Board of Executive Directors
For consideration
On or after 26 October 2016

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Simultaneous Disclosure

To: The Executive Directors

From: The Secretary

Subject: Guyana. Proposal for a loan for the project “Support to Improve Maternal and Child Health”

Basic Information:

Loan type .....Specific Investment Operation (ESP)
Borrower ..... Co-operative Republic of Guyana
Amount ..... up to US$4,000,000
Source .....Single Currency Facility Ordinary Capital
Amount ..... up to US$4,000,000
Source .....Fund for Special Operations

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Remarks: This operation is not included in Annex III of document GN-2849, "2016 Operational Program Report", approved by the Board of Executive Directors on 3 March 2016. Therefore, the operation does not qualify for approval by Simplified Procedure.

The financing for this operation corresponds to a parallel loan within the framework of the multilateral debt relief and concessional finance reform of the Bank.

Reference: GN-1838-1(7/94), DR-398-17(1/15), GN-2849(3/16), AB-2504(11/06), AG-9/06, AB-2946(6/13), AG-9/13

PUBLIC
SIMULTANEOUS DISCLOSURE

DOCUMENT OF THE INTER-AMERICAN DEVELOPMENT BANK

GUYANA

SUPPORT TO IMPROVE MATERNAL AND CHILD HEALTH

(GY-L1058)

LOAN PROPOSAL

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ELECTRONIC LINKS

REQUIRED

1. Pluriannual Execution Plan (PEP)
2. Monitoring and Evaluation Plan
3. Environmental and Social Management Report (ESMR)
4. Procurement Plan

OPTIONAL

1. Institutional Assessment of the Ministry of Public Health
2. Ex-Ante Economic Analysis
3. Environmental and Social Analysis
4. Safeguard Policy Filter (SPF) and Safeguard Screening Form (SSF)
5. Operations Manual

ABBREVIATIONS	
AOG	Auditor General's Office
CHWs	Community Health Workers
CMO	Chief Medical Officer
DHS	Demographic Health Survey
EmONC	Emergency Obstetric and Newborn Care
EONC	Essential Obstetric and Newborn Care
ESMP	Environmental and Social Management Plan
FSO	Fund for Special Operations
GPHC	Georgetown Public Hospital Corporation
ICAS	Institutional Capacity Assessment System
ICER	Incremental cost-effectiveness ratio
LAC	Latin America and Caribbean
LB	Live Births
MCH	Maternal and Child Health
MHI	Mesoamerican Health Initiative
MICS	Multiple Indicator Cluster Survey
MoPH	Ministry of Public Health
MoU	Memorandum of Understanding
OC	Ordinary Capital
OM	Operations Manual
PAHO	Pan-American Health Organization
PEP	Project Execution Plan
PIH	Pregnancy Induced Hypertension
PP	Procurement Plan
PPH	Postpartum Hemorrhage
QIS	Quality Improvement Strategy
RDC	Regional Democratic Councils
RHA	Regional Health Authorities
TC	Technical Cooperation
UNFPA	United Nations Population Fund
WHO	World Health Organization

PROJECT SUMMARY
GUYANA
SUPPORT TO IMPROVE MATERNAL AND CHILD HEALTH
(GY-L1058)

Financial Terms and Conditions					
Borrower: The Co-operative Republic of Guyana				**Ordinary Capital (OC)**	**Fund for Special Operations (FSO)**
Executing Agency: Ministry of Public Health (MoPH)			**Amortization Period:**	30 years	40 years
			Disbursement Period:	5 years	5 years
Source	**Amount (US$)**	**%**	**Grace Period:**	6 years	40 years
IDB (OC):	4,000,000	50	**Supervision and Inspection Fee:**	(b)	N/A
IDB (FSO):	4,000,000	50	**Interest rate:**	SCF Fixed (a)	0.25%
			Credit Fee:	(b)	N/A
			Currency of Approval:	United States dollars drawn from the OC	United States dollars drawn from the FSO
Total:	8,000,000	100			

Project at a Glance

Project Objective/Description:

The objective of this project is to contribute to the reduction of maternal, perinatal, and neonatal deaths in Guyana (¶1.33).

Special Contractual Clauses prior to the first disbursement:

The following conditions prior to first disbursement shall be met: (i) the Permanent Secretary of MoPH has approved and put into effect the project's Operations Manual (OM), in terms and conditions previously approved by the Bank; (ii) the five key personnel have been hired in accordance with terms of reference duly approved by the Bank; and (iii) the Steering Committee has been established by the MoPH (¶3.6).

Special Contractual Clauses of execution:

The implementation of the Environmental and Social Management Plan (ESMP) will be a condition prior to the execution of hospital activities under Component II, (ii) and (iii) (¶2.3).

The implementation of a Risk Management and Emergency Response Plan (RM&ERP) will be a condition prior to the execution of hospital-related construction under Component II, (ii) (¶2.3).

Exceptions to Bank Policies:

None.

Strategic Alignment

Challenges(c):	SI	☑	PI	☐	EI	☐
Cross-Cutting Themes(d):	GD	☑	CC	☐	IC	☐

(a) The Borrower shall pay interest on the outstanding balance of the OC loan at a Libor based rate. Each time the outstanding balance reaches 25% of the net approved amount or $3 million, whichever is greater, the interest rate will be fixed.

(b) 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.

(c) SI (Social Inclusion and Equality); PI (Productivity and Innovation); and EI (Economic Integration).

(d) 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, Justification

1.1 **Macroeconomic conditions.** Guyana has experienced a decade of real positive economic growth between 2006 and 2015, averaging 4.3% per year. Economic growth for 2016 is projected at 4%, as a result of high remittances, low oil prices, and oil-related FDI inflows. Inflation continues to be low (CPI was -1.8% in 2015[1]), currency and international reserves are stable, and total public debt as a share of GDP is manageable at 52%. The fiscal deficit will continue to be manageable at around 5% of GDP in 2016. The government has developed an investment strategy for the infrastructure and social sectors aimed at boosting productivity and fostering economic activity in the medium-term[2]. Recent analysis has shown that access to external financing appears to be a major constraint to accelerating growth in Guyana.[3]

1.2 **Improvements in health indicators.** Guyana has made significant advancements in the health sector in the past two decades, with the burden of communicable diseases such as HIV/AIDs, malaria, and tuberculosis decreasing and life expectancy increasing from 62 years in 1991 to 67 years in 2015.[4] The Country met the Millennium Development Goals targets for nutrition, child health (under five years of age), communicable diseases[5], and water and sanitation,[6] with positive impacts on health outcomes. The maternal mortality ratio decreased 26% between 2000 and 2014, while the infant mortality rate (less than one year of age) decreased 12% in the same period[7].

1.3 **The health system in Guyana.** The national health system is public, universal, and free to all Guyanese. Most people depend directly on the public sector, while an estimated 5% of the population access private services through voluntary private health insurance. Out-of-pocket payments are estimated at 8-10% of total health spending[8]. The Ministry of Public Health (MoPH) is the steward of the system, responsible for policy-setting, regulation and supervision, and health surveillance. The public system is financed by general taxation; public health expenditures represented 3.1% of GDP in 2014.[9] Regional Democratic Councils (RDCs) are responsible for service provision, under the guidance and oversight

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1 http://www.statisticsguyana.gov.gy/prices.html.
2 2016. IMF Country Report N16/216.
3 CDC Guyana 2016.
4 PAHO Basic Indicators.
5 The percentage of children under five who suffer from moderate/mild malnutrition reduced from 12% in 1997 to 6% in 2008. The under-five mortality rate declined from 102/1,000 live births (LB) in 1991 to 24 in 2014. Although prevalence of HIV/Aids remains high, incidence has decreased and access to antiretroviral drugs reached 93% in 2012. Sources: MDG Progress Report 2011, Chief Medical Officer (CMO) Report 2014, Health Vision 2020, and WHO Observatory.
6 94% of households have access to improved sources of drinking water and 95.4% to improved sanitation facilities. Guyana Multiple Indicator Cluster Survey (MICS) 2014.
7 Hogan et al. 2010 and World Bank data.
8 Guyana Health Financing Review, PAHO 2013.
9 Below regional average of 3.7%. MoPH and World Development Indicators 2016.

of the MoPH[10]. The health care network includes health posts, health centers, district hospitals, regional hospitals, and national referral hospitals, the primary of which is Georgetown Public Hospital Corporation (GPHC), a reference for highly specialized care for the entire country.

1.4 **Country's administrative structure.** Guyana is organized in 10 regions, with 90% of the population concentrated in the coastal eastern part of the country (regions 2, 3, 4, 5, 6 and 10) and the remaining 10% located in the rural interior (regions 1, 7, 8 and 9) (see map of Guyana). The main ethnic groups in the coastal areas are Indo-Guyanese and Afro-Guyanese, while the majority of the people living in the rural interior are indigenous.[11]

1.5 **Challenges remaining in maternal and neonatal health.** Despite the progress achieved, Guyana continues to experience maternal and infant mortality rates that are among the highest in the Latin America and Caribbean (LAC) region.[12] The maternal mortality ratio is estimated at 121 per 100,000 LB and the infant mortality rate is estimated at 22 per 1,000 LB.[13] The majority of infant deaths occur in the neonatal period (up to 28 days after birth); in 2014, 93% of deaths in children less than one year of age occurred in the neonatal period. In the same year, there were 177 cases of stillbirth.[14] The main causes of maternal mortality are postpartum hemorrhage (PPH) and pregnancy induced hypertension (PIH), while 70% of neonatal deaths are caused by prematurity, followed by respiratory illness (20%).[15] Pregnancy in adolescence (10-19 year of age) is high (about 20% of all LB),[16] representing a higher risk for both mothers and newborns.[17]

1.6 **The main factors contributing to maternal and neonatal outcomes in Guyana** are related to inadequate access, use, and quality of reproductive, maternal, and neonatal health services and the organization of the health care network[18].

1.7 **Access and use of reproductive, maternal, and neonatal health services.** In Guyana, over 90% of pregnant women attend at least one antenatal consultation with a skilled professional, 87% have access to four antenatal consultations, and 93% of births are delivered in a health facility.[19] Although these indicators are positive, important challenges remain. For instance, the unmet need[20] for contraception is 28%[21] and only 54% of women initiated

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10 Health care provision was decentralized to RDCs in 1986. In 2005, Regional Health Authorities (RHAs) were established to assume responsibility for service provision in the regions. RHAs boards are appointed by the Minister of Health and they have service contracts with the MoPH. So far, one RHA has been implemented (Region 6) and it is expected that another four will be established by 2020.

11 Indigenous people (70,000 in total) exhibit the lowest health indicators in the country.

12 In LAC maternal mortality is 62.9 and infant mortality is 15.7 (PAHO Basic Indicators 2014).

13 CMO 2014.

14 2% of all births.

