hospital bed capacity.

12 In 2017/18, only US$6.7 million, around 1.4% of total recurrent expenditure in health.

the average distance to reach a health centre is 3.1 kilometres and the maximum is 14.6 kilometres [10]. Compared to their counterparts in several other countries of the region, Jamaicans report a higher frequency of contact with primary care facilities that have the essential attributes of this level of care (easy-to-contact, continuity of providers with relevant information on patients, and proper care coordination) and rank the quality of their general practitioner much higher [11]. However, almost 60% of patients still bypass health centres to visit the Accident and Emergency Departments (AED) of hospitals for conditions that after screening are found to require routine primary care [11]. At the same time, there is a high rate of hospital admissions and readmissions for avoidable complications of NCDs that should be handled by primary care.[13]

1.12 Some of the primary care problems are attributable to insufficient diagnostic, screening, and resolutive capacity at the health centre level. While there are 322 health centres (1 per 5,000 to 14,000 population depending on the region), most offer low-complexity services. Only 15 centres have extended hours and 19 (6%) have first level laboratory services, corresponding to one facility per 62,000 to 298,000 population, depending on the region. Radiology services and electrocardiogram are installed in just two and six health centres, respectively. Finally, the availability of pharmacy services in these facilities varies among the four health regions from 16% to 29%. Therefore, the challenge is to improve the capacity of existing centres and not to create new ones.

1.13 The inadequate performance of primary care exacerbates existing issues in secondary and tertiary care. In the hospital AEDs, many cases turn out to be non-urgent, which generates overcrowding and longer waiting times.[14] Inpatients with primary-care sensitive conditions result in an inefficient allocation of hospital resources, and limited clinic capacity reduces the possibility to manage these cases as outpatients. Certain wards in some hospitals, especially the type A specialty and type B general hospitals,[15] show Bed Occupancy Rates (BOR) over the recommended safe limit of 85%, as well as longer than desired Average Lengths Stays for patients (ALOS).[16] The capacity deficit of the general hospitals outside the capital in imaging, laboratory, pharmacy, and general outpatient services, including day surgery, is also evident in the Ambulatory Care Ratio (ACR),[17] which is much lower in the health regions of the interior (for example, 17.0% in the Northeast), compared to the Southeast region that contains Kingston 27.9%. This is partially explained by the Southeast region's better ability to attend to its assigned population, due to the concentration of type A and specialty hospitals but referred cases and self-derived demand from the other regions also contribute to this phenomenon. Hence, a disequilibrium has been produced in outpatient care due to lack of containment by the secondary level of attention throughout the country. This could be addressed by strengthening services of the general hospitals in the regions.

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13 Kingston Public Hospital has readmission rates of 17%-34%, with hypertension and diabetes among the leading causes [12].

14 Average waiting time at public hospitals was 4.7 hours in 2015 [13].

15 As opposed to Type C community hospitals.

16 Many patients with long stays could be attended in lower-complexity facilities or in community or family contexts; however, they often lack social and family support, and alternative care modalities are limited.

17 The ACR by health region is the ratio of total ambulatory cases presenting at hospital to the total population.

1.14 In addition to the ambulatory services, there is need to expand and improve hospital inpatient care, to account for demand and correct accrued deficiencies. Based on factors including population demand, network role,[18] and physical needs assessment, the MOH identified five hospitals for potential upgrading, and of these, three are especially strategic to relieve the overflow of demand to Kingston/St. Andrew. In these hospitals the BOR on the general medicine and surgery wards is consistently above the 85% threshold, violating standards on minimum space requirements and patient safety (in 2016-2017, the BOR in the general medicine ward was 131% at St. Ann's Bay Hospital and 138% at May Pen Hospital). Reducing the ALOS to around five days could help alleviate the high BOR, increase efficiency and generate patient benefits in terms of lower acquired infection rates and less functional loss [15]. According to a recent inventory of medical equipment at the priority facilities, around one-third of the items should be replaced or discarded, often because they received little or no maintenance. Additionally, to meet current clinical demand significant additional equipment is necessary [16]. The assessment of the hospitals' infrastructure recommended interventions to improve operations as well as to guarantee patient and health worker safety [17]. Furthermore, construction of extra ward space and expansion and/or addition of buildings would help ameliorate critical problems.

1.15 To improve linkages between primary and hospital care, it is necessary to establish better referral and cross-referral and treatment protocols, and care or discharge pathways in an integrated network approach. Although the MOH conducted a pilot project of the CCM, it performed no systematic assessment of the results, and there has been no sustained effort to expand this approach. An Auditor General Department's performance audit on the MOH's management of diabetes [36] substantiated the poor application of clinical guidelines as well as deficient monitoring and control of service provision practices. The guidelines mandate annual patient blood glucose monitoring with the Hemoglobin A1c (HbA1c) test, depression screening, foot inspection and oral examination, but audits from the Western and Northeast regions revealed that of sampled patients, 63% had not had glucose tests, while over 75% and 85% had not been referred to a nutritionist/dietician or for eye exams or mental health consultation. The other regions did not report properly on the indicators, and the NHF stopped funding the blood glucose test for 21 of 25 facilities due to inactivity. All these screening and health maintenance measures can prevent or delay complications and associated costly treatments, such as dialysis and amputations. Similar situations exist with other NCDs; for example, patient hypertension control in the Western region has been consistently below the 51% goal.

1.16 Access to timely and high-quality health information remains a challenge in Jamaica. A National Health Information System assessment performed in 2011 noted key strengths, such as the existence of data sources, but also important weaknesses, including the inability to establish and maintain effective systems/procedures for stakeholder collaboration and participation; inadequate infrastructure, human resources and financing; poor reporting mechanisms; and

[18] A hospital network reorganization process could imply a reformulation of the number of beds per type of service vis-à-vis the expected number of discharges, closure of departments or clinical units that duplicate services or have low production, reallocation of services from one hospital to another, and the role re-specification among facilities [14].

limited use of data [18]. In 2015, the MOH published the 2014-2018 National Health Information System Strengthening and e-Health Strategic Plan with the vision of providing "…a single electronic health record for every person that facilitates patient safety, quality and continuity of care." Some of the plan's activities have been implemented, including the pilot of an open-source solution for Electronic Patient Administration (ePAS), GNU Health;[19] the design and deployment of a pilot e-triage portal at the Bustamante Hospital for Children, which resulted in decreased waiting times; and the application of the Extension for Community Healthcare Outcomes (ECHO) tele-mentoring portal,[20] in ten facilities to improve the provider capacity to treat Human Immunodeficiency Virus (HIV) patients.

1.17 Jamaica's health information system needs to focus on key foundational areas, such as formal governance structure, design of system architecture, definition of a data dictionary, and adoption of international standards for patient privacy, interoperability and disease classification. Incorporation of interoperability standards is critical for cost-effectiveness and efficiency given that many health information systems are "digitally walled", preventing them from effectively exchanging information.[21] Additionally, the existing paper-based system is outdated, and the storage capacity in health facilities for such records is limited, making security and safety of patient records a major issue. During 2017, the MOH conducted the first stage of the Information Systems for Health (IS4H) assessment with Pan American Health Organization (PAHO) support and identified critical areas for building on previous work, in addition to the need to make strategic decisions regarding governance and assess the sustainability of the current approach to reach the MOH's vision. Support is required to surmount these difficulties.

3. Programme strategy

1.18 The Government of Jamaica (GOJ) developed the National Strategic and Action Plan for the Prevention and Control of Non-Communicable Disease (NSAP-NCD), which is consistent with the WHO's Action Plan on NCDs and aims to reduce the burden of NCDs and injuries by 25% by 2025. It has two priority programme areas to: (i) reduce exposure to modifiable risk factors for NCDs and promote health throughout the lifecycle; and (ii) strengthen and reorient health systems to address prevention and control of NCDs through people-centred primary health care and universal health coverage.

1.19 Jamaica will intensify its implementation of cost-effective policies to address NCDs. In the context of the Global Action Plan for the Prevention and Control of NCDs[22] 2013-2020 and its updates, the WHO has identified a list of 'best buys' and other recommended interventions to address NCDs and their preventable risk factors, as well as clinical management of the most important diseases.[23] The

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19 GNU Health is a Free and Open-Source Software (FOSS).

20 ECHO is platform run by the University of New Mexico Health Sciences Center to develop capacity to treat chronic, common and complex diseases in rural and underserved areas.

21 Health Information Systems Interoperability Maturity Toolkit: Users' Guide, 2017.

22 http://www.who.int/nmh/events/ncd_action_plan/en/.

