Project Information Document/Integrated Safeguards Data Sheet (PID/ISDS)

Concept Stage | Date Prepared/Updated: 21-Sep-2017 | Report No: PIDISDSC21137
# BASIC INFORMATION

## A. Basic Project Data

<table>
<thead>
<tr>
<th>Country</th>
<th>Project ID</th>
<th>Parent Project ID (if any)</th>
<th>Project Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dominican Republic</td>
<td>P163031</td>
<td></td>
<td>Pro-Mejora: Improving the Quality and Efficiency of Health Services in the Dominican Republic (P163031)</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Region</th>
<th>Estimated Appraisal Date</th>
<th>Estimated Board Date</th>
<th>Practice Area (Lead)</th>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Financing Instrument</th>
<th>Borrower(s)</th>
<th>Implementing Agency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Investment Project Financing</td>
<td>Government of the Dominican Republic</td>
<td>Ministry of Public Health</td>
</tr>
</tbody>
</table>

## Proposed Development Objective(s)

The Project will support the Government of the Dominican Republic to improve the efficiency and quality of prioritized health services in intervention areas and strengthen essential public health functions at the national level.

## Financing (in USD Million)

<table>
<thead>
<tr>
<th>Financing Source</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>International Bank for Reconstruction and Development</td>
<td>50.00</td>
</tr>
</tbody>
</table>

**Total Project Cost** 50.00

## Environmental Assessment Category

<table>
<thead>
<tr>
<th>Category</th>
<th>Concept Review Decision</th>
</tr>
</thead>
<tbody>
<tr>
<td>B-Partial Assessment</td>
<td>Track II-The review did authorize the preparation to continue</td>
</tr>
</tbody>
</table>

Other Decision (as needed)
B. Introduction and Context

Country Context

1. **The Dominican Republic (DR) has achieved high economic growth since 1991, contributing to reductions in income inequality, non-income based poverty, and improvements in the overall quality of life of its citizens.** It is an upper middle income country with a GDP per capita in current Purchasing Power Parity/PPP terms of US$14,327 in 2015 (WDI 2016). From 1991 to 2013, the DR’s annual GDP growth averaged 5.3 percent and increased to 7.1 percent in 2014-2016, contributing to a reduction in its Gini coefficient from 0.52 in 2000 to 0.47 in 2016, as well as a steady reduction in non-monetary poverty which is defined as lack of access to essential services. In particular, the share of the population with no access to two services (out of six) decreased from 44 percent in 2000 to 25 percent in 2016, while the share of the population lacking access to four services fell from 16 percent to 6 percent in the same period. In addition, DR’s Human Development Index (HDI) score rose from 0.59 in 1990 to 0.65 in 2000 to a high HDI score of 0.72 in 2015, placing the DR in 99th place out of 188 countries in 2015 (UNDP 2016).

2. **However, the DR’s economic growth has not led to a commensurate improvement in income-based poverty; limited income mobility persists together with gender inequality and differences in access to quality services between rural and urban areas and across socioeconomic groups.** Poverty incidence in the DR increased from 32 percent in 2000 to 50 percent in 2004, and then fell to 30.5 percent in 2016. While incomes grew faster in poorer quintiles than incomes in richer quintiles between 2005 and 2015, the effects of the 2003 financial crisis disproportionately affected the poor. Limited upward economic mobility also seems to be an issue in the DR because over the past 15 years, just 7 percent of the population moved up to a higher socioeconomic group (e.g., from vulnerable to middle class), compared to 41 percent in the LAC Region (WB DR Policy Note 2016). The DR is the fourth most unequal country in LAC in terms of gender equality (UNDP 2014) and the third most unequal among the countries with a high level of human development (UNDP 2015). Inequality between women and men is observed in three areas: reproductive health, empowerment, and access to the labor market. Also, while economic growth has contributed to increasing the coverage of services, access gaps remain between urban and rural areas and socioeconomic groups. For example, a significantly higher share of children in high income quintile households have access to early childhood development services in both urban and rural areas (77 percent and 56 percent, respectively) compared to children in lower income quintiles in urban and rural areas (24 percent and 20 percent, respectively). In addition, only 89 percent of women without any education gave birth assisted by a trained health professional compared to 98 percent of women with tertiary education (ENDESA 2013).