15 CMO 2014.

16 MDG Acceleration Framework, Government of Guyana 2014.

17 Adolescent Pregnancy: Review of Evidence. United Nations Population Fund (UNFPA) 2013.

18 MDG Acceleration Framework 2014; Demographic Health Survey (DHS) 2009; PAHO 2009.

19 MICS 2014.

20 Percentage of women 15-49 years married or in union who want to space or limit the number of births but are not using contraception.

antenatal care during the first trimester of pregnancy.[22] Of these, one in every 10 women had their first visit when they were already six or seven months pregnant. There are significant geographic inequities in access to health care, particularly in the rural interior locations. In Region 1, for instance, only 67% of women had four antenatal consultations, and in Region 9 institutional deliveries are estimated at 47%.[23] Unmet need for contraception varies between 22% in Region 6 to 40% in Region 1.[24]

1.8 According to the last Demographic and Health Survey (2009), the main barriers for accessing contraceptives, as reported by women of reproductive age, are health concerns and fear of side effects, which may be improved by health education and information through adequate family planning counselling and communication campaigns. According to the women interviewed, the main barriers for access and use of health care, on the supply side, are related to the insufficient availability of providers (reported by 49% of women) and drugs and other supplies (44%). On the demand-side, the main barriers include not wanting to go alone (16.8%) and having to take transport (15.8%).

1.9 Demand-side barriers can affect important patient decisions regarding the use of health services, particularly in the rural interior. Delays in recognizing signs of complications and deciding to seek care for an obstetric emergency, for instance, contribute to negative maternal and neonatal outcomes. In 2015, preliminary data indicates that 18% of all maternal deaths occurred during transportation to a health facility.[25]

1.10 **Quality of reproductive, maternal, and neonatal health services.** Quality of care remains a challenge in Guyana. Despite the high antenatal care coverage, for instance, only 22% of pregnant women were given at least two doses of tetanus toxoid vaccine and 67% received counselling on HIV. In Region 9, only 62% of pregnant women had their blood pressure measured and urine and blood samples taken, versus 98% in Region 4. In the postpartum period, merely 47.8% of check-ups occur less than four hours after delivery and 52% of newborns do not receive a postnatal care visit following birth.[26,27]

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[21] Studies estimate that 30% of maternal deaths are avoidable by the provision of family planning (Winikoff and Sulivan 1997). Access to reproductive services, information, and modern methods of contraception are key to maternal and neonatal wellbeing, as it helps delay the age of first birth and promotes optimum spacing between pregnancies. Planning a pregnancy also allows women to identify and mitigate underlying risk factors such as anemia.

[22] The relative contribution of antenatal care to reduce maternal and neonatal mortality is difficult to estimate; nevertheless, all care provided in these visits have been proved to make a difference: prevention, detection, and treatment of anemia; early detection and treatment of preeclampsia and eclampsia, with referral if necessary; screening for infections; and tetanus immunization, among others (Brouwere and Lerberghe 2001).

[23] It is estimated that 40% of maternal and neonatal deaths and stillbirths occur around the time of birth. A significant proportion of maternal mortality, for instance, is due to conditions not detectable antenatally (e.g. hemorrhage, sepsis). Hence, facility-based delivery and care around the time of birth is key to preventing avoidable deaths (Lancet Newborn Series 2014).

[24] MICS 2014.

[25] According to CMO Reports, in 2014 there were no cases of maternal deaths during transportation. In 2013, 11% of deaths occurred in the community or during transportation.

[26] Postnatal care is critical for newborns, particularly immediately after birth. Around three quarters of neonatal deaths occur in the first week, with up to half occurring within 24 hours of birth. UNICEF 2014.

[27] MICS 2014 and DHS 2009.

1.11 The quality of health care depends on many factors, including the availability of skilled health workers, an enabling environment (infrastructure, equipment, and supplies), and optimized clinical and management processes, which encompass the way in which care is delivered. In terms of human resources, the high rates of out migration of nurses and doctors trained in the country and the concentration of remaining health professionals in or near to the capital city of Georgetown constitute a challenge for the health system.[28] In addition, the available evidence suggests that the health workforce lacks the appropriate skills and competencies[29] as a result of insufficient on-the-job training and poor human resources management practices. While quality of care is a priority for the MPH, there is no quality improvement system in place at the majority of health facilities.

1.12 A survey conducted in 2010[30] showed that very few public hospitals have all the equipment required for the provision of essential and emergency obstetric and newborn care (EmONC), such as equipment for episiotomy, vacuum extraction, and forceps delivery. Only 10 hospitals, of 25, had a complete delivery set, a condition also found in 9 of 19 health centers. Essential supplies such as oxytocin, magnesium sulphate, and blood products are not always readily available.

1.13 In terms of processes, only 54% of public hospitals use partographs to monitor labour; a simple yet effective tool to reduce the incidence and outcomes of prolonged and obstructed labor. Documentation of key actions and decisions during the management of labor was also found to be low, even though this is a best practice in the treatment of any medical condition.[31] Failure in the way care is delivered, including the adherence to evidence-based clinical and management guidelines and protocols, can lead to inefficiencies and poor outcomes, such as avoidable mortality. Poor provider attitudes, lack of communication skills, and cultural insensitivities can also affect quality, and anecdotal evidence from Guyana suggests that patients can be exposed to such practices in public health facilities. Having updated guidelines and protocols in place, adequate supervisory capacity, accountability mechanisms, accurate information, and patient-centered and culturally-appropriate care are crucial to improve quality.

1.14 **Effectiveness of the healthcare network.** According to national norms, the maternal and neonatal healthcare network in Guyana should be organized as follows: district hospitals should have the capacity (infrastructure, equipment, supplies, and skilled workers) to perform low-risk births, initial EmONC, and appropriate referrals. In the rural interior, where geographical access to hospitals may be limited, health centres could be equipped to perform similar tasks. Regional hospitals should have the ability to resolve most obstetric and neonatal complications, including the provision of blood products (for transfusions) and cesarean sections (comprehensive EmONC). Finally, GPHC should be able to

[28] Many hospitals and health centers outside region 4 do not meet the MoPH' human resources standards (UNFPA 2010). Region 4 employs 73.6% of Guyana's physician workforce (PAHO 2010).

[29] In the 2010 UNFPA survey, a group of 36 providers scored an average of 75% on how to diagnose asphyxia and what to do if a newborn is not breathing or breathing slow.

[30] UNFPA 2010.

[31] UNFPA 2010.

manage all complications and very high-risk cases, such as pregnancies with twins (comprehensive EmONC).

1.15 The 2010 UNFPA survey revealed that most regional hospitals in Guyana do not fulfill all nine criteria to be considered a comprehensive EmONC facility[32]. While three of the regional hospitals carry out cesarean sections and blood transfusions, all were found to be lacking in at least one of the basic EmONC functions, such as manual delivery of the placenta or removal of retained products. A more recent health care assessment found similar results.[33] Although GPHC also presents deficiencies,[34] the population generally perceives the hospital to be better prepared to provide ambulatory and inpatient care. As a consequence, women and families from nearby regions often bypass district and regional hospitals to deliver low-risk births at the GPHC.[35] Currently, 41% of all births that happen in the country are concentrated at the GPHC. In 2014, 73% of these births were low risk cases that could have been delivered at a facility with a lower level of complexity.[36]

1.16 This excessive demand, combined with limitations in human resources, infrastructure and equipment, supplies, and processes affect GPHC's ability to provide quality care for women and newborns, particularly the most complicated cases; today, the majority of maternal and neonatal deaths that occur in the country are concentrated at this facility.[37] Given the country's resource constraints, it is important that the maternal and neonatal healthcare network operates effectively and efficiently, with the appropriate package of evidence-based and cost-effective interventions delivered at each level and the optimal mix of health workers.

1.17 **Theory of change.** The strategies proposed in this project are guided by two frameworks: the Safe Motherhood Initiative and the "three delays" model. The Safe Motherhood Initiative outlines that strategies to improve maternal and neonatal outcomes should focus on four pillars: (i) family planning; (ii) quality antenatal care; (iii) clean and safe delivery; and (iv) obstetric and neonatal emergency care. The "three delays" model proposes that maternal and neonatal outcomes can be improved by mitigating delays in: (i) deciding to seek appropriate medical help for an obstetric emergency; (ii) reaching an appropriate obstetric facility; and (iii) receiving adequate care when a facility is reached.[38]

1.18 **Expected results based on the theory of change and the problems identified.** To improve maternal and neonatal outcomes in Guyana, this project will focus on evidence-based interventions that will: (i) improve healthy pregnancy planning and spacing; (ii) increase iron prophylaxis; (iii) increase the detection of early signs of preeclampsia, placenta previa, and other risk factors

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[32] Criteria are: administer parenteral antibiotics; administer parenteral anticonvulsants; administer parenteral oxytocics; perform manual removal of the placenta; perform removal of retained products; perform assisted vaginal delivery; perform neonatal resuscitation (bag and mask); perform blood transfusions; and perform caesarean sections.

[33] Rapid healthcare system diagnostic conducted as part of project preparation.

[34] UNFPA 2010.

[35] Goede 2014.

[36] CMO 2014.

[37] In 2014, 55% and 93% of all maternal and neonatal deaths occurred in GPHC. CMO 2014.

[38] Barnes-Josiah et al. 1998.

for PPH, pregnancy-induced hypertension, and other maternal and neonatal conditions; (iv) improve knowledge, attitudes, and practices related to sexual and reproductive health, pregnancy, safe delivery, and newborn care; (v) improve access to essential and emergency obstetric and neonatal care services; (vi) increase institutional delivery (particularly for women located in the rural interior); (vii) increase the quality of skilled birth attendance; (viii) increase the number of complications that are treated according to norms; and (ix) increase the number of mothers and newborns that receive immediate postpartum care according to best practices.

1.19 **Interventions to improve access, use, quality, and effectiveness of reproductive, maternal, and neonatal health services.** Interventions targeted at the supply and demand for health services will be implemented in regions 3, 4, and 9,[39,40] benefiting directly an estimated 140,000 women and 9,000 newborns per year.[41] Interventions will be directed at the entire life-cycle: women of reproductive age, including adolescents, pregnancy, delivery, obstetric and neonatal complications, and postpartum.[42,43]

[39] Regions were selected based on two criteria: (i) burden of maternal and neonatal mortality; and (ii) scalability of interventions to other regions. Regions 3 and 4 are amongst the most populated and have the highest number of maternal and neonatal deaths. The context in these regions is urban or semi-urban, with the population closely located along the coastline. The MoPH has achieved high coverage of key interventions, such as institutional birth, so a strong push to improve quality is necessary. Interventions implemented in these regions could be scaled to other regions with similar contexts, such as 2, 5, and 6. On the other side, region 9 is located in Guyana's hinterlands, where indigenous communities are dispersed along a wide geographic area. Coverage of key interventions, such as institutional birth, is relatively low, so there is a need to improve the supply of services and encourage the demand. Lessons learnt in region 9 could be scaled up to other regions in the hinterlands, such as 1, 7, and 8. Regions 3, 4 and 9 concentrate 60% of the country's population. According to CMO Reports, 64% of maternal deaths, 93% of neonatal deaths, and 59% of stillbirths occur in these regions. By targeting interventions to these regions the project aims to achieve significant results.