23 Further details on the Best-buys are provided in the Economic Analysis. https://ncdalliance.org/sites/default/files/resource_files/WHO-NMH-NVI-17.9-eng.pdf.

MOH has identified pathways to adapt and implement best-buys in Jamaica, which constitute an important strategic component to this programme.

1.20 The MOH is incorporating gender considerations in strategies to combat NCDs. Biological differences and gender roles determine the type of access and use of health services by men and women, as well as different behaviours regarding health care. These factors affect the incidence, manifestations and consequences of NCDs. Developing effective treatments requires that health systems have the capacity to analyse the gender determinants and the different associated risk factors [19]. The programme has incorporated this perspective by identifying gender differences in risk factors and disease prevalence and signalling the need to employ a gender-sensitive approach in policy formulation and prevention and screening efforts.

1.21 Jamaica has made advances in meeting its obligation under the FCTC in the areas of protection from exposure to tobacco smoke and implementation of graphic warning and other packaging requirements, and through the adoption of public health regulations and taxes. In 2015 a needs assessment for implementation of the FCTC in Jamaica provided a detailed analysis of the progress made and the gaps related to tobacco control measures, including stricter policies on advertisement, information campaigns and treatments for smoking cessation, as well as actions needed to close them. Since the assessment was compiled, the GOJ has updated its taxation on tobacco products policy aligned to the FCTC standards: from 2014/15 to 2017/18 the tax on cigarettes increased by 62%.

1.22 The GOJ will pursue the further development and implementation of evidence-based strategies for the prevention and control of harmful alcohol consumption. According to the 2014 WHO Global Status Report on Alcohol and Health, Jamaica has adopted some best-buys and other recommended measures through provisions to curb excessive alcohol consumption, such as excise taxes, minimum age restrictions to buy and consume alcohol and some regulations on advertisement. However, existing regulations are not comprehensive and for the most part do not meet international best practices and current prevailing evidence. There are no comprehensive restrictions on advertisement, promotion and/or sponsorship, and labelling, limitations on physical availability and pricing policies are inadequate to achieve the desired public health gains. These aspects will be included in the National Alcohol Policy to be developed under this programme.

1.23 The GOJ will strengthen policies to reduce unhealthy dietary habits and to encourage physical activity. Recognizing the importance of healthy nutrition in the early years and the rise in childhood obesity, the GOJ is developing a National Infant and Young Child Feeding Policy (NIYCFP). This policy will include provisions to increase the uptake of breastfeeding, promote exclusive breastfeeding for the first six months of life followed by adequate complementary feeding, and ensure that all facilities providing maternity and child health services obtain accreditation in line with the Baby Friendly Hospital Initiative (BFHI).[24] In addition, the MOH recently announced a ban on sugar-sweetened beverages above a maximum sugar concentration in public schools and public health facilities that will begin in January 2019. The MOH and Ministry of Education are working

[24] http://www.who.int/nutrition/topics/bfhi/en/.

with manufacturers and distributors of sugary drinks to develop the requirements for products that will be allowed. Forthcoming school nutrition policies include the promotion of healthy eating habits, physical activity and age-appropriate health check-ups through the Jamaica Moves at School Initiative, which is based both on the Ottawa Charter for Health Promotion and the Caribbean Charter for Health Promotion and includes a settings approach (reaching people at appropriate places) and is mindful of the importance of social media and behavioural communication tools for effective health promotion.

1.24 The GOJ is committed to the objectives of the WHO Mental Health Action Plan and is developing its own National Mental Health Action Plan (NMHAP) to guide the reform of mental health services focusing on scaling up the Community Mental Health Service (CMHS). The MOH has decreased bed capacity at Bellevue Hospital, the sole mental health hospital in Jamaica, by 23%, and has also led a mental health promotional campaign to reduce stigma and raise awareness of these disorders. However, problems persist, and 50% of the patients admitted to Bellevue Hospital remain as long-stay patients, highlighting a strong need for the development of more community-based residential living facilities. The NMHAP will strengthen leadership and governance in mental health, as well as mental health promotion, mental illness prevention and rehabilitation and recovery. Additionally, the GOJ plans to continue restructuring mental health services away from long-term hospital stay and towards community-based general health care settings that include short-stay inpatient and outpatient care services in general hospitals, primary care and day care centres.

1.25 The GOJ has recognized the international evidence regarding the importance of primary care in integrated health services networks, especially for chronic disease management [20], including the development and implementation of screening and clinical management guidelines for NCDs. Hence, it approved the Primary Health Care Renewal Policy in 2015 and a year later initiated a project to extend the type of services, the physical capacity to attend patients, and the opening hours at eight health centres. At the same time, in hospitals closely affiliated with these centres, it improved the AED services to reduce patient waiting times by standardizing patient flow to triage, computerizing the process, increasing physical capacity for waiting and triage, and establishing customer service areas [21]. From 2015/16 to 2016/17, there was a 41% increase in visits to these health centres, compared to 13%, from 2014/15 to 2015/16, and one centre had a 129% increase. In one of the hospitals chosen for study, at the beginning of the project only 34% of patients were triaged under 30 minutes, while a year later, this percentage more than doubled to 69%.[25] Since a single health centre does not have the capacity to absorb all the patients referred from a hospital AED, the MOH recommended strengthening additional centres in each hospital's area of influence, an approach being incorporated into this programme.

1.26 In addition to strengthening primary care services and clinical guidelines for NCDs, MOH realizes that it must address the deficit of investment in hospital diagnostic and clinical capacity to properly complete the spectrum of NCD management and control from primary and secondary prevention through treatment. It

[25] 83% of the 69,333 patients triaged ranked levels 4 and 5 (essentially non-urgent) on the Emergency Severity Index scale. Of these patients, around 7,000 were referred to health centre and 10,422 were sent home.

commissioned the United Nations Office for Project Services (UNOPS) to assess the infrastructure and equipment needs to upgrade five strategic hospitals and present options for services configurations under a network approach. This work has informed the prioritization of three hospitals to include in the programme.[26]

1.27 The MOH intends to improve the procedures and practice of health service provision for NCDs. One of the five priority programme areas in the NSAP-NCD relates to the reorientation of the health system to address prevention and control of NCDs through people-centred primary care. It calls for the development and/or update of guidelines for screening and controlling NCDs and risk factors, as well as promoting improved patient self-management. To increase the use of evidence-based protocols and care pathways by health sector professionals, it is important to make them available in user-friendly formats and to provide training in their application [22]. Jamaica has also employed the Chronic Care Passport [23] on a pilot basis and plans to deploy it and the CCM more extensively to encourage patient empowerment and self-involvement in care as part of the programme.

1.28 Information systems for health are critical to primary health care and the CCM, as well as complex care. The WHO espouses the need for information systems for health as part of the Package of Essential Noncommunicable (PEN) Disease Interventions for Primary Health Care in Low-Resource Settings [25]. Additionally, research shows that digital tools can contribute to chronic care provision when patients and providers are connected to share information, compare this information to evidence-based standards, and monitor results through regular feedback and interaction [26]. Figure 1 illustrates the potential ways eHealth tools can be integrated into the CCM [27]. Adoption of health information technology has produced mortality rate reductions for complex patients whose diagnoses require cross-specialty care coordination and extensive clinical information management in hospital settings [28] and improvements in resource allocation efficiency [29]. Health information systems have the potential to improve clinical practice by reducing staff errors, improving automated harm detection, monitoring infections more effectively, and enhancing the care continuity during physician handoffs. The Hospital Information Management System (HIMS) has the potential to reduce waste and allow a more efficient use of resources in the health system.[27]