[40] GPHC, in region 4, is the hospital with the highest capacity for maternal and neonatal care; it is important to improve the capacity of the hospital to attend complicated patients and to strengthen the network in this region to decentralize care for normal deliveries. Region 3 refers the highest number of low risk births to GPHC due to its proximity and the population's perception of improved quality of care. Strengthening the network in region 3 will decrease the number of unnecessary referrals to GPHC.

[41] Number of women in reproductive age and adolescents that reside in regions 3, 4, and 9 and number of expected LB per year in these regions.

[42] Most interventions proposed have been proven effective in countries that participate in the Mesoamerican Health Initiative (MHI) (Belize, Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua, and Chiapas, Mexico) (see Bernal et al. (forthcoming)). Given the similarities between these countries and Guyana in terms of GDP, size, socio-economic conditions, and overall level of development, the proposed interventions and expected results are considered applicable to the Guyanese context. See Monitoring and Evaluation Plan for information on effectiveness and applicability of interventions.

[43] MHI is a public-private association amongst Bill & Melinda Gates Foundation, Carlos Slim Health Institute, Government of Spain, IDB, and countries of the Mesoamerica region. MHI supports countries to reduce maternal and infant mortality. It emphasizes improving the supply and demand for services, implementing results-based financing schemes, and adopting evidence-based and cost-effective interventions to improve the health status of the poorest 20%.

1.20 At the primary level of care, new strategies will be implemented to improve **access and use of health services**.[44] The community platform for service delivery will be strengthened to include the distribution of family planning methods, folic acid, and other primary healthcare interventions, particularly in the most remote locations.[45] Community-based identification and referral of pregnant women for prenatal, institutional delivery, and postnatal care will also be promoted through the use of demand-side incentives that have been tested in similar settings, such as baskets for newborns and transportation vouchers.[46,47] Community health workers (CHWs) will be equipped with the tools needed to perform their job, such as radios, bicycles, and rain gear. In health posts and health centers, a screening tool to identify and capture women at early stages of pregnancy will be introduced.[48] Pregnant women censuses to monitor prenatal care visits and actively search for mothers and newborns in the postpartum period will also be adopted.[49]

1.21 Although maternity waiting homes exist in Guyana,[50] their occupancy rate is low. In Lethem (Region 9), for instance, a recently built unit is underutilized. In Georgetown, women and their families reportedly resist accommodation in the maternity waiting home located in the city because it might take a few weeks for them to be sent home, given the current arrangements between the MPH and the Ministry of Indigenous Affairs, responsible for financing return transport.[51] Assessing the operation of these facilities and designing and implementing a strategy to increase demand for these services will be supported by this project. The adoption of family and community plans for birth and emergency transport will also be a part of this strategy.[52]

1.22 On the demand-side, to promote the use of health care, this project will support the design and implementation of important behavior change communication

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44 In many countries, particularly in areas with high proportions of indigenous populations, the use of health services may be determined by multiple factors, such as cultural norms and practices regarding childbirth and gender roles (e.g. women cannot leave children at home to someone else's care to go to a hospital). In Guyana, these factors will be examined through a supply and demand assessment, which consists of a qualitative analysis conducted at the local level to determine supply and demand barriers to access and use of services. This assessment will be financed through technical cooperation (TC) "Support for Maternal and Child Health Improvement Program (GY-L1058)". Results will inform the design and implementation of community outreach, education, and communication activities.

45 CHWs have been proven to be an effective mean of distribution of primary healthcare interventions (Maternal Mortality Series, Lancet 2006).

46 Baskets with clothes, blankets, and other supplies/goods needed for newborns.

47 Studies have shown that such incentives can be effective at encouraging the utilization of health services (Wang et al. 2016, Bernal et al. *forthcoming).* Potential risks related to the misuse of incentives will be mitigated in the design and implementation of the intervention.

48 Screening tools implemented at the community and facility level through MHI have provided promising evidence that this intervention increases early detection of pregnancy and family planning needs and reduces missed opportunities to provide care. This project will explore the introduction of questions aimed at identifying women who are experiencing intimate partner violence.

49 El Salvador and Nicaragua have created a "census of pregnant women" per community to help health personnel track women throughout their pregnancy, birth, and postpartum, allowing for planning of critical visits and counseling to increase the probability of timely institutional care.

50 WHO 2015.

51 Goede 2014.

52 Families create a "birth plan" with providers/CHWs to help them decide how they will travel to the health facility, how they will pay for transport, with whom they will leave other children, and what to do in emergencies. Hard-to-reach communities can also create community plans, where they agree on how to transport emergency cases.

strategies aimed at women, men, and adolescents for diverse purposes, such as increasing demand for family planning services and recognizing signs of obstetric and newborn complications.

1.23 In terms of quality, this project will support an in-depth revision of all guidelines, protocols, and strategies related to the health of women of reproductive age (e.g. nutrition, family planning), pregnancy, delivery, emergency care, postpartum, and newborn care (e.g. breastfeeding), including a focus on the specific needs of adolescents, men, and indigenous people[53]. The operation will support the design and implementation of a Quality Improvement Strategy (QIS) to create a continuous quality improvement culture in the health system. Evidence shows that norms and training are not enough to improve the performance of health workers: improvements occur when work processes are analyzed, discussed, changed, and monitored on a continuous basis. The Bank's experience in other countries has shown that to create an effective QIS strategy, it is necessary to map and optimize critical systems, establish standards and measurement tools, and create competencies to analyze data and test new actions through rapid quality improvement (QI) cycles at various levels of the system. The QIS will also promote the implementation of patient-centered and culturally-appropriate care, ensuring that women and their families are empowered, involved in decisions regarding childbirth, and treated with respect.[54]

1.24 The development of skills in health workers (doctors, nurses, midwives, nursing assistants, and CHWs) to provide quality reproductive, maternal, and neonatal care, in line with the updated guidelines and protocols will also be a priority. Many challenges related to the health workforce in Guyana are structural; nevertheless, in other similar contexts, key interventions focused on increasing the productivity and performance of existing personnel, through non-financial incentives and the establishment of clear lines of supervision and accountability, have yielded positive results.[55] These changes will be promoted through the QIS.

1.25 To guarantee the timely availability of supplies in health facilities, the project will strengthen the supply chain for contraceptive methods, drugs, supplies, and blood products. This will involve a revision of all processes related to planning (based on needs), procurement, storage, distribution, and monitoring and evaluation, the implementation of new management practices, and the acquisition of basic equipment for health facilities and the MPH (e.g. computers, storage racks). Lastly, to improve the quality of the health information, actions to improve collection, systematization, reporting, and use of the data generated by health facilities will be supported.

1.26 To improve the **effectiveness** of the healthcare network, interventions will include an assessment and reorganization of the healthcare and referral

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[53] Educational materials and family planning counseling will differ for adolescents, men, and indigenous peoples. Focus groups will be conducted to provide information on the main demand-side barriers for each group, to facilitate the development of targeted strategies. In the case of indigenous groups, educational materials will be formulated in local languages. This approach will be used in all interventions. During pregnancy, for instance, fathers will be encouraged to participate in antenatal care visits to stimulate the emotional bond with the child and promote men's involvement in childcare and household activities.

[54] Attitudes and behaviors of providers influence health care seeking and quality of care (Mannava et al. 2015).

[55] Dieleman and Harnmeijer 2006.

networks based on the parameters of the Essential Obstetric and Newborn Care (EONC) strategy[56], including the revision of the portfolio of services delivered at each facility and the roles of different cadres of health workers. Strengthening of the maternal and infant health care network will require investments in key equipment for health facilities to provide access to quality EmONC, including GPHC. It will also require investments in health facilities located in regions 3 and 4 to decentralize attention of low risk births and increase access to essential and EmONC, diminishing unnecessary referrals to GPHC.[57]

1.27 **Government of Guyana health strategy.** Health in the life cycle, including children, adolescents, and women's health is one of the priorities of the National Health Sector Strategy 2013-2020 (Health Vision 2020), which also includes among its goals addressing the health challenges that affect the indigenous people. In addition, Guyana has developed a Maternal, Perinatal, and Neonatal Health Strategy 2011-2020 that aims to reduce maternal and infant mortality by 2020. The analysis and the interventions proposed in this project are in line with the national priorities identified by the Government in maternal and child health.

1.28 **Bank's support to the health sector and lessons learned.** Over the last decade, the Bank has supported the health sector in Guyana through a series of operations, such as the Health Sector Program (1544/SF-GY), the Basic Nutrition Program (1120/SF-GY), and the Expansion and Integration of Basic Nutrition Program (2270/BL-GY). From these experiences the following lessons have been integrated into this project: (i) involving stakeholders in preparation and ensuring that interventions are aligned with national priorities to ensure political and technical support (see footnote 56 and ¶1.27); (ii) providing close technical support to the executing agency throughout implementation to guarantee that activities and products are carried out according to plan (¶1.29); and (iii) defining the project's execution governance with all stakeholders and setting out clear roles and lines of accountability amongst the MPH, the Ministry of Finance, and the RDCs/RHAs to prevent delays due to coordination issues (¶3.3). The implementation arrangements of operation GY-L1028 have also provided important insights, as having a separate executing unit outside the governance structure of the MoPH created coordination challenges, limited capacity building, lack of ownership and, eventually, the abdication of project responsibilities entirely to the executing unit. The implementation arrangements proposed in this project take these lessons under consideration (¶3.1).

1.29 **Innovations and lessons learned from the Mesoamerican Health Initiative.** This operation draws from the experiences of MHI, from which it has

[56] The EONC Strategy is a proven health care model that defines the essential and emergency maternal and neonatal evidence-based interventions that should be accessible to women and newborns. It establishes population parameters for the availability of each service and guidelines for their organization in a network and for patients' referral and counter-referral, among others.