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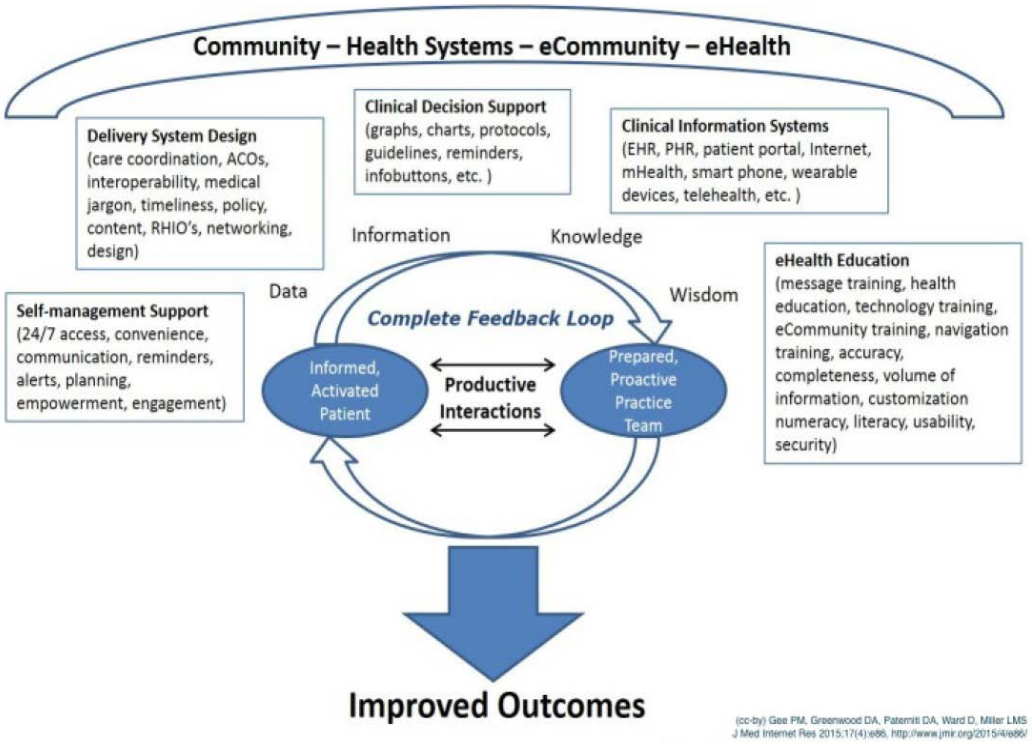
[26] The programme will finance the preparation of the specific construction plans and the corresponding physical works.

[27] Conservative estimates suggest if the United States healthcare system were interoperable, at least US$77 billion would be saved annually [37].

Figure 1. The eHealth Enhanced Chronic Care Model (eCCM)



1.29 Telemedicine[28] and mobile health (mHealth) present possibilities to improve the effectiveness and efficiency of NCD management, which can occur principally in the outpatient setting [31]. For example, blood pressure control consultations by way of 10-15 emails and/or phone calls can occur across weeks and the cost is approximately 29% of the cost of in-person acute care [32]. mHealth tools, such as text messages, medication reminders, symptom monitoring, educational resources, and facilitated patient-provider communication to increase adherence targeting low-income, elderly, and minority groups were found to lessen the burden of travel to a care provider. They have also facilitated better management and improved patient confidence to monitor chronic diseases [33]. Telehealth, or the remote diagnosis and treatment of patients by means of telecommunications technology, has been especially effective in the management of chronic diseases, and has demonstrated improvement in outcomes (diabetes), empowerment and self-management (diabetes and high-risk dialysis patients) [33]. As mobile-cellular subscriptions are high in Jamaica (115 per 100 inhabitants) [34] mHealth and telemedicine may provide an opening to improve patient adherence and aid in follow-up. Given Jamaica's experience using ECHO's tele-mentoring portal for HIV, this platform could be expanded to support chronic illness, and use-cases could be developed to pilot the use of mHealth and telemedicine for chronic care.

1.30 **Programme logic: summary of policy reforms and link to proposed investments.** For the Policy Matrix of the Programmatic Policy-Based Loan (PBP), the GOJ and the Bank have identified key policies to reduce the risk factors of

[28] Telemedicine allows patients, providers and other health care system players to overcome geographical barriers by connecting users who are not in the same physical location [30].

NCDs and to improve clinical management and care of NCDs, considering the processes and timeframe of such policy measures and the duration of the PBP series. The policy actions of the first operation prioritize the formulation of regulatory frameworks (national plans, intersectoral policies, models, regulations, protocols and technical standards that require ministerial or cabinet approval or mandate) aimed at reducing the risk-factor behaviours of the population and at aligning health policies, guidelines and protocols for the efficient management of NCDs. For the second operation, the conditions emphasize the initial implementation of the reforms, have robust means of verification, are balanced in relation to those of the first, and can be fulfilled within 18 months (expected period between the approval of both policy-based operations). For risk factors, the reforms will address key issues related to the regulation of advertisement, promotion, sponsorship, access and pricing to alcohol and tobacco according to WHO best practices, as well as the institutionalization as health policy tools of information, communication and behavioural change interventions related to nutrition and physical activity, with an emphasis on infant nutrition, as well as exercise and eating habits at schools. A second set of measures refer to strengthening MOH capacity to provide NCD management aligned to best practices; these measures will close gaps regarding the need for a national CCM, for guidelines pertaining to primary health care screening and nutritional management of priority NCDs; for the development of a strategic plan for mental health to provide comprehensive, integrated and responsive mental health in community based settings; and for the development and approval of an action plan for information systems for health. In summary, the first operation will provide the necessary regulations and policies to implement a coherent and comprehensive strategy to address NCD risk factors and the clinical management of NCDs, while the second operation will support the implementation of such regulations and policies, which will contribute to easing the burden of disease caused by NCDs. Further progress will be contingent on effective behaviour change of the population in terms of healthy lifestyles, which is supported by both operations, and the continued strengthening of the integrated health network approach with strong primary health care.

1.31 The Investment Loan supports the implementation of some of the initiatives of the policy loan and establishes a more conducive environment in the health facilities for NCD risk factor reduction and clinical management. In general, it will provide for increased capacity in health centres and hospitals to diagnose and treat NCD patients. Specifically, it includes resources for the review and application of guidelines and screening procedures for the early detection of NCDs. Additionally, the investment loan will finance the roll-out of the CCM, which is a comprehensive approach toward patient support whose development is foreseen in the policy loan. The health information system is another area in which the policy loan establishes a framework for intervention that the investment loan effectively adopts for implementation on a pilot basis. The programme´s strategy considers gender factors in the policies to combat NCDs through prevention, promotion and clinical management.

1.32 The additionality of the programme comes from coordinating key interventions at the population level (first component of the programmatic policy-based loan), at the clinical management level (second component) and at the functioning of integrated health networks (supported with the investment operation). The Bank´s

vale added arises from the experience in working in strengthening health networks through operations (BR-L1376, 3051/OC-BR; BR-L1415, 3400/OC-BR; GY-L1058, 3779/BL-GY; AR-L1196, 3772/OC-AR; and Mesoamerica Health Initiative) and analytical and policy dialogue (RG-E1560) The incorporation of the information system for health and telemedicine in the programme design has generated collaboration among the MOH, IDB and other actors such as PAHO.

1.33 **Bank experience and lessons learned.** Jamaica has not implemented a loan operation in the health sector within 15 years, but the Bank currently supports a variety of initiatives through Technical Cooperation (TC) projects. For example, the Strengthening Health Systems in Jamaica project (JA-T1092; ATN/OC-14953-JA) supports strategic planning, the primary care renewal process, and financing strategy development. The Energy Management and Efficiency Programme (JA-L1056; 3877/OC-JA) aims at implementing energy conservation methods in Government facilities, including four hospitals.[29] The principal lesson derived from the Bank's experience in the health sector relates to the need to establish strong capacity for project management within the MOH, and this is addressed both through the investment loan Project Executing Unit (Component 3) and additional TC resources that were mobilized to support programme preparation and implementation (Improvement to Health Service Delivery (JA-T1141; ATN/OC-16573-JA) and Strengthening Health Services Delivery in Jamaica (JA-T1152; ATN/OC-16789-JA). Furthermore, the programme incorporates recommendations from IDB Health and Nutrition Framework regarding: (i) the adoption of a service delivery approach built around primary care that stresses health prevention (PBP Component 3, Investment Component 1.1); (ii) the streamlining of hospital functions and their integration in care networks (Investment Component 1.2); (iii) the careful incorporation of information and communication technologies to promote efficiency in care provision and health worker training (PBP Component 3, Investment Component 2); and (iv) the need to increase capacity for the maintenance and sustainability of health infrastructure (Investment Components 1.1 and 1.2).

1.34 **Strategic alignment.** The Health Hybrid Loan Programme is consistent with the Update of the Institutional Strategy (UIS) 2010-2020 (AB-3008) and is strategically aligned with the development challenge of social inclusion and equality by improving access of the population to health care services. The programme is also aligned with the cross-cutting themes of: (i) gender equality and diversity, by being able to increase women's access to health services for diseases that affect them disproportionately and (ii) institutional capacity and rule of law, by being able to improve the quality of public health services and policy formulation and implementation. Additionally, the Programme will contribute to the Corporate Results Framework (CRF) 2016-2019 (GN-2727-6) by expanding the number of beneficiaries receiving health services. It is consistent with the Health and Nutrition Sector Framework's (GN-2735-7) priority to ensure that all people have timely access to quality health services. Furthermore, the programme contributes to the objective of the IDBG Country Strategy with Jamaica 2016-2021 (GN-2868) to improve the public health system and achieve an increase in the usage of primary

[29] Seven additional hospitals will undergo deep energy efficiency retrofits with European Union Caribbean Investment Facility (EU-CIF) grant funding, including St. Ann's Bay and Spanish Town Hospitals.

care facilities and a reduction in risk factors and the burden of NCDs,[30] and is included in the Update to Annex III of the 2018 Operational Programme Report (GN-2915-2).

1.35 **Donor coordination.** For this programme, the Bank is working closely with PAHO regarding NCD policy measures and information systems for health. The Bank is also coordinating with UNOPS, which is conducting a needs assessment that will inform hospital investments as part of the strengthening of integrated health networks. In this line of work, the programme is also coordinating with PAHO/WHO and the United Kingdom Department for International Development (DFID) on the SMART Hospital Development Programme that aims to strengthen hospital infrastructure to sustain services during times of national disaster. Lastly the Bank is coordinating with the European Union, which is financing a €22 million programme to improve maternal and neonatal health care services, principally through infrastructure and equipment upgrade. [31]

1.36 **Sustainability.** The policies and investments supported through this programme represent significant advances in the health system, and provisions have been taken to guarantee their sustainability. The policies of the PBP are set at the appropriate normative level (i.e. bill, policy, guidelines) to ensure that they have the intended regulatory and clinical management incidence. For the investment operation, prioritisation and analyses have included the total operation costs including human resources and equipment maintenance to ensure continuity and sustainability of services. Loan resources have been allocated to equipment and infrastructure maintenance and the programme will strengthen internal capacity in this area.

B. Objective, Components and Cost

1.37 **Objective.** The programme objective is to contribute to the improvement of the health of Jamaica's population by strengthening comprehensive policies for the prevention of NCDs risk factors and improved access to an upgraded and integrated primary and secondary health network in prioritized areas with an emphasis on chronic disease management, that provide more efficient and higher quality care.

1.38 The policy-based operation of this Hybrid Programme is the first operation of a PBP series which will be made up of two contractually independent and technically linked loans. The policies in the Programmatic Series will consolidate regulatory measures to address the preventable causes of NCDs and to reorient health systems to address prevention and control of NCDs through a people-centred primary health chronic care model.

1.39 The investment component, in turn, will finance activities to consolidate integrated health networks and improve the management, quality and efficiency of health services. While the PBP will benefit the Jamaican population at-large, the Investment Loan will have approximately 800,000 potential direct beneficiaries

[30] It should also contribute to reducing hospital readmissions for NCDs.

[31] The Bank is also pursuing, at the request of the GOJ, additional grant financing from the European Union Caribbean Investment Fund to complement the investment component of the programme.

who reside in the catchment areas of the health services networks that will receive investments.

1. Programmatic Policy Based Loan JA-L1080 (US$50 million)

1.40 **Component 1. Macroeconomic stability.** The objective is to maintain an appropriate macroeconomic policy framework consistent with the programme's objectives and in accordance with the provisions of the Policy Letter and the Policy Matrix (Annex 2).

1.41 **Component 2. NCDs risk factors reduction.** Policies in this component will address the four principal avoidable risk factors that cause NCDs: tobacco, problematic alcohol consumption, unhealthy diets and lack of adequate physical activity.

1.42 To reduce the prevalence of tobacco usage (policy condition 2.1), a Tobacco Control Legislation (TCL) will be drafted in keeping with the obligations under FCTC. The TCL will include, among others: (i) the regulation of interactions of GOJ officials with the tobacco industry to ensure that GOJ bodies interact with the industry only when and to the extent necessary to effectively regulate the industry; (ii) regulation of price and tax measures on all tobacco products so that these taxes are mandatory and need to maintain basic levels as to reduce consumption; (iii) the full and mandatory prohibition on tobacco advertising, promotion and sponsorship, including a ban on point-of-sale tobacco displays; and (iv) compliance with the Protocol to Eliminate Illicit Trade on Tobacco Products [35]. The first operation will support Cabinet´s decision to write the Bill, while the second operation will see a draft bill submitted to the Legislative Committee of Cabinet, as well as the ratification of the Protocol to Eliminate Illicit Trade in Tobacco Products, which is a part of the FCTC.

1.43 To reduce the harmful consumption of alcohol (policy condition 2.2), a policy paper will be developed and approved by the MOH. The policy will be aligned to WHO guidelines and best-buys regarding advertisement and sponsorship, availability and pricing. The first operation will support the development and approval by the minister at MOH of the Concept Paper for the Reduction of Harmful Use of Alcohol Policy, while the second operation will support approval by the MOH and submission to the Human Resources Committee of Cabinet of the Green Paper for the Reduction of Harmful Use of Alcohol Policy.

1.44 To promote healthy eating habits, physical activity and age appropriate health check-ups (policy condition 2.3), a plan within the Jamaica Moves at School Initiative will be developed, approved and implemented. It will include provisions to limit the sugar content of beverages offered at school; measures to facilitate increased physical activities amongst students; and measures to strengthen capacity at schools to identify and respond to at-risk students for NCDs. The first operation will support the development and approval of the plan to implement the initiative, while the second operation will support its implementation.

1.45 To reduce malnutrition in infancy and childhood (policy condition 2.4), an Infant and Young Child Feeding Policy and Strategic Plan (IYCFPSP) will be approved and implemented. The policy will include measures to address deficiencies and

obstacles experienced in infant and young child nutrition and to provide the context for the development of innovative approaches to influence the determinants of nutritional behaviour, including exclusive breastfeeding during the first six months of an infant's life, adequate complementary feeding, support to the mother and the BFHI. The first operation will support the approval of the policy by the MOH and its submission to Cabinet and the second operation will support the early implementation of the policy in key areas such as BFHI accreditation, establishment of community support groups and certification of key personnel.

1.46 To promote healthy eating and to provide useful, actionable and timely information (policy condition 2.5), the second operation of the programmatic series will support the implementation of a social marketing campaign to promote behavioural change as related to eating habits in support of the implementation of the National Food-based Dietary Guidelines.

1.47 **Component 3. NCD early detection and clinical management.** This component will include regulatory and policy measures to improve the management of NCDs.

1.48 To strengthen the delivery system design for priority NCDs care (policy condition 3.1), a CCM Concept Paper and Policy for the risk factor reduction, early detection, treatment, diagnosis and support for cardiovascular disease, diabetes, cervical, breast, prostate and colorectal cancer, depression and asthma will be developed. The CCM will emphasize a gender-sensitive approach to the prevention, diagnosis and treatment of NCDs, including prioritizing the importance of training health personnel in the gender determinants, that influence NCDs and barriers to care, as well as addressing the different manifestations of disease, prevalence, health seeking behaviour and feasibility of complying with treatment according to gender. The first operation will support the development of the CCM Concept Paper and Policy and the second operation will begin the implementation of the CCM Policy by the MOH in at least one health network.

1.49 To promote early detection of priority NCDs (policy condition 3.2), screening guidelines for the primary health care level will be developed and implemented. The first operation will support the approval of a concept paper for the development of the screening guidelines while the second operation will include the approval and early implementation of the screening guidelines through a pilot at the primary care level.

1.50 To improve the decision-making in the delivery of NCDs care through guidelines of standards of care (policy condition 3.3), the programme will support the development, approval and publication of guidelines for the nutritional management of obesity, diabetes, hypertension and cancer in hospitals and health centre settings, which will include the development and implementation of the nutrition care plan based on nutritional adequacy, caloric control, nutrient density, variety and balance, as well as the individual anthropometric, biochemical, clinical and dietary data; the evaluation, documentation and monitoring of nutritional care; directives for self-management and indications for referrals to health care team. The first operation will support the development of the nutritional guidelines while the second operation will see their approval by the MOH and on-line publication.

1.51 To strengthen Jamaica´s record on providing mental health services in community-based settings and of mental health promotion and prevention strategies (policy condition 3.4), the programme will support the development and approval of the National Strategic Plan on Mental Health. The first operation will support the development of the plan, and the second operation will support the approval of the plan by the MOH.

1.52 To provide the foundational elements for Information Systems for health (policy condition 3.5) a National Plan of Action for IS4H (NPAI) will be developed that includes elements to support interoperability standards across components of information systems to facilitate tracking of patients throughout the public health sector, a referral system, modules to support NCD self-management and follow-up appointments, and TeleMedicine and TeleHealth initiatives. The first operation will support the development of the plan of action and the second operation will support the approval of the plan, as well as the implementation of the Policy and Legal Framework Work Stream of the NPAI through the development of a policy to govern the collection, use and disclosure of personal health information whether it exists on paper or other formats, as provided in the draft Data Protection Bill.