[57] Includes the physical remodeling of C.C. Nicholson Hospital in region 4 to perform low risk births. This is a district-level hospital that is not prepared to deliver births; nevertheless, due to demand, it is delivering about 36-48 births/year. Given its catchment area, if equipped properly, it could be delivering around 700/800 births/year. This hospital would need few additional staff and the Government has already decided it will operate 24/7 (currently opened until 9pm). It is located 28km away from GPHC (trip varies between 25-45 minutes). An ambulance will be stationed in the hospital. Low risk delivery centers backed up by quality referral care have proven effective in many countries, such as Malaysia and Thailand. Brouwere and Lerberghe 2001.

incorporated the following lessons into this project: (i) designing, planning, and monitoring for results to ensure that all interventions contribute to the achievement of expected impacts[58]; (ii) incorporating evidence-based biomedical interventions and promising operational interventions, such as the creation of family and community plans for birth and emergency transport, pregnant women censuses, and screening tools (paragraphs 1.20-1.23); and (iii) providing strong technical assistance throughout project implementation to facilitate knowledge and skills transfer to the Government while at the same time ensuring project's physical and financial progress. This will be achieved through the competitive selection of a consultancy firm to design several interventions[59] and technically support implementation and the development of capacities and competencies at the central and local levels.[60]

1.30 **Strategic alignment.** This project is consistent with the Update of the Institutional Strategy 2010-2020 (AB-3008) and is aligned with the development challenge of social inclusion and equality, by increasing access and use of health services and diminishing inequities. It is aligned with the cross-cutting theme of gender equality and diversity, by improving women and indigenous people's access to sexual and reproductive health services and enhancing their capacities to make informed choices. Additionally, it will contribute to the Corporate Results Framework 2016-2019 (GN-2727-6) by reducing maternal mortality and increasing the number of beneficiaries receiving health services.[61] It is also aligned with the Strategy on Social Policy for Equity and Productivity. It is consistent with the Sector Framework for Health and Nutrition and its priority that all people have timely access to quality health services. Although the program is not directly aligned with any specific strategic objectives in the Bank's country strategy with the Cooperative Republic of Guyana 2012-2016 (GN-2690), it will support the Country Strategy goal of improving access to basic social services to the indigenous people.

1.31 **Gender equality.** This project will contribute to promote gender equality by increasing women's access and use of quality reproductive and maternal health services, by enhancing women's and girl's capacity to make informed decisions, by reducing adolescent pregnancy, and by promoting the involvement of men in reproductive, maternal, and neonatal care activities.

1.32 **Coordination with donors.** Several donors are currently working in Guyana's health sector and the IDB will engage with partners to identify opportunities for collaboration. The Pan-American Health Organization (PAHO) is providing grant financing to evaluate the health information system and to train personnel in emergency obstetric and neonatal care. This project will build on these initiatives. PAHO and the Global Fund are supporting actions to prevent and eliminate the

[58] The project was designed using a participatory methodology encompassing staff from the MoPH from all levels and different departments. It followed a results-oriented approach in which the first step was to identify the expected impact at the population level. Then, using a backward approach other results were identified and discussed, including outcomes, outputs, products, and inputs.

[59] Guaranteeing a comprehensive and integral approach to the technical assistance.

[60] Which is facilitated by the long-term engagement with the MoPH.

[61] Country Development Results, Intermediate Outcome Indicator "2" and Immediate Outcome Indicator "9".

mother-to-child transmission of HIV/AIDS, in line with the strengthening of pregnancy and delivery care. USAID is working on the prevention of HIV/AIDS among vulnerable groups and worked closely with representatives of the civil society and indigenous communities in Region 9. The Bank is liaising with USAID to identify partners in this region to support the implementation of key project activities. The United Nations Children Fund (UNICEF) is supporting clean water and adequate sanitation efforts, which are crucial to reduce the incidence of diseases, including zika. In the case of UNFPA, the Bank will promote that the organization and the Government explore potential areas of cooperation related to the procurement of supplies through "UNFPA Supplies", which supports nations with the international procurement of reproductive health supplies.

B. Objective, Components and Cost

1.33 The objective of this project is to contribute to the reduction of maternal, perinatal, and neonatal deaths in Guyana. To meet this objective, the project will support the following activities:

1.34 **Component 1. Strengthening reproductive, maternal, and neonatal health services.**

1.35 **Sub-component 1.1. Access and use of reproductive, maternal, and neonatal health services (US$1.230.000 million).** The objective of this component is to increase access and use of reproductive, maternal, and neonatal health services. To achieve this objective, this component will finance: (i) strengthening of the community platform and the primary level of care (levels I and II) for service delivery in regions 3, 4, and 9;[62,63] (ii) procurement of equipment/supplies; (iii) strengthening of the maternity waiting home strategy, including the development of individual and community plans to support women and newborns to access facilities in region 9; and (iv) design and implementation of behavior change communication strategies targeting regions 3, 4, and 9, including messages targeted at adolescents, men, and indigenous people.

1.36 **Sub-component 1.2. Quality of reproductive, maternal, and neonatal health services (US$1.690.000 million).** The objective of this component is to improve the quality of reproductive, maternal, and neonatal health services. To achieve this objective, this component will finance: (i) design and implementation of a QIS in hospitals of regions 3, 4, and 9, including the improvement of clinical and management practices and the promotion of patient-centered and culturally-appropriate care; (ii) revision and update of guidelines, protocols, and strategies; (iii) improvements in the supply chain for contraceptive methods, drugs, and blood products[64], including procurement of equipment; (iv) improvements in health information[65] in regions 3, 4, and 9; and (v) training of

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62 Includes training and equipping CHWs and strengthening the delivery of supplies and other primary health care interventions, such as screening tools and pregnant women censuses (¶1.20).

63 Distribution of repellent and insecticide-treated mosquito nets for the prevention of malaria and other mosquito-borne diseases, such as zika, will be included.

64 Technical assistance to analyze bottlenecks that may contribute to disruptions in the supply chain (critical activities to guarantee the availability of inputs, such as purchasing, storage, and distribution).

65 Revising and improving which/how information is collected, systematized, reported, and used by health facilities and acquiring hardware/software.

health workers in regions 3, 4, and 9 to provide quality reproductive, maternal, and neonatal care.

1.37 **Component 2. Strengthening the healthcare network (US$3.734.000 million).** The objective of this component is to increase the effectiveness of the maternal and neonatal healthcare network. To achieve this objective, this component will finance: (i) assessment and reorganization of Guyana's healthcare and referral networks, including the revision and adjustment of the portfolio of services and the roles of different cadres of health workers; (ii) infrastructure improvements to C.C. Nicholson Hospital[66]; (iii) procurement of equipment for health facilities, including GPHC maternal and neonatal units, C.C. Nicholson Hospital, and the Georgetown maternity waiting home; and (iv) ambulances and communication system (radios for health facilities and ambulances) for regions 3, 4, and 9.

1.38 **Component 3. Administration and evaluation (US$1.196.000 million).** The objective of this component is to support project administration and evaluation activities, including ancillary expenses and strengthening the capacity of the Maternal and Child Health (MCH) Unit of the MoPH, which will assume responsibility for project implementation (¶3.1). This component will support the recruitment of: a project coordinator; two fiduciary officers; a health specialist; and a planning, monitoring, and evaluation officer (¶3.2).[67]

TABLE 1.1. COSTS

	Components and sub-components	IDB US$	%
1	**Strengthening reproductive, maternal, and neonatal health services**	**2,920,000**	**36.5**
	Access and use of reproductive, maternal, and neonatal health services	1,230,000	
	Quality of reproductive, maternal, and neonatal health services	1,690,000	
2	**Strengthening the healthcare network**	**3,734,000**	**46.7**
3	**Administration and Evaluation**	**1,196,000**	**15.0**
	Staff	984,000	
	Monitoring, follow up and evaluation process	212,000	
	Contingencies	**150,000**	**1.9**
	TOTAL	**8,000,000**	**100.0**

C. Key Results Indicators

1.39 At the impact level, the main indicators included in the Results Matrix are the maternal mortality ratio and the neonatal mortality rate. At the outcome level, indicators include: first time users of family planning methods; percentage of women with anemia on their first antenatal checkup; percentage of births from adolescent mothers; percentage of women who receive antenatal care before 12 weeks; percentage of women who gave birth in a health facility in the rural

[66] Building an access ramp to the first floor, a laboratory, and a turnaround area for the ambulance, among other minor adjustments.

[67] The Auditor General's Office is currently eligible to audit all Bank-financed TCs and loan operations deemed to be of low or medium complexity and risk; it will conduct the financial auditing of this project (see Annex III).

interior; percentage of women who received quality antenatal care; percentage of deliveries with partograph used according to best practices, active management of the third stage of labor, and immediate neonatal care provided according to norms; percentage of neonatal and obstetric complications managed according to norms; and percentage of women who receive immediate postpartum care. The data for these indicators will be collected from the routine health information system, Guyana's vital statistics, and surveys for quality improvement in health facilities performed as part of this operation (see Results Matrix).

1.40 A cost-effectiveness analysis was performed for the main elements of the project. The effectiveness data was obtained from the main goals of the Results Matrix. The costs were obtained from the project budget; in the case of costs not directly financed by the project, references in the literature were used. A discount rate of 12% was used. For the base case it was estimated an incremental cost-effectiveness ratio (ICER) of US$3.504 per disability-adjusted life years (DALY) averted. The comparison of this value per DALY averted with the estimated 2017 GDP per capita (US$4.545) indicates that this project is very cost effective. Sensitivity analysis with different time horizons and discount rates were conducted. The model was found to be robust vis-à-vis the changes in these variables. Given the results of the base case and the sensitivity analysis and the limitations and assumptions of the model, this operation can be considered very cost effective and its implementation will generate an increase in net welfare for the population.

II. Financing Structure and Main Risks

A. Financing Instruments

2.1 This is an investment loan for US$8 million drawn from the Bank's Ordinary Capital (OC) and Fund for Special Operations (FSO). The planned disbursement period is five years. Table 2.1 shows disbursement projections over the life of the project. Projections are that disbursements will commence in April 2017 and end the last quarter of 2021, in accordance with the five year duration of the loan.

Table 2.1. Schedule of Disbursements 2017-2021

	Component/year	2017	2018	2019	2020	2021	TOTAL
1	Strengthening reproductive, maternal, and neonatal health services	253,021	1,282,464	829,578	446,471	108,466	2,920,000
2	Strengthening the healthcare network	309,583	2,520,126	824,291	40,000	40,000	3,734,000
3	Administration and Evaluation	253,300	249,587	260,091	243,533	189,489	1,196,000
	Contigencies				150,000		150,000
	TOTAL	**815,904**	**4,052,177**	**1,913,960**	**880,004**	**337,955**	**8,000,000**

B. Environmental and Social Safeguard Risks

2.2 In accordance with the Bank's Environment and Safeguards Compliance Policy (OP-703), this operation is classified as Category "B" because the potential negative environmental and social impacts and risks associated with the activities are localized and temporary and mitigation measures are known and

easily implemented. The most significant environmental and social impacts would be related to the execution phase: (i) generation of hospital waste; (ii) common wastewater generated from daily activities of the hospital staff, patients, and visitors; (iii) generation of wastewater contaminated by hospital activities; (iv) increased demand for power and water; (v) power shortages; (vi) air emissions from incinerators; and (vii) occupational health and safety hazards for the workforce.