2. Investment Loan JA-L1049 (US$50 million)

1.53 **Component 1. Organization and consolidation of integrated health services networks (US$40,155,000).** This component will finance the purchase of medical equipment and the improvement of infrastructure for primary health care services in the catchment areas of three priority hospitals to increase their capacity in health promotion and disease prevention, especially regarding chronic, noncommunicable diseases. The investments will focus on strengthening the diagnostic and screening capability as well as the clinical and resolutive- capacity of health clinics. This will allow for more early detection and better management of the chronic disease burden and a reduction in the rate of avoidable hospitalizations. Concomitantly, the programme will provide resources for the upgrading and or expansion of three (3) hospitals selected on criteria relating to strategic role in the national hospital network, supply-demand gap analyses, and physical needs assessment. The hospitals will benefit from infrastructure upgrading and or expansion as well as modernization.[32] The interventions of this component will provide for a more rational utilization of health sector resources and will facilitate the more efficient distribution of cases according to complexity, with clinics and health centres attending to primary care patients while hospitals concentrate more exclusively on the higher complexity cases.

1.54 **Subcomponent 1.1. Strengthening primary care (US$9,500,000).** The purpose of this subcomponent is to increase the physical capacity for service provision at the primary care level in three priority geographical areas. Based on an extensive review of the demographic, epidemiological, and service supply and demand gap information, the MOH has identified ten health centres to receive investments in medical equipment and infrastructure refurbishment and expansion. The subcomponent will finance: (i) the preparation of building designs for the

[32] In the infrastructure upgrading efforts, the MOH is considering the options and lessons learned in the ongoing effort to retrofit public buildings to improve energy efficiency that has been led by the Petroleum Corporation of Jamaica.

construction of new infrastructure on the sites of existing facilities (three centres), expansion of existing structures (four centres), and refurbishing (three centres); (ii) the physical works required for infrastructure improvement; (iii) the purchase of medical equipment (including essential diagnostic and treatment items for NCDs, such as sphygmomanometers, electrocardiogram machines, pulse oximeters, defibrillators, computerized chemistry machines, etc.); (iv) engineering services for construction supervision; and (v) the design and implementation of corrective and preventive maintenance of medical equipment programme.

1.55 **Subcomponent 1.2. Increasing the capacity and efficiency of hospital services (US$30,655,000).** This subcomponent will address urgent needs to enhance patient safety and services in three hospitals whose catchment areas contain the health centres identified in Subcomponent 1.1. Raising the level of complexity of services and the installed capacity to provide them at the centres and their reference hospitals should generate a more rational utilization of resources at both types of facilities, since the hospitals will be less burdened by primary care patients and will be able to utilize their assets on treatment of acute cases. Financing from this subcomponent will be allocated to: (i) the building and engineering designs for infrastructure improvement and expansion; (ii) the construction in three hospitals according to contracted plans and designs; (iii) the purchase of medical equipment to raise clinical capacity to partially account for existing demand; (iv) the purchase of imaging equipment, including computerized tomography machines; (v) industrial style laundry machines; (vi) construction supervision services; and (vii) the design and implementation of a corrective and preventive equipment maintenance programme.

1.56 **Component 2. Improvement of management, quality and efficiency of health services (US$7,500,000).** The component will provide technical assistance to design and implement the CCM in the participating health services networks; to review and develop care pathways and protocols; and to prepare change management, continuous quality improvement and social marketing for behaviour change strategies. It will also finance the implementation of the fourth Jamaica Health and Lifestyle Survey. Considering the lack of reliable and timely information for policy formulation and planning, as well as patient clinical management, this component will support: (i) the creation of a strong foundation for a digital health ecosystem, including the adoption of standards for interoperability, system architecture, updated governance structure, and other key elements; (ii) the design and implementation of a sustainable Electronic Health Record (EHR) platform focusing on digitalization of key processes within the improved CCM; and (iii) the strengthening of telehealth/telemedicine/telementoring capacity to include chronic care management, and the establishment of norms and processes for its institutionalization.

1.57 **Programme administration and evaluation (US$2,345,000).** These activities will support the MOH in terms of strengthening its institutional capacity for project implementation. It will finance, inter alia, the consultants of the Programme Executing Unit (PEU), specialized technical services, independent auditing, as well as surveys and studies regarding the implementation of the programme and evaluation of its impact. The PEU will be structured to provide additional capability in the areas of project management, procurement, financial management,

infrastructure upgrading, medical equipment specification, and health information technology.

C. Key Results Indicators

1.58 The key results indicators will track progress in reducing prevalence of diabetes and hypertension as well as premature mortality associated with NCDs; and in achieving Jamaica´s targets related to the prevalence of risk factors (tobacco use, alcohol consumption), the clinical management of NCDs (awareness and control) and the functioning of the chronic care model within the health networks approach at the health centre (access to care with the visits to population ratio; wait times; proper management of diabetes) and hospital level (length of stay, readmission rates and timely access to accident and emergency services when required). These indicators measured at the appropriate level will measure the combined results of the investment and policy components of the programme.

1.59 **Economic analysis.** The strategies promoted in this operation are based on the evidence on the effectiveness of the WHO Best Buys against NCDs, the Integrated Health Services Networks approach and the Chronic Care Model. The Economic Analysis (OEL#1) for the investment loan quantifies the incremental benefits derived from the programme´s investments in terms of efficiency gains due to the reduction of avoidable hospitalizations; gains in productivity due to the reduction in morbidity and mortality associated with the adopted care model; and benefits for the implementation of the care pathways within the Chronic Care Model. The analysis quantifies DALYs that can be saved by the implementation of investments in a context of integrated health networks, analysing the increase in effective coverage and the time it takes to materialize the results. Under the base scenario discussed in the OEL#1, the Net Present Value (NPV) with a discount rate of 3% is US$ 5,721,533. [33] Accordingly, the implied Economic Rate of Return (EER) for this scenario is 18% and the benefit-cost ratio is 1.09.Sensitivity analyses show that the benefit/cost ratio is higher than one even in most of the less favourable scenarios.

1.60 Based on OVE recommendations in its review of Evaluability of Bank Projects in 2011[34] and in the results of the review of evaluation practices and standards for policy reform support loans carried out by the Evaluation Cooperation Group (ECG, consisting of the Independent Evaluation Offices of Multilateral Development Banks),[35] foreseen in paragraph 1.3 of document GN-2489-5 (Review of the Development Effectiveness Matrix for Sovereign Guaranteed and Non-Sovereign Guaranteed Operation) that, among others, indicate that it would not be necessary to include an analysis of efficiency in the use of financial resources,[36] it was determined that an economic analysis will not

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[33] As discussed in the OEL#1, the WHO recommends 2% as discount rate for health projects. The sensitivity analyses use values from 2% to 9%.

[34] RE-397-1: Currently, the score for the economic analysis section is calculated using the maximum value of the cost-benefit analysis and the analysis of cost-effectiveness. However, these analyzes cannot be applied to loans in support of policy reform.

[35] Good Practice Standards for the Evaluation of Public Sector Operations. Evaluation Cooperation Group, Working Group on Public Sector Evaluation, 2012 Revised Edition. February 2012.

[36] According to the ECG, PBPs should be evaluated according to relevance, effectiveness and sustainability. Efficiency was not included as a criterion, given that the dimensioning of the PBP is linked to the financing gap of a country, being independent of the benefits of the project.

be carried out for this type of loan as reported to the Bank's Board. Therefore, JA-L1080 does not include an economic analysis and, therefore, the economic analysis is not considered for purposes of measuring the evaluability score in the DEM of this programme.

II. FINANCING STRUCTURE AND MAIN RISKS

A Financing Instruments

2.1 The programme's total cost is estimated to be US$100 million, financed by the Ordinary Capital of the Bank (OC). The programme will be financed through: (i) a loan for the first operation of the programmatic policy-based loan series in the amount of up to US$50 million; and (ii) a specific investment loan in the amount of up to US$50 million (Table 1). Jamaica's projected gross financing requirements for FY 2018/2019 are estimated at around J$146.9 billion, equivalent to 7.2% of GDP, mostly caused by principal repayments (overall deficit estimated at 2.8% of GDP). [37] Over two-thirds of financing is expected to come from domestic sources. This operation will contribute to the external, official financing. Therefore, the loan dimensioning is justified under the Bank's Policy- Based Loans Guidelines for Preparation and Implementation (CS-3633-2), paragraph 3.27 (b).