2.3 In compliance with OP-703, an Environmental and Social Analysis (ESA) was conducted and a draft Environmental and Social Management Plan (ESMP) was developed and disclosed according to OP-102. The ESMP will be implemented by the MoPH and it will incorporate mitigation measures to all risks identified (pages 60-66 of ESA). The implementation of the ESMP will be a condition prior to the execution of hospital activities under Component II, (ii) and (iii). The implementation of a Risk Management and Emergency Response Plan (RM&ERP) will be a condition prior to the execution of hospital-related construction under Component II, (ii). This project complies with the Policy on Gender Equality in Development (OP-761) by increasing women's access and use of quality reproductive and maternal health services. It complies with the Indigenous Peoples Policy (OP-765) by improving indigenous people access and use of quality health services and not having direct/indirect adverse impacts on communities (pages 18-21 of Environmental and Social Management Report).

C. Fiduciary Risk

2.4 The Bank conducted the institutional capacity assessment system (ICAS) analysis of the MoPH in June 2016. The project has been assessed as having a medium fiduciary risk due to the potential limited initial capacity of the MCH Unit as it relates to staffing and execution of fiduciary activities. Supervision and mitigation actions will focus on building the capacity of the Unit regarding the IDB fiduciary policies and procedures, including the hiring of financial and procurement officers (¶3.2). Further details can be found in Annex III.

D. Other Key Issues and Risks

2.5 To achieve the project's desired results in the targeted regions, an important risk relates to the insufficiency of health personnel with knowledge and skills in maternal and neonatal healthcare, which may compromise service delivery and quality of care. TC "Support for Maternal and Child Health Improvement Program (GY-T1121)" will design a range of solutions to contribute to close the human resource gap in the rural interior in the short-term, potentially including the use of telemedicine and the development of alliances with non-governmental organizations (NGOs). TC funds will also finance key studies related to the country's human resource policies (¶3.9). Meanwhile, the Bank will continue to support the Government in the development of a long-term strategy related to the health workforce.

2.6 Another important risk to monitor, particularly in Region 9, relates to the impact of resistance to change due to the persistence of social norms and beliefs that guide behavior and influence individual choices in reproductive, maternal, and newborn care. This is considered an important risk for the project and mitigation

measures will include the identification of the main supply and demand barriers for the communities and the conduction of focal groups to better understand cultural beliefs and practices, which will inform the design and implementation of the interventions proposed in this document. Strategies to mitigate this risk present opportunities to partner with other donors and civil society organizations, such as USAID, who are already working at the community level.

2.7 A third risk that is deemed to be medium relates to maintaining effective inter-agency coordination among government ministries who are partners in delivering health services, providing resources or other key related activities, such as the Ministry of Indigenous Affairs. Based on lessons learned from other projects in Guyana and in the region, an inter-agency Steering Committee will be established at the policy level as an important mitigation measure (¶3.3). The project's OM will include a plan to improve communication amongst stakeholders.

2.8 A fourth risk relates to insufficient knowledge regarding the project at the health facility level and amongst some agencies, which could generate resistance to the adoption of the updated maternal and neonatal health guidelines and protocols. To manage this risk, mitigation measures will focus on the conduction of workshops with all staff prior to execution, to disseminate information. Finally, a risk related to the lack of accountability has been identified, whereas there could be poor documentation by service providers at the different levels, affecting data collection and reporting. Mitigation measures will focus on training and improving staff supervision.

2.9 **Sustainability.** The Government's strong commitment to improving maternal and neonatal health, as expressed in Health Vision 2020 and the Maternal, Perinatal, and Neonatal Health Strategy 2011-2020, will ensure the continuity and sustainability of interventions. The estimated increase in recurrent costs, as a result of the proposed interventions, is low (0.67% of public health expenditure) and has already been contemplated by the Government in the Maternal, Perinatal, and Neonatal Health Strategy (see Economic Analysis). In terms of capital costs, the procurement of equipment will include preventive maintenance for a minimum of three years and training of the staff from the Maintenance Unit of the MoPH and GPHC to continue to perform such activities. A manual for the maintenance of infrastructure work, with corresponding training, will also be developed and implemented. Both the MoPH and GPHC have Maintenance Units equipped with qualified personnel and a dedicated budget. A clause about the responsibility of the borrower/executing agency regarding the maintenance of the goods and work financed by the project will be included in the Loan Contract.

III. IMPLEMENTATION AND MANAGEMENT PLAN

A. Summary of Implementation Arrangements

3.1 **Implementation arrangements.** The MoPH, through its MCH Unit, will assume responsibility for project implementation, including planning, execution,

monitoring and evaluation, and financial and procurement activities.[68] Under the MoPH's governance structure, the MCH Unit forms part of the Family Health Department - one of six divisions that report directly to the CMO, who leads all public health and clinical/technical decisions. The MCH Unit is headed by the head of MCH, who will assume technical responsibility for the project to facilitate integration with complementary activities of the MoPH and to ensure the sustainability of results. In order to strengthen the project management capacity of the MCH Unit, loan resources will finance a project coordinator who will report to the head of MCH on technical aspects of the project, in collaboration with the Permanent Secretary of MoPH.

3.2 **Additional specialist staff.** In order to adequately address the workload demands of the project, the MCH Unit will be strengthened with five additional staff: a project coordinator; a health systems specialist who will provide technical oversight for the implementation of all health related and institutional strengthening activities financed by the project; a monitoring and evaluation specialist who will strengthen the related function within the Unit by instituting monitoring and evaluation practices in line with the project Results Matrix and the Monitoring and Evaluation; and two fiduciary officers (one procurement officer and one financial officer) to carry out the fiduciary functions of the project.

3.3 **A project Steering Committee** will be formed at the policy level to provide policy and strategic direction, support coordination across sectors, discuss and resolve execution challenges, and formalize access to technical inputs from the relevant agencies. The Steering Committee will also oversee the implementation of the ESMP; a sub-committee will be composed for this purpose. Chaired by the MPH, this committee will comprise senior representatives from the following agencies: Ministry of Finance; Ministry of the Presidency; Ministry of Communities, under which RDCs and RHAs lie; and Ministry of Indigenous Affairs. A Memorandum of Understanding (MoU) will be signed amongst the participating ministries/agencies to formalize roles and responsibilities in the Steering Committee; a draft of the MoU will be included in the project's Operations Manual (OM).

3.4 **The project's OM** will define all administrative, financial, procurement, and execution rules and procedures required for project implementation and management, including: (i) detailed description of implementation arrangements; (ii) definition of roles and responsibilities of all personnel; (ii) establishment of financial and procurement norms and flows; (iii) definition of the Steering Committee's structure and operationalization; (iv) draft of the MoU; and (v) Indicator Manual with detailed information on the indicators of the Results Matrix.

3.5 **Procurement execution.** Procurement for the proposed project will be carried out in accordance with the Policies for the Procurement of Works and Goods financed by the IDB (GN-2349-9) and the Policies for the selection and contracting of consultants financed by the IDB (GN-2350-9), as well as with the provisions established in the Loan Contract and the Procurement Plan (PP).

[68] The results of ICAS indicate that the MoPH has the institutional capacity necessary for the implementation of GY-L1058.

Procurement of goods, works, and consulting services will be reviewed using ex-ante procedures for all critical processes.

3.6 **Special contractual conditions prior to first disbursement. The following conditions prior to first disbursement shall be met: (i) the Permanent Secretary of MoPH has approved and put into effect the project's OM, in terms and conditions previously approved by the Bank; (ii) the five key personnel have been hired in accordance with terms of reference duly approved by the Bank; and (iii) the Steering Committee has been established by the MoPH**.

B. Summary of Arrangements for Monitoring Results

3.7 **Monitoring.** The MCH in coordination with the Bank will be responsible for implementing the Monitoring and Evaluation Plan. The MCH will provide the Bank all the information required to assess project execution. The Bank will supervise the execution and provide technical assistance when needed. The Bank and the borrower have agreed to use the Results Matrix and the activities defined in the Progress Monitoring Report (PMR) to monitor the operation. Other key monitoring tools are: (i) Semi-annual Monitoring Reports, including financial reports; (ii) Financial Audits Reports; (iii) Project Execution Plan (PEP); (iv) PP; (v) Project Completion Report (PCR); and (vi) Supervision and monitoring meetings.

3.8 **Evaluations.** A quasi-experimental evaluation will be performed at the end of the project to estimate the impact of the two major components. The chosen methodology is synthetic control and the preliminary identified outcome indicators are those of the Result Matrix. This evaluation will be financed by the loan with close IDB's technical support.

C. Design Activities post-approval

3.9 TC GY-T1121[69] will finance an assessment of the organizational structure of the MCH Unit and recommend a new organigram in line with the activities proposed under the loan, to guarantee the sustainability of the results of the program. The new structure will be used as a basis for staffing a reorganized MCH Unit, possibly absorbing some of the staff recruited under the loan. The TC will also support the development of core technical and operational capacities in the MCH Unit, including knowledge exchange and TC with countries of the MHI. As mentioned previously, it will finance the design of solutions to contribute to close the human resource gap in the rural interior. Finally, it will fund key technical studies to inform project execution, including: (i) a supply and demand assessment, which consists of a qualitative analysis and participatory diagnostic conducted at the local level to determine supply and demand barriers to access and use of reproductive, maternal, and neonatal health services; and (ii) a review of the country's health educational system and recruitment and retention policies for health personnel.

[69] TC Abstract was approved on July 1, 2016 and QRR closed on September 26, 2016.

Development Effectiveness Matrix			
Summary			
I. Strategic Alignment			
1. IDB Strategic Development Objectives	**Aligned**		
Development Challenges & Cross-cutting Themes	**-Social Inclusion and Equality -Gender Equality and Diversity**		
Regional Context Indicators			
Country Development Results Indicators	**-Maternal mortality ratio (number of maternal deaths per 100,000 live births) -Beneficiaries receiving health services (#)**		
2. Country Strategy Development Objectives	**Not Aligned**		
Country Strategy Results Matrix			
Country Program Results Matrix		**The intervention is not included in the 2016 Operational Program.**	
Relevance of this project to country development challenges (If not aligned to country strategy or country program)		**Given that maternal and neonatal mortality is high and above average for comparator countries, the project was deemed relevant and justifiable. In addition, it is consistente with the Country Strategy´s cross-cutting theme of indigenous peoples.**	
II. Development Outcomes - Evaluability	**Highly Evaluable**	**Weight**	**Maximum Score**
	9.0		**10**
3. Evidence-based Assessment & Solution	**9.5**	**33.33%**	**10**
3.1 Program Diagnosis	**3.0**		
3.2 Proposed Interventions or Solutions	**4.0**		
3.3 Results Matrix Quality	**2.5**		
4. Ex ante Economic Analysis	**10.0**	**33.33%**	**10**
4.1 The program has an ERR/NPV, a Cost-Effectiveness Analysis or a General Economic Analysis	**4.0**		
4.2 Identified and Quantified Benefits	**2.4**		
4.3 Identified and Quantified Costs	**1.2**		
4.4 Reasonable Assumptions	**1.2**		
4.5 Sensitivity Analysis	**1.2**		
5. Monitoring and Evaluation	**7.5**	**33.33%**	**10**
5.1 Monitoring Mechanisms	**2.5**		
5.2 Evaluation Plan	**5.0**		
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, External control.**	
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:			
Gender Equality			
Labor			
Environment			
Additional (to project preparation) technical assistance was provided to the public sector entity prior to approval to increase the likelihood of success of the project			
The ex-post impact evaluation of the project will produce evidence to close knowledge gaps in the sector that were identified in the project document and/or in the evaluation plan	**Yes**	**The proposed evaluation will use the Synthetic Control Method to compare the results of the interventions implemented in a region of the country with a synthetic region. There is little evidence regarding what works to improve the health of indigenous people; this evaluation aims to contribute to answering this question.**	

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

The objective of the program is to reduce maternal, perinatal and neonatal mortality in Guyana. The program supports the strengthening of reproductive, maternal and neonatal health services, through activities that seek to increase the access and use of health services, improve the quality of health services and strengthen the healthcare network. The project documents provide a diagnosis of the maternal and child health situation and its determinants in Guyana, as well as references to the literature sustaining the efficacy of the proposed interventions.

The project simulates the magnitude of the expected effects on maternal and neonatal mortality, a key assumption for economic analysis and program logic. The results matrix includes SMART indicators suitable for measuring impacts, outcomes and outputs.

Monitoring activities have been identified with their particular costs. The project proposes a quasi-experimental impact evaluation to measure impacts in one region based on a Synthetic Control Method. However, insufficient information is provided in the evaluation plan to assess the viability of the proposed identification strategy.

RESULTS MATRIX

EXPECTED IMPACTS

Indicators	Unit	Baseline		Goals		Means of verification	Observations
		Value	Year	Value	Year		
Objective: Contribute to the reduction of maternal, perinatal, and neonatal deaths in Guyana by 2021							
Maternal Mortality Ratio (MMR).	Maternal deaths x 100,000	121.7	2014	87.9	2021	Chief Medical Officer (CMO) Report	MMR at the national level estimated using preliminary data from the CMO Report.
Neonatal Mortality Rate (NMR).	Neonatal deaths x 1,000	21.7	2014	15.2	2021	CMO Report	NMR at the national level estimated using preliminary data from the CMO Report.

EXPECTED RESULTS

Indicator	Unit	Baseline		Goals		Means of verification	Observations
		Value	Year	Value	Year		
COMPONENT 1. STRENGTHENING REPRODUCTIVE, MATERNAL, AND NEONATAL HEALTH SERVICES							
Sub-Component 1.1. Objective: Increase access and use of reproductive, maternal, and neonatal health services							
First time users of family planning methods for the year.	Number of clients	5,799	2014	9,799	2021	MCH Report, Clinic Summary Report (CSR)	Calculated for intervention areas.
Pregnant women with anemia at first antenatal visit (hemoglobin under 11 g/dl).	%	21.1%	2014	11.1%	2021	MCH Report, CSR	Calculated for intervention areas. Excludes “result not known”.
Births from adolescent mothers (19 years and younger).	%	19.1%	2012	15.1%	2021	Vital Statistics, Ministry of Health Statistical Bulletin	Calculated for intervention areas.
Women who receive antenatal care before 12 weeks pregnant.	%	23.9%	2014	30.9%	2021	MCH Report, CSR	Calculated for intervention areas. Excludes “unknown”.
Women who gave birth in a health facility in the rural interior.	%	15.8%	2014	25.8%	2021	MCH Report, CSR	Calculated for region 9. Numerator considers “hospital” and “health center” deliveries.
Sub-Component 1.2. Objective: Improve quality of reproductive, maternal, and neonatal health services							
Pregnant women receiving quality antenatal care according to best practices.	%	(1)	2017	+15PP	2021	Health Facility Surveys (HFS), Medical Record Review (MRR) module	Calculated for health facilities in intervention areas that provide antenatal care.

Indicator	Unit	Baseline		Goals		Means of verification	Observations
		Value	Year	Value	Year		
Deliveries for which the partograph was used according to best practices.	%	(1)	2017	+20PP	2021	HFS, MRR	Calculated for health facilities in intervention areas that provide routine birth services.
Institutional deliveries for which oxytocin was administered immediately following birth as part of Active Management of the Third Stage of Labor.	%	(1)	2017	85%	2021	HFS, MRR	Calculated for health facilities in intervention areas that provide routine birth services.
Institutional deliveries for which immediate neonatal care was provided to the infant according to the norms	%	(1)	2017	85%	2021	HFS, MRR	Calculated for health facilities in intervention areas that provide routine birth services.
Neonates with complications (prematurity, low birth weight, asphyxia and sepsis) managed according to norms.	%	(1)	2017	+20PP	2021	HFS, MRR	Calculated for health facilities in intervention areas that provide routine birth services.
Obstetric complications (sepsis, hemorrhage, severe pre-eclampsia and eclampsia) managed according to norms.	%	(1)	2017	+20PP	2021	HFS, MRR	Calculated for health facilities in intervention areas that provide routine birth services.
Women that received immediate postpartum care according to best practices (every 15 minutes in the first hour and every 30 minutes in the second hour).	%	(1)	2017	85%	2021	HFS, MRR	Calculated for health facilities in intervention areas that provide routine birth services.
COMPONENT 2. STRENGTHENING THE HEALTHCARE NETWORK							
Objective: Increase the effectiveness of the maternal and neonatal healthcare network							
Women that are referred to the national hospital for obstetric conditions that could have been resolved at another level of care.	%	(1)	2017	Decrease by 50PP	2021	HFS, MRR	Calculated for health facilities in intervention areas.
Health facilities with continuous availability of inputs and equipment to provide essential and emergency obstetric and neonatal care.	%	(1)	2017	85%	2021	HFS, MRR	Calculated for health facilities in intervention areas that provide routine birth services.
Health facilities with continuous availability of inputs and equipment to provide quality antenatal and post-natal care.	%	(1)	2017	85%	2021	HFS, MRR	Calculated for health facilities in intervention areas that provide antenatal and postnatal care.

(1) Data will be updated with the baseline Health Facility Survey results.
PP: Percentage Points to increase over baseline value.

PRODUCTS

Products	Estimated Cost (US$)	Unit	Baseline	Y1	Y2	Y3	Y4	Y5	Final goal	Means of verification	Observations
Component 1. Strengthening reproductive, maternal, and neonatal health services											
Sub-Component 1.1. Access and use of reproductive, maternal, and neonatal health services											
Community health workers (CHWs) trained and equipped to provide reproductive, maternal, and neonatal services.	470.000	CHWs	0	00	200	225	0	0	425	Report from technical assistance with documental evidence that CHWs have been trained and equipped	Calculated for CHWs in intervention areas.
Communities with plans for institutional birth implemented.	225.000	Communities	0	0	50	38	0	0	88	Report from technical assistance with documental evidence that plans have been implemented	Calculated for communities in region 9. “Implemented” refers to communities that have designed and operationalized plans for institutional birth.
Communities with communication strategy for behavior change implemented.	535.000	Communities	0	0	50	100	75	0	225	Report from technical assistance with documental evidence that the communicatio n strategy was aired in each community	”Implemented” refers to communities that have received the messages/spots aired by the communication strategy by radio, television, social media, printed media or others.
Sub-Component 1.2. Quality of reproductive, maternal, and neonatal health services											
Health facilities with integrated health care strategy for women of reproductive age	255.000	Health facilities	0	0	50	50	43	0	143	Report from technical assistance with	Calculated for health centers in intervention areas that provide

Products	Estimated Cost (US$)	Unit	Baseline	Y1	Y2	Y3	Y4	Y5	Final goal	Means of verification	Observations
implemented.										documental evidence that guidelines and procedures have been implemented	primary care. "Implemented" refers to health facilities that have updated and operationalized guidelines and procedures on the health of women of reproductive age.
Health facilities with new family planning strategy implemented.	170.000	Health facilities	0	0	50	50	43	0	143	Report from technical assistance with documental evidence that guidelines and procedures have been implemented	Calculated for health centers in intervention areas that provide primary care. "Implemented" refers to health facilities that have updated and operationalized guidelines and procedures for family planning.
Health facilities with updated model for prenatal, birth, postnatal, and post-partum care implemented.	125.000	Health facilities	0	0	100	50	0	0	150	Report from technical assistance with documental evidence that guidelines and procedures have been implemented.	Calculated for health facilities in intervention areas. "Implemented" refers to health facilities that have updated and operationalized guidelines and procedures for prenatal, birth, postnatal, and post-partum care.
Hospitals with Quality Improvement Strategy (QIS) for maternal and neonatal health	455.000	Hospitals	0	0	1	3	3	0	7	Report from technical assistance with	Calculated for hospitals in intervention areas. "Implemented"

Products	Estimated Cost (US$)	Unit	Baseline	Y1	Y2	Y3	Y4	Y5	Final goal	Means of verification	Observations
implemented.										documental evidence that processes have been mapped and optimized	refers to hospitals that have mapped and optimized key clinical, management, and support processes.
Health facilities with supply chain management improved.	100.000	Health facilities	0	0	0	90	60	0	150	Report from technical assistance with documental evidence that supply chain have improved	Calculated for health facilities in intervention areas. "Improved" refers to health facilities that have adopted best practices in estimating need, planning, requesting, storing, and distributing critical supplies to the population
Health workforce trained to provide quality reproductive, maternal, and neonatal care.	235.000	Health staff	0	0	120	90	46	0	256	Report from technical assistance with documental evidence that workers have been trained	Calculated for health facilities in intervention areas.
Health facilities with health information system strengthened.	350.000	Health facilities	0	0	0	60	60	30	150	Report from technical assistance with documental evidence that health facilities have strengthened health information system	Calculated for health facilities in intervention areas. "Strengthened" refers to health facilities that collect and report key statistics on a routine basis.

Products	Estimated Cost (US$)	Unit	Baseline	Y1	Y2	Y3	Y4	Y5	Final goal	Means of verification	Observations
Component 2. Strengthening the healthcare network											
Integrated healthcare network for reproductive, maternal, and neonatal health enabled.	759.000	Network	0	0	1	2	0	0	3	Report from technical assistance with documental evidence that network has been enabled	Calculated for intervention areas. "Enabled" refers to regions that have revised and adjusted the service and referral and counter-referral networks
Health facilities with infrastructure improved to provide reproductive, maternal, and neonatal services.	500.000	Health facilities	0	0	0	1	0	0	1	Project's semi-annual monitoring reports with documental evidence that infrastructure improvements have been concluded and that the health facility is in operation	Calculated for health facility in region 4.
Health facilities with equipment improved to provide reproductive, maternal, and neonatal services.	2.250.000	Health facilities	0	0	0	2	2	0	4	Project's semi-annual monitoring reports with documental evidence that the new equipment is operating	Calculated for health facilities in intervention areas.
Ambulances equipped for emergency obstetric and newborn care delivered.	225.000	Ambulances	0	0	3	0	0	0	3	Project's semi-annual monitoring reports with documental evidence that ambulances are operating	Calculated for health facilities in intervention areas.