Table 1. Investment Loan- Budget (US$)

Category	IDB
Component 1: Organization and consolidation of integrated health services networks	**40,155,000**
Subcomponent 1.1 Strengthening primary care	9,500,000
Subcomponent 1.2 Increasing the capacity and efficiency of hospital services	30,655,000
Component 2: Improvement of management, quality and efficiency of health services	**7,500,000**
Programme administration and evaluation	**2,345,000**
TOTAL	**50,000,000**

2.2 The hybrid structure of the programme has been chosen to meet the programme's objectives. The policy measures in the first programmatic operation will address the risk factors that cause NCDs and promote early detection and adequate clinical management of these illnesses. The policy measures of the second operation will show progress in the implementation of these policies and programmes. The investment loan components, in turn, will finance activities that will strengthen integrated health networks including primary health care. Additionally, the investment loan will provide resources for the adoption of innovative technologies in telehealth, and for the finalization and implementation of the IS4H. These investments will allow the government to enhance the quality of public health services available to address NCD prevention, management and treatment.

2.3 Use of the programmatic loan option, wherein disbursement conditions are specified at the beginning of each operation, is appropriate since the key steps of the policies it supports are clear and are part of well-established government agenda, but flexibility is required to finalize the policy conditionalities. The use of

[37] On October 22nd, 2018 the exchange rate is JMD134=US$1.

this modality also signals the high level of commitment by the government to making advancements in the health sector in close collaboration with the Bank. The specific policy measures that must be fulfilled as a requirement for disbursements are presented in the Policy Matrix (Annex II).

2.4 The PBP loan disbursement is planned during the first year. Given the fiscal space limitations that could arise and the length of the procurement processes, it was agreed with the government that the execution of the programme's investment loan will be spanned over five years to ensure achieving the desired outcomes and impact.

Table 2. Investment Loan - Disbursements (US$)

	2019	2020	2021	2022	2023	TOTAL
IDB	1,530,547	15,625,940	17,685,330	11,209,926	3,948,257	50,000,000
%	3.0	31.3	35.5	22.4	7.8	100

B Environmental and Social Safeguard Risks

2.5 According to the Environment and Safeguards Compliance Policy (OP-703) this operation was classified as Category “B”, due to the social and environmental risks and impacts generated by infrastructure works in three Hospitals (Spanish Town Hospital, May Pen Hospital and St. Ann’s Bay Hospital). These impacts will be temporal, localized, and mitigated by defined ESMP’s measures. The Programme’s Environmental and Social Analysis (ESA) and Environmental and Social Management Plan (ESMP) prepared, included meaningful consultations. These documents were published by the IDB[38] website on July 26, 2018. The Programme evaluation for natural disaster risk OP-704 was classified as type 1 moderate, because flooding, earthquake and tropical storm exposures. According to the OP-761 negative gender impacts among women are not likely, due to the operation.

2.6 The key Programme’s estimated risks and impacts are temporal and related to demolition, expansion and upgrading of infrastructure, as follows: (i) environmental and occupational health and safety, which were assessed as low; and (ii) potential food vendors income in St. Ann’s Bay Hospital, and patient’s medical services disruption, both assessed as moderate. The ESMP defined the required mitigation measures in the case of income losses with special attention to address vulnerable sellers’ needs; and with activities to ensure continuity of the medical services, avoiding health risks.

C Fiduciary Risk

2.7 The two fiduciary risks of the programme's investment loan components (and mitigation measures), evaluated using the Institutional Capacity Assessment System methodology, are: (i) If there is weak financial management and procurement capacity in the MOH, the programme execution could incur delays (medium-high)(the Procurement Specialist and Financial Specialist personnel should be suitably skilled, recruited and assigned to the programme in a timely

[38] https://www.iadb.org/es/project/JA-L1049.

manner; and (ii) If programme fiduciary staff are unfamiliar with IDB procurement, disbursement, and financial reporting procedures, fiduciary processes could be affected, negatively impacting programme implementation (medium)(create capacity within the PEU through in-house training in IDB's procurement and financial management procedures and requirements).

D Other Key Issues and Risks

2.8 An institutional and risk assessment has identified six Public Management and Governance risks (and their mitigation measures): (i) If there is no/low knowledge transfer from PEU/suppliers to MOH staff and users, institutional strengthening may not occur, which would affect current/future implementation capacity for programmes (medium-high) (PEU terms of reference must incorporate knowledge transfer); (ii) if the programme execution plan, developed by key stakeholders and approved through consensus, may include an unrealistic schedule, may cause delays in work (high) (receive input from multiple stakeholders to ensure a realistic PEP timeline); (iii) tension between MOH and PEU staff as a result of salary differences (medium-high) (develop operational chart to outline governance structure, role and function of PEU in relation to wider MOH functions and sensitize staff); (iv) if there is low perception of ownership within the MOH, behavioural change may not occur as expected, reducing the possibility of achieving programme objectives (medium-high) (high level sponsorship and internal promotion of the project); (v) if there is little information sharing among the PEU, MOH, MOFPS and IDB, coordination may be lacking, resulting in low-quality products (medium-high) (establish communication plan among relevant actors with monitoring mechanisms); and (vi) if health information systems are not compatible between primary and secondary health facilities and the MOH, information will not flow as required, leading to patient care delays and lower quality services (medium) (contract system development to ensure compatibility). Participants agreed that the most appropriate PEU model to mitigate these risks would be the hiring of individual consultants in an integrated PEU with loan financing. The PEU would be coordinated by a focal point appointed by the MOH with a Steering Committee with high-level management and monitoring functions composed of MOH executives and broad representation of Government stakeholders.

III. IMPLEMENTATION AND MANAGEMENT PLAN

A. Summary of Implementation Arrangements

1. Programmatic Policy Based Loan

3.1 The Executing Agency (EA) will be the Ministry of Finance & Public Service (MOFPS), which will be responsible for: (i) coordinating with the MOH and other relevant entities involved in the PBP's execution and presenting to the Bank evidence of the fulfilment of the policy conditions of the policy matrix; (ii) promoting actions to achieve the policy objectives defined in the programme; and (iii) compiling, maintaining, and delivering to the Bank the necessary information, indicators, and parameters to monitor and evaluate programme outcomes.

3.2 The disbursement of the first operation of the PBP is planned for December 2018.

3.3 **Special Contractual Conditions prior to single loan disbursement of the PBP: The single disbursement of loan resources will be subject to the Borrower's compliance with the policy conditions of the first operation summarized in the Policy Matrix and the Policy Letter, as well as the compliance with the conditions contained in the loan contract.**

2. Investment Loan

3.4 The EA will be the MOH, which will establish a PEU responsible for programme administration, including planning, budgeting, accounting, procurement, application of social and environmental safeguards, monitoring, and reporting regarding progress on programme implementation. The PEU will include a project manager and specialists in civil engineering, health informatics, procurement, financial management, monitoring and evaluation, as well as project support staff. Specialized external consulting services will be contracted by the PEU for the preparation of infrastructure renovation and building plans, supervision of construction, and development of technical specifications for medical equipment procurement. Technical and fiduciary staff from the MOH will work closely with PEU specialists so that the MOH benefits from knowledge transfer and capacity strengthening.

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

3.6 **Programme Operating Manual.** The policies, procedures, rules, and detailed responsibilities of the PEU during programme execution are defined in the Programme Operating Manual (POM), which sets forth standards and guidelines for the EA regarding all areas of programme execution, including programming, execution and financial plan, fiduciary arrangements, monitoring and reporting, among others. The POM also describes the roles and means of coordination among stakeholder agencies, particularly regarding assigning budget space, accompanying programme implementation, and processing potential adjustments to activities and goals.

3.7 **Special contractual Conditions prior to the first disbursement of the Investment Loan: The Executing Agency will provide evidence to the Bank's satisfaction of: (i) the approval of the POM by the EA in accordance with the terms and conditions previously agreed upon between the MOH and the Bank; and (ii) the creation of the PEU, including the assignment or hiring of its project**

manager, as well as one procurement management specialist and one financial management specialist. These conditions are essential to guarantee that the rules of operation and an adequate team will be in place to initiate and conduct programme execution.

3.8 **Procurement.** The PEU will apply the Policies for the Procurement of Works and Goods Financed by the Bank (GN-2349-9) and the Policies for the Selection and Contracting of Consultants Financed by the Bank (GN-2350-9), in addition to the dispositions contained in the Fiduciary Agreements and Arrangements based on the fiduciary context of the MOH as revealed through the institutional analysis exercise. For all contracts below the Bank's threshold for Price Comparison (shopping) for works (US$150,000) and goods and non-consulting services (US$25,000), the Bank permits the use of the Jamaican Procurement Sub-system of Limited Tender/Restricted Bidding. The Bank will exercise ex ante supervision of the procurement processes for the first of each type of acquisition (works, equipment, consulting firms, etc.) as well as those involving international competition.

3.9 **Direct contracting.** The individual consultants of the PEU initially hired through a competitive process with resources from the Technical Cooperation projects ATN/16573-JA and ATN/16789-JA will have the financing source of their contracts shifted to the loan operation under a direct contracting procedure in order to provide continuity of services per GN-2350-9, ¶5.4 (a) (REL#7, ¶5.1).

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

3.11 **Auditing.** The PEU will be responsible for submitting the following documents to the Bank: (i) Annual Audited Financial Statements (AFS) of the programme, to be submitted within 120 days after the close of each fiscal year; and (ii) final audited financial statements, to be submitted within 120 days after the final disbursement date of the programme. The audit of the programme activities and financial statements must be conducted by an independent external audit firm acceptable to the Bank and contracted by the EA. Audits will be performed in compliance with the Bank's guidelines and terms of reference for external audit.

B. Summary of Arrangements for Monitoring Results

3.12 **Monitoring.** The programme will be monitored according to the dispositions contained in the Monitoring and Evaluation Plan and referring principally to: (i) the policy and means of verification matrices, for the programmatic loan; and (ii) the results and outputs indicators of the Results Matrix.

3.13 Monitoring in terms of the PBP loan will involve the following Bank instruments: (i) Results Matrix; (ii) Means of Verification Matrix; (iii) PMR; (iv) Project Completion Report (PCR); and (v) administration missions. The MOFPS will follow progress regarding the fulfilment of the conditions of the policy matrix and will submit a request for the single disbursement with evidence in agreement with the means of verification.

3.14 The monitoring of the programme for the investment loan will employ the following standard Bank instruments: (i) PEP and AOP; (ii) PP; (iii) Result Matrix; (iv) PMR; and (v) audited financial statements. Semi-annual progress reports will be presented by the EA, through the PEU, within thirty (30) days after the end of the corresponding semester and should include a description of the physical and financial execution of activities in the corresponding period as well as the relevant issues relating to implementation, risks, mitigation measures, and environmental and social safeguards.

3.15 **Evaluation.** An evaluation will measure the impacts using the model of differences in differences, which compares treatment units with units not treated with data from before and after the implementation. In this case, the main comparison will be between the primary health care centres and their associated hospitals with similar centres in neighbouring parishes, using instruments to measure access to care and quality of service at the health centres, as well as information on wait time and referrals to and from the accident and emergency departments at the hospital level. An evaluation will also determine the feasibility of scaling up the CCM model based on operational and clinical management results.

IV. POLICY LETTER

4.1 The Bank and the Government of Jamaica have agreed on the macroeconomic and sector policies set out in the Policy Letter (REL#1), which sets forth the strategy supported by the programme's areas of action described in this document.

Development Effectiveness Matrix		
Summary		
I. Corporate and Country Priorities		
1. IDB Development Objectives	**Yes**	
Development Challenges & Cross-cutting Themes	**-Social Inclusion and Equality -Gender Equality and Diversity -Institutional Capacity and the Rule of Law**	
Country Development Results Indicators	**-Maternal mortality ratio (number of maternal deaths per 100,000 live births) -Beneficiaries receiving health services (#)***	
2. Country Development Objectives	**Yes**	
Country Strategy Results Matrix	**GN-2868**	**Improve the Public Health System: Increase the usage of primary care facilities; Reduce the disability-adjusted life years lost due to NCDs;Reduce the prevalence of adult risk factors.**
Country Program Results Matrix	**GN-2915-2**	**The intervention is included in the 2018 Operational Program.**
Relevance of this project to country development challenges (If not aligned to country strategy or country program)		
II. Development Outcomes - Evaluability		**Evaluable**
3. Evidence-based Assessment & Solution	**10.0**	
3.1 Program Diagnosis	**3.0**	
3.2 Proposed Interventions or Solutions	**4.0**	
3.3 Results Matrix Quality	**3.0**	
4. Ex ante Economic Analysis**	**9.0**	
4.1 Program has an ERR/NPV, or key outcomes identified for CEA	**3.0**	
4.2 Identified and Quantified Benefits and Costs	**3.0**	
4.3 Reasonable Assumptions	**1.0**	
4.4 Sensitivity Analysis	**2.0**	
4.5 Consistency with results matrix	**0.0**	
5. Monitoring and Evaluation	**10.0**	
5.1 Monitoring Mechanisms	**2.5**	
5.2 Evaluation Plan	**7.5**	
III. Risks & Mitigation Monitoring Matrix		
Overall risks rate = magnitude of risks*likelihood	**Medium**	
Identified risks have been rated for magnitude and likelihood	**Yes**	
Mitigation measures have been identified for major risks	**Yes**	
Mitigation measures have indicators for tracking their implementation	**Yes**	
Environmental & social risk classification	**B**	
IV. IDB´s Role - Additionality		
The project relies on the use of country systems		
Fiduciary (VPC/FMP Criteria)	**Yes**	**Financial Management: Budget, Treasury. Procurement: Information System, Price Comparison.**
Non-Fiduciary	**Yes**	**Monitoring and Evaluation National System.**
The IDB's involvement promotes additional improvements of the intended beneficiaries and/or public sector entity in the following dimensions:		
Additional (to project preparation) technical assistance was provided to the public sector entity prior to approval to increase the likelihood of success of the project	**Yes**	

Note: (*) Indicates contribution to the corresponding CRF's Country Development Results Indicator.

(**) The efficiency analysis corresponds only to the benefits and costs of the investment operation. □

Evaluability Assessment Note:

The program's objective is to improve the health of Jamaica's population by strengthening comprehensive policies for the prevention of NCDs risk factors and for the implementation of a chronic care model with an improved access to strengthened and integrated services.

The project presents a good description of the problems to be addressed supported by contextualized evidence of the burden of disease associated with NCDs in Jamaica and its main risk factors. Also, the description presents evidence of the challenges of the health sector to improve the efficiency in NCDs prevention and treatment. The proposed solutions in the policy-based and investment components complement each other adequately and present a clear vertical logic. The Results Matrix reflects this vertical logic, incorporating expected results that reflect both components of the operation and output and outcome indicators that are SMART.

The economic analysis considers only the benefits and costs of the investment component and presents a rate of return of 18%. It is noted, however, that some benefits considered, although they could be attributable to the proposed interventions, are not included in the vertical logic of the program (particularly those derived from improvements in sexual and reproductive health and child health).

The project includes a quasi-experimental impact evaluation that will contribute to evaluate the effectiveness of the program on some expected results and to inform the attribution analysis.

□

POLICY MATRIX

Specific Objectives	Programmatic I Policy Conditions	Compliance Status of Each Policy Measure for First Tranche[1]	Triggers for the Programmatic II Policy Conditions
Component 1. Macroeconomic Stability			
Maintain a stable macroeconomic framework, in line with what is established in the Policy Matrix and Policy Letter.	(1.1) Maintenance of an appropriate macroeconomic policy framework consistent with the programme's objectives and in accordance with the provisions of the Policy Matrix and the Policy Letter.	To be completed by Q4 2018.	(1.1) Maintenance of an appropriate macroeconomic policy framework consistent with the programme's objectives and in accordance with the provisions of the Policy Matrix and the Policy Letter.
Component 2. NCD risk factors reduction			
Reduce prevalence of tobacco use in the population.	(2.1). Decision by Cabinet to draft a Bill on Tobacco Control Legislation that is in keeping with the obligations under the World Health Organization (WHO) Framework Convention on Tobacco Control (FCTC), related, among others to: (i) the regulation of interactions of GOJ officials with the tobacco industry; (ii) regulation of price and related measures, (iii) the full and mandatory prohibition on tobacco advertising, promotion and sponsorship, including a ban on point-of-sale tobacco displays; and (iv) compliance with the Protocol to Eliminate Illicit Trade on Tobacco Products.	Completed.	(2.1a) Draft Bill of a CTL submitted to the Legislative Committee of Cabinet that keeps with the treaty obligations under the FCTC, related, among others to: (i) the regulation of interactions of GOJ officials with the tobacco industry; (ii) regulation of price and related measures, (iii) the full and mandatory prohibition on tobacco advertising, promotion and sponsorship, including a ban on point-of-sale tobacco displays; and (iv) compliance with the Protocol to Eliminate Illicit Trade on Tobacco Products. (2.1b) Ratification of the WHO FCTC Protocol to Eliminate Illicit Trade in Tobacco Products.