Products	Estimated Cost (US$)	Unit	Baseline	Y1	Y2	Y3	Y4	Y5	Final goal	Means of verification	Observations
Component 3. Administration and Evaluation											
Final evaluation conducted.	20.000	Evaluation	0	0	0	0	0	1	1	Evaluation completed and published in the Ministry's webpage	
Health facility survey conducted.	100.000	Survey	0	1	0	0	0	1	2	Survey completed and published in the Ministry's webpage	

PROJECT FIDUCIARY AGREEMENTS AND REQUIREMENTS

COUNTRY: Guyana
PROJECT Nº: GY-L1058
NAME: Support to Improve Maternal and Child Health
EXECUTING AGENCY: MINISTRY OF PUBLIC HEALTH

I. EXECUTIVE SUMMARY

1.1 The general objective of the program is to contribute to the reduction of maternal, perinatal and neonatal deaths in Guyana. The total estimated budget is US$8,000,000, all of which will be financed of the IDB from the OC/FSO resources.

1.2 The Executing Agency (EA) is the Ministry of Public Health (hereafter MoPH). MoPH executed three Bank financed Loan – *Health Sector Program* 1548/SF-GY, *Basic Nutrition Program* 1120/SF-GY and the *Expansion and Integration of Basic Nutrition* 2270/BL-GY which was reformulated in December of 2015. The fiduciary aspects of the execution mechanism for the present Loan are analyzed accordingly.

1.3 An institutional capacity assessment of MoPH was conducted in June 2016 using the Institutional Capacity Assessment System (ICAS) methodology. The ICAS assessment concluded that the fiduciary risk is considered as medium. A re-evaluation of the fiduciary risks will be conducted during execution as part of the regular fiduciary supervision to ensure efficient support to project execution.

1.4 **Fiduciary Context of the country.** An Integrated Fiduciary Assessment (IFA) was conducted in 2012/2013. It provided an update to the 2007 combined Public Expenditure and Financial Assessment (PEFA) performance measurement framework and OECD-DAC procurement assessment. The results of the 2012/2013 IFA and the 2007 PEFA, concluded that Guyana's overall budget planning, accounting and reporting systems worked well; IFMAS (Integrated Financial Management Accounting System)) operated consistently and reliably providing updated information about all elements of budget execution, and budget planning and reporting was being done in accordance with the cash basis of accounting and its standards. The Public Financial Management (PFM) indicator scores from the 2012/2013, continued to show encouraging results with slight improvements in areas such as Strengthened External Audit Function, Budget Preparation Process, Revenue Administration etc. Notwithstanding, the IFA highlighted that attention needed to be paid to the internal control environment, Internal Audit, Payroll Control and Procurement Control among others. To date, confirmations from the Borrower on the results of the 2012/2013 IFA as well as 2007 PEFA remain outstanding. The Bank's Guide for the Use of Country Systems (GUS) Assessment was also conducted in 2013; it is also awaiting Government's validation. The Auditor General's Office (AOG) is currently eligible to audit all Bank-financed TCs and loan operations deemed to be of low or medium complexity and risk. This was based on an assessment of the capacity of the AOG undertaken by the Bank in 2011 and the continued institutional strengthening support given by the Bank to the AOG. For this operation, the Bank is recommending: (i) the use of the national accounting system, IFMAS, or any other system acceptable to the Bank, for the financial administration of the project; and (ii) for external control, a firm of independent public accountants acceptable to the Bank or the Auditor General of Guyana.

1.5 With regards to procurement, assessments of the national system (MAPS) have been performed in 2007 and 2013. The results are not yet endorsed by the Government of Guyana (GoG). Guyana has a dedicated legislation that governs public procurement, namely the *Procurement Act of 2003* and its associated regulations. It established the National Procurement and Tender Administration Board (NPTAB) which is responsible for exercising jurisdiction over the country's tender processes, reporting to the Ministry of

Finance with policy making, advisory oversight, and monitoring and information functions. In accordance with the existing legal framework, the NPTAB is a temporary entity while awaiting the creation of the Public Procurement Commission (PPC). The PPC is foreseen in the Consitution.and. Its members are appointed by the President and approved by the National Assembly. The country is in the process of strengthening its centralized website for publication of opportunities for requests for proposals, but to date, it is not regularly used across procurement entities or by the independent public corporations. Additionally, efforts are placed to strengthen capacity to retain records of procurement processes and related information, as well as a registry for protests, suspension and debarment and contractors' performance. Statistics on public procurement awards is also an area of focus for GoG. Notwithstanding, to date, the Country Procurement System has not been approved and hence will not be used under the present Loan. Consequently, the Bank requires the use of its Procurement Policies GN-2349-9 and GN-2350-9 for all projects approved after 2011. The Bank will bring adequate support to the procurement function to ensure efficiency of the procurement activities and to provide support to the prompt execution of the operation in accordance with the Bank's rules and procedures.

II. FIDUCIARY CONTEXT OF THE EXECUTING AGENCY

2.1. The Maternal and Child Health (MCH) Unit of the MoPH headed by the MCH Officer, will be responsible for the execution of the Loan and for carrying out all related fiduciary activities. In accordance with the existing structure at the MoPH, the MCH Unit of the Family Health Department will discharge its duties in coordination with the Office of the Permanent Secretary and the Office of the Chief Medical Officer"[1]. As per ICAS findings, the Office of the Permanent Secretary ensures "proper allocation of organizational, personnel and financial resources towards the attainment of the Ministry's strategic and operational goals and broad sector objectives"[2]. All administrative responsibilities which include the fiduciary duties are placed under the direct responsibility of the Office of the Permanent Secretary. However, the Chief Medical Officer provides "technical leadership and guidance for the implementation of sector specific programs and actions"[3], hence creating a need for a dual reporting line to coordinate activities involving planning, execution and monitoring and evaluation of the fiduciary activities. This will have to be clearly described in the Operations Manual. To strengthen the execution capacity of the MCH Unit, loan resources will fund the dedicated human resources who will discharge all expected fiduciary duties for the duration of the Loan. Staff to be recruited will include a Financial Officer and a Procurement Officer. Their recruitment will be a condition prior to first disbursement.

2.2. MoPH uses the country's IFMAS. IFMAS was successfully piloted on previous IDB-financed loans; and an operations manual for Bank funded operations using IFMAS as its accounting system was developed by the Ministry of Finance. It is recommended that this program use IFMAS for the financial management and accounting of the program.

2.3. As far as the procurement function is concerned, findings of the ICAS indicate that, under the organizational scheme currently in force at MoPH, procurement activities are conducted by the Materials Management Unit (MMU), placed under the Office of the Permanent Secretary. The MMU has a total of 15 staff members, 10 of whom are responsible for the purchase of medical equipment and pharmaceuticals, while the remaining five are responsible for the other purchases. At present, the initial procurement plan for the Loan includes purchases of medical equipment. As mentioned in Section 2.1 above, this Loan will be implemented by the MCH Unit, and in particular the dedicated personnel within the MCH Unit who will be in charge of all procurement activities under the present Loan. This personnel is yet to be recruited. Once in place, the personnel will coordinate with the Office of the Permanent Secretary and the Office of the Chief Medical Officer and other applicable

[1] Support to improve MCH – GY-L1058; Institutional Evaluation; Andres Garrett, Institutional and Financial Consultant, June 2016.

lines of authorities to ensure that the technical specifications and the terms of references are in accordance with the norms in force at the MoPH. Training to the new staff will be provided to ensure that procurement duties are discharged in the most efficient manner and in keeping with the Bank's Procurement Policies.

III. FIDUCIARY RISK EVALUATION AND MITIGATION ACTIONS

3.1. The Project Team and the MoPH developed a preliminary Risk Mitigation Matrix included in the package of project documents. Yearly assessments will be conducted to introduce additional mitigating actions as a result of such reviews and as deemed necessary.

3.2. The Loan will be executed by the dedicated personnel embedded within the MCH of the MoPH. Consequently, it is reasonable to expect challenges in the execution of the expected activities due to human resource capacity and constraints. A dedicated Financial Officer and Procurement Officer assigned to MCH Unit are considered essential elements for the execution of the fiduciary activities under this Loan and to ensure the maintenance of a strong system of internal reporting and control mechanism. As a mitigation measure, the newly recruited Financial and Procurement Officers will be trained in Bank's rules and procedures.

3.3. Taking into consideration the ICAS assessment, the financial management arrangements revealed medium financial management risk.

3.4. With regards to procurement activities, the ICAS identified a medium risk in terms of organizational structure. It also noted that the MMU discharges its procurement duties in accordance with the Procurement Act of 2003. The personnel who will be in charge of the project's execution will have to discharge its duties in accordance with the Bank Policies. This will require coordination which will be set out in the Operation's Manual. The latter will be considered a condition prior to eligibility and should include, among others: (i) norms tailored to the characteristics and administrative practices of the MoPH and in accordance with the Bank's policies; (ii) identification of workflows and corresponding purchasing and contracting modalities addressing also issues of planning and levels of delegation of authority; (iii) definition of a filing system designed to ensure that all procurement related files will remain fully accessible for seven years in accordance with Bank's policies. Additionally, given the nature of the expected procurement activities under this Loan as described in the attached procurement plan, the risk is identified as being medium provided that technical specifications and terms of references are in line with the MoPH's requirements and the requirements of the Loan Agreement.

IV. SPECIAL CONDITIONS OF CONTRACT TO BE ADHERED TO

4.1. **Conditions prior to first disbursement:** The presentation of evidence that MoPH has recruited a designated Financial Officer for the program. Another condition prior will include the recruitment of a Procurement Officer. The last condition prior will be the validation of an Operation's Manual which will capture all the necessary fiduciary arrangements, as well as all items as expected in such document.

4.2. **Type of exchange rate to be used by EA.** The type of funds to be used are established in the following manner: (i) Reimbursement of actual expenses: the effective rate of exchange on the date of payment of each expenditure, as published by the Central Bank of Guyana; (ii) Reporting on accounts (Advance of Funds): the effective rate of exchange used in the conversion of the currency of the operation to the local currency. In cases of reimbursement of a guarantee of letter of credit, the equivalent of the currency of the operation will be fixed in accordance with the amount effectively disbursed by the IDB.