[1] This information is merely indicative as of the date of this document. As set forth in document CS-3633-2 (Policy-based Loans: Guidelines for Preparation and Implementation), compliance with all of the conditions specified for disbursement, including the maintenance of an appropriate macroeconomic policy framework, will be verified by the Bank at the time of the request for the corresponding disbursement made by the Borrower and duly reflected in the Disbursement Eligibility Memorandum.

Specific Objectives	Programmatic I Policy Conditions	Compliance Status of Each Policy Measure for First Tranche[1]	Triggers for the Programmatic II Policy Conditions
Reduction in Harmful consumption of alcohol.	(2.2) Development and approval by MOH of a Concept Paper for the Reduction of Harmful Use of Alcohol Policy aligned to WHO guidelines and best-buys regarding advertisement and sponsorship, availability and pricing and related measures.	To be completed by Q4 2018.	(2.2) Approval by MOH and submission to Cabinet of the Green Paper for the Reduction of Harmful Use of Alcohol Policy aligned to WHO guidelines and best-buys regarding advertisement and sponsorship, availability and pricing and related measures.
Jamaica Moves: Health promotion and prevention of Non-Communicable Diseases (NCDs).	(2.3) Within the Jamaica Moves at School Programme, development and approval by MOH of a plan to promote healthy eating habits (that include provisions to limit the sugar content of beverages offered at school), physical activity (that include measures to facilitate increased physical activities amongst students) and age appropriate health check-ups (that include strengthening capacity at schools to identify and respond to at-risk students for NCDs).	Completed.	(2.3) Jamaica Moves at School Programme implements the plan to promote healthy eating habits, physical activity and age appropriate health check-ups, achieving at least the following results: institutionalize at least one measure in at least 50% of targeted schools that facilitate increased physical activity amongst students by June 2019; to institutionalize at least two measures in at least 50% of targeted schools that facilitate healthier food options by June 2019.
Healthy diet: reduce malnutrition in infancy and childhood.	(2.4) MOH approval and Cabinet submission of an Infant and Young Child Feeding Policy and Strategic Plan to address deficiencies and obstacles experienced in infant and young child nutrition and to provide the context for the development of innovative approaches to influence the determinants of nutritional behaviour, including exclusive breastfeeding during the first six-months of an infant's life, adequate complementary feeding, support to the mother and the Baby Friendly Hospital Initiative (BFHI).	Completed.	(2.4) Implementation of an Infant and Young Child Feeding Policy and Strategic Plan to address deficiencies and obstacles experienced in infant and young child nutrition and to provide the context for the development of innovative approaches to influence the determinants of nutritional behaviour, demonstrated by at least five hospitals meeting the BFHI standards, at least 14 community support groups established and at least 70 persons certified as Community Infant and Young Child Feeding Support Group Facilitators.

Specific Objectives	Programmatic I Policy Conditions	Compliance Status of Each Policy Measure for First Tranche[1]	Triggers for the Programmatic II Policy Conditions
Healthy eating: providing useful and actionable information to consumers.			(2.5) Implementation of the National Food-based dietary guidelines through a social marketing campaign to inform consumers regarding healthy eating habits.
Component 3. NCD early detection and clinical management			
Strengthening the delivery system design for priority NCDs Care.	(3.1) MOH approval for the development of a Chronic Care Model (CCM) Concept Paper and Policy for the risk factor reduction, early detection, treatment, diagnosis and support for priority NCDs (cardiovascular disease, diabetes; cervical, breast, prostate and colorectal cancer; depression; asthma).	To be completed by Q4 2018.	(3.1) MOH approval of the CCM Concept Paper, Policy and Implementation Plan for the risk factor reduction, early detection, treatment, diagnosis and support for priority NCDs (cardiovascular disease, diabetes; cervical, breast, prostate and colorectal cancer; depression; asthma) and of a phased implementation of the plan to be piloted in at least one health network.
	(3.2) MOH approval of a Concept Paper for the Development of Screening Guidelines of Priority NCDs (hypertension; diabetes; cervical, breast, prostate and colorectal cancer; depression) at the primary health care (PHC) level to promote early detection.	To be completed by Q4 2018.	(3.2) Approval by MOH and initiation of the implementation of the screening guidelines for at least two of the priority NCDs (hypertension; diabetes; cervical, breast, prostate and colorectal cancer; depression) at the PHC level in at least one health network to promote early detection.
Improving decision support for the delivery of priority NCDs care through Guidelines of Standards of Care for Priority NCDs.	(3.3) Development of guidelines for the nutritional management of obesity, diabetes, hypertension and cancer in hospital and health centre settings, which include the development and implementation of the nutrition care plan based on nutritional adequacy, caloric control, nutrient density, variety and balance, as well as the individual anthropometric, biochemical, clinical and dietary data; the evaluation,	To be completed by Q4 2018.	(3.3) Approval by MOH and on-line publication of guidelines for the nutritional management of obesity, diabetes, hypertension and cancer in hospital and health centre settings which include the development and implementation of the nutrition care plan based on nutritional adequacy, caloric control, nutrient density, variety and balance, as well as the individual anthropometric, biochemical, clinical

Specific Objectives	Programmatic I Policy Conditions	Compliance Status of Each Policy Measure for First Tranche[1]	Triggers for the Programmatic II Policy Conditions
	documentation and monitoring of nutritional care; directives for self-management and indications for referrals to health care team.		and dietary data; the evaluation, documentation and monitoring of nutritional care; directives for self-management and indications for referrals to health care team.
Strengthening of mental health services in community-based settings and of mental health promotion and prevention strategies.	(3.4) Development of the National Strategic Plan on Mental Health (NSPMH) with the objective, among others, to provide comprehensive, integrated and responsive mental health services in community-based settings and to implement strategies for promotion and prevention in mental health.	To be completed by Q4 2018.	(3.4) Approval by MOH of the NSPMH with the objective, among others, to provide comprehensive, integrated and responsive mental health services in community-based settings and to implement strategies for promotion and prevention in mental health.
Strengthening the Health Information Systems for NCD surveillance and clinical monitoring and evaluation.	(3.5) Development of the National Plan of Action for Information Systems for Health (IS4H) which includes among others, elements that will support a set of standards, interoperability across components of information systems and facilitate tracking of patients throughout the public health sector, a referral system, modules to support NCD self-management and follow-up appointments, as well as TeleMedicine and TeleHealth initiatives.	Completed.	(3.5a) Approval by Cabinet of the NPAI which includes among others, elements that will support a set of standards, interoperability across components of information systems and facilitate tracking of patients throughout the public health sector, a referral system, modules to support NCD self-management and follow-up appointments, as well as TeleMedicine and TeleHealth initiatives. (3.5b) Implementation of the Policy and Legal Framework Work Stream of the NPAI through the development of a Policy to govern the collection, use and disclosure of personal health information whether it exists on paper or other formats, as provided in the draft Data Protection Bill (and the Personal Health Information Protection (PHIP) Policy Provisions).

DOCUMENT OF THE INTER-AMERICAN DEVELOPMENT BANK

PROPOSED RESOLUTION DE-__/18

Jamaica. Loan ____/OC-JA to Jamaica. Support for the Health Systems Strengthening for the Prevention and Care Management of Non-Communicable Diseases Programme

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 Jamaica, as Borrower, for the purpose of granting it a financing to cooperate in the execution of the Support for the Health Systems Strengthening for the Prevention and Care Management of Non-Communicable Diseases Programme. Such financing will be for the amount of up to US$50,000,000 from the resources of the Bank's Ordinary Capital, and will be subject to the Financial Terms and Conditions and the Special Contractual Conditions of the Project Summary of the Loan Proposal.

(Adopted on ___ _____ 2018)

LEG/SGO/CCB/EZSHARE-1331705865-7171
JA-L1049

DOCUMENT OF THE INTER-AMERICAN DEVELOPMENT BANK

PROPOSED RESOLUTION DE-__/18

Jamaica. Loan ____/OC-JA to Jamaica. Support for the Health Systems Strengthening for the Prevention and Care Management of Non-Communicable Diseases Programme

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 Jamaica, as Borrower, for the purpose of granting it a financing to cooperate in the execution of the Support for the Health Systems Strengthening for the Prevention and Care Management of Non-Communicable Diseases Programme. Such financing will be for the amount of up to US$50,000,000 from the resources of the Bank's Ordinary Capital, and will be subject to the Financial Terms and Conditions and the Special Contractual Conditions of the Project Summary of the Loan Proposal.

(Adopted on ___ _____ 2018)

LEG/SGO/CCB/EZSHARE-1331705865-7172
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