V. FINANCIAL MANAGEMENT

5.1 **Financial Statements and Reports, audited or unaudited.** (i) semi-annual financial reports of the program are to be included in the semi-annual progress report which will be submitted by the MoPH to the Bank; (ii) annual financial statements of the project, audited by the Auditor General of Guyana are to be submitted to the Bank within 120 days at the

end of each fiscal year, beginning with the fiscal year in which the first project expenditures are incurred; and (iii) a final financial audit report of the program is to be submitted by MoPH within 120 days after the date of the last disbursement.

5.2 **Programming and Budget:** The Borrower has committed to allocate, for each fiscal year of project execution, adequate fiscal space to guarantee the unfettered execution of the project; as determined by normal operative instruments such as the Annual Operating Plan and the PP.

5.3 **Accounting and Information Systems.** It is expected that IFMAS accounting system will facilitate the recording and classification of all financial transactions.

5.4 **Disbursements and Cash Flow.** The Bank will supervise the creation of an Advance of Funds, using the Advance of Funds methodology. Whenever resources from the financing are requested through an Advance of Funds, it will be deposited into a Special Account, denominated in US$, established exclusively for the Project at the Central Bank of Guyana. Required resources from this Special Account will be transferred to another bank account, denominated in Guyana Dollars to be utilized for payment of expenditures in local currency.

5.5 The project will provide adequate justification of the existing Advance of Funds balance, whenever **80%** of said balance has been spent. Advances will normally cover a period not exceeding 180 days and no less than 90 days. In order to request disbursements from the Bank, the EA will present the following forms and supporting documents:

Type of Disbursement	Mandatory Forms	Optional forms/ information that can be requested by the IDB
Advance	Disbursement Request/Financial Plan	List of Commitments Physical/Financial Progress Reports
Reimbursements of Payments Made	Disbursement Request/Project Execution Status/Statement of Expenses	List of Commitments Physical/Financial Progress Reports
Direct Payment to Supplier	Disbursement Request/Statement of Expenses/Acceptable Supporting Documentation	List of Commitments Physical/Financial Progress Reports

5.6 Generally, supporting documentation for Justification of Advances and Reimbursement of Payments Made will be kept at the office of the EA. Disbursements' supporting documents may be reviewed by the Bank on an ex-post basis.

5.7 **Internal Control and Internal Audit:** The management of the project will assume the responsibility for designing and implementing a sound system of internal controls for the project.

5.8 **External Control and Reports.** For each fiscal year during project execution, MoPH will be responsible to produce semi-annual financial reports for the project, annual Audited Financial Reports of the Program and one final Audited Financial Report at the end of the Program, audited either by the Auditor General of Guyana or by a firm of independent public accountants acceptable to the Bank.

5.9 **Financial Supervision Plan.** Financial Supervision will be developed based on the initial and subsequent risk assessments carried out for the project. Inspection visits will be performed based on the risk assessed, covering the following: (a) review of the bank reconciliation and supporting documentation for Advances and Justifications; (b) compliance with procedures; (c) review of compliance with the lending criteria; (d) ex-post review of disbursements.

5.10 **Execution Mechanism.** MoPH will be the EA and will be responsible for the financial administration of the program. MoPH's responsibility will include: (i) preparation of required project reports; (ii) monitoring product, output and outcomes achievement using established indicators; (iii) preparation and submission of disbursement requests to the Bank and justification of expenses; (iv) preparation of financial reports; (v) ensure compliance with all aspects of the Operating Manual; and (vi) maintain adequate documentation filing system.

VI. REQUIREMENTS AND AGREEMENTS FOR EXECUTION OF PROCUREMENT

6.1 **Procurement Execution.** Procurements for this project will be carried out in accordance with the Policies for the Procurement of Works and Goods Financed by the Inter-American Development Bank (GN-2349-9), of March 2011; and the Policies for the Selection and Contracting of Consultants Financed by the Inter-American Development Bank (GN-2350-9), of March 2011, and with the provisions established in the Loan contract. In addition, for all projects, the Borrower is required to prepare and submit to the Bank, a draft General Procurement Notice as well as an initial procurement plan which will be updated in accordance with the applicable sections of the Policies and the Loan Agreement.

6.2 **Exception to Bank Procurement Policies.** None are requested for this Loan.

6.3 **Procurement of Goods, Works, and Non-Consulting Services.** In accordance with Section 1.2 of GN-2349-9, "the responsibility for the implementation of the project, and therefore for the award and administration of contracts under the project, rests with the Borrower". In accordance with the findings of the ICAS for this Loan and given the level of risk as identified above, all procurement activities will be carried out under ex-ante supervision as described in the following section of the present Annex III.

6.4 **Procurement of Consulting Services.** In accordance with Section 1.4 of GN-2350-9. "The Borrower is responsible for preparing and implementing the project, and therefore for selecting the consultant, and awarding and subsequently administering the contract." As such, the Borrower is responsible for preparing and implementing the scheduled activities, and therefore for preparing the TORs, short lists, selecting the consultants, awarding the contract and subsequently administering it. In accordance with the findings of the ICAS for this Loan and given the level of risk as identified above, all procurement activities will be carried out under ex-ante supervision as described in the following section of the present Annex III.

6.5 **Sole Source Selection and/or Direct Contracting.** None foreseen under this Loan.

6.6 **Selection of Individual Consultants.** Individual consultants are employed in accordance with Section V (Selection of Individual Consultants) of GN-2350-9.

6.7 **Recurring Expenses.** Include payment of utilities and other office operating expenses of the Executing Unit, if any.

6.8 **Advance Contracting/Retroactive Financing.** No advance contracting is foreseen under the present operation.

6.9 **Domestic Preference.** Domestic Preference is not requested under this Loan.

6.10 **Country Threshold.** Table (US$ Thousands) www.iadb.org/procurement

International Competitive Bidding Threshold*			National Competitive Bidding Range ** (complex works and non-common goods)			Consulting Services
Works	**Goods**		**Works**	**Goods**		**International Short List**
>1,000,000	>100,000		<1,000,000	<100,000		>100,000

** When procuring simple works and common goods and their amount is under the International Competitive Bidding thresholds, Shopping may be used.*

No.	PEP identification	Category and Description of Procurement Contract	Method of Procurement		Review
WORKS					
1	2.2.2	Remodeling of Nicholson Hospital	$500.00	NCB	ex-ante
GOODS					
1	2.2.1	Medical equipment for the new building of Georgetown Hospital, the Nicholson Hospital and other health facilities in the sphere of influence of the project (ICB in several lots)	$2,225.00	ICB	ex-ante
2	1.2.6.1.5	Hardware and software purchased and distributed (several processes)	$200.00	NCB	ex-ante
NON-CONSULTING SERVICES					
1	1.1.3.1	Materials for communication for behavior change strategy printed and distributed to 225 communities (several processes)	$125.00	NCB	ex-ante
2	1.1.3.1	Communication campaign implementing in 225 communities (several processes)	$125.00	NCB	ex-ante
CONSULTING SERVICES					
1	1.1.1.1	Technical assistance to design and support the implementation of interventions to strengthen reproductive, maternal, and neonatal health services and develop capacities and competencies at the central and local levels	$1.670.00	QCBS	ex-ante

*** When procuring non-complex works or common goods with amounts under the NCB range, Shopping shall be used.*

6.11 **Procurement Plan.** The Procurement Plan for the operation covering the first 18 months of project execution can be accessed through the following electronic link. The on-line Electronic Procurement Execution System (known by its Spanish acronym as SEPA) will be used for the publication and updates of the Procurement Plan during execution. It is expected that the EA will use the SEPA program for management of its procurement activities. The Procurement Plan will be updated annually or whenever necessary, or as required by the Bank (www.iadb.org/procurement; http://www.iniciativasepa.org/bid/sitio/guyana/index-_ing.htm). The initial procurement plan for the operation lists all procurement activities foreseen under this operation. The table below includes the list of the main procurement activities for this Loan.

Main Procurement Activities:

6.12 **Supervision.** The supervision modalities for this operation are tailored to keep with the most efficient execution mechanism while ensuring compliance with the applicable procurement rules and procedures. Under this Loan, procurement activities (i) are not expected to be complex in nature, nor will they involve the acquisition of medical of therapeutic equipment; (ii) will be subject to ex-ante review given the level of risk as identified above; (iii) will be explicitly listed in the approved and updated procurement plan in SEPA; (iv) will be launched once all technical specifications and/or terms of reference are validated by the Bank's Sector Specialist; and (v) will be documented in accordance with the general filing guidelines that will be provided as part of the inception training of the fiduciary staff and in accordance with the applicable Bank Policies.

6.13 All modifications to the present arrangement are subject to a prior written agreement between the EA and the Bank. The evaluation of capacity and the level of risk may vary during the project's execution depending on the findings of the regular supervision activities that will be conducted during the project's lifespan. As such, supervision modalities may vary as capacity increases.

6.14 **Records and Files.** All records and files will be maintained by the EA, according to accepted best practices and to the general guidelines that will be provided by the Bank at the initial training of the fiduciary staff. All records must be kept for seven years beyond the end of the operation's execution period. It is also recommended, and yet not mandatory, that the Executing Agencies developed electronic filing to avoid losing all paper files.

DOCUMENT OF THE INTER-AMERICAN DEVELOPMENT BANK

PROPOSED RESOLUTION DE-__/16

Guyana. Loan ____/BL-GY to the Co-operative Republic of Guyana
Support to Improve Maternal and Child Health

The Board of Executive Directors

RESOLVES:

That the President of the Bank, or such representative as he shall designate, is authorized, in the name and on behalf of the Bank, to enter into such contract or contracts as may be necessary with the Co-operative Republic of Guyana, as Borrower, for the purpose of granting it a financing to cooperate in the execution of a program for the support to improve maternal and child health. Such financing will be for the amount of up to US$4,000,000 from the resources of the Bank's Fund for Special Operations, corresponds to a parallel loan within the framework of the multilateral debt relief and concessional finance reform of the Bank, 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 _____)

LEG/SGO/IDBDOCS#40662119
GY-L1058

DOCUMENT OF THE INTER-AMERICAN DEVELOPMENT BANK

PROPOSED RESOLUTION DE-__/16

Guyana. Loan ____/BL-GY to the Co-operative Republic of Guyana
Support to Improve Maternal and Child Health

The Board of Executive Directors

RESOLVES:

That the President of the Bank, or such representative as he shall designate, is authorized, in the name and on behalf of the Bank, to enter into such contract or contracts as may be necessary with the Co-operative Republic of Guyana, as Borrower, for the purpose of granting it a financing to cooperate in the execution of a program for the support to improve maternal and child health. Such financing will be for the amount of up to US$4,000,000 from the resources of the Single Currency Facility of the Bank's Ordinary Capital, corresponds to a parallel loan within the framework of the multilateral debt relief and concessional finance reform of the Bank, 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 _____)

LEG/SGO/IDBDOCS#40662107
GY-L1058