3. **Poverty reduction and increased shared prosperity in the DR would require improving both equity and access to quality social services and economic opportunities.** Social development is one of the four major pillars that support the Government's National Development Strategy 2010-2030. The Government’s long-term strategy envisions a society with equal rights and opportunities, guaranteeing universal access to education, health, decent housing and

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1 Purchasing Power Parity (PPP) or international dollars refer to currencies adjusted across countries to make the value of purchased goods and services comparable.

2 Indicators of access to services include school attendance, level of schooling, drinking water, sanitation, quality of housing, overcrowding, and ownership of assets. Cited in World Bank. 2016. DR Policy Notes.

3 The Human Development Index (HDI) is a composite statistic of life expectancy, education, and income per capita indicators. A country scores higher HDI when the life expectancy at birth is longer, the education period is longer, and the income per capita is higher.

4 The only Latin American countries below the Dominican Republic are Honduras, Guatemala, and Haiti.

5 In the group of countries with high human development only Iran and Tonga have lower indexes.
quality basic services, while promoting progressive reductions in poverty and inequality. Its medium term goals in the health sector aim to expand access to public health insurance and enhance the quality of services. By 2030, the Government of the Dominican Republic (GoDR) aims to: (a) ensure access to quality services, that promote health and preventive care, through an integrated National Health System; (b) guarantee universal access to health insurance to ensure access to services and reduce out of pocket costs; and (c) implement an integrated, transparent, and sustainable health and social security system.

Sectoral and Institutional Context

4. Most health outcomes in the DR have improved yet several remain lower than regional averages; infant and maternal mortality remain high and the country is currently facing a double burden of diseases (persistent and emerging health problems). While DR’s infant and under-five mortality rates decreased from 47 to 25.7 and from 60 to 30.9 per 1000 live births, respectively from 1990 to 2015, they both remain much higher than the averages for Latin America and the Caribbean (LAC) of 15.2 and 18 per 1000 live births, respectively and the averages for Upper Middle Income Countries (UMIC) of 14.7 and 18.5 per 1000 live births, respectively. In addition, while the share of women in the DR that have access to professionally attended births is equal to the UMIC average (98 percent) and higher than the LAC average (93 percent), the DR’s Maternal Mortality Ratio/MMR (92 per 100,000 live births) is significantly higher than averages for both LAC (67) and UMIC (54) in 2015. In recent years, cardiovascular diseases, diabetes and cancers have increasingly become the main causes of morbidity and mortality and a significant burden for the health services, increasing the need for treatments and medication for chronic conditions. In the year 1990, non-communicable diseases accounted for 44.5% of disability-adjusted life years (DALYs), and that figure grew to 64.3% in 2015 (the LAC average was similar in this period - 48.1% in 1990 and 69.8% in 2015).

5. While access to health services is generally high, quality of care is a major health sector concern. As mentioned above, despite very high maternal care coverage rates, DR’s maternal mortality ratio remains high. Various assessments indicate that majority of maternal deaths in the DR could have been prevented by improving adherence to norms, protocols, and quality standards by properly trained personnel, access to required equipment, and enforcement of monitoring and supervision and regulatory arrangements. Another sign that the DR has a quality of care issue is that cervical cancer is the most frequent type of cancer among women 15 to 44 years of age. It also accounts for 11.8 percent of total cancer deaths among Dominican women (ICO Information Centre on HPV and Cancer 2016). Since cervical cancer is preventable and treatable when diagnosed at an early stage, the relatively high mortality rate from cervical cancer suggests issues in the screening process and continuity of care. The lack of continuity of care is a factor that contributes to health indicators in the DR being less than those in countries with similar incomes. For example, in 2015, the DR had lower coverage rates for the third dose of Polio and Hepatitis B vaccinations (87% and 81%, respectively) relative to averages for LAC (91% and 89%, respectively) and UMIC (94% and 93%, respectively). A number of clinical guidelines have also been

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7 A gynecologist/obstetrician attends to deliveries of 78.6 percent of women in urban areas and 69.7 percent of women in rural areas while a general practitioner attends to deliveries of 22.9 percent of women in urban areas and 28.8 percent of women in rural areas.
9 Some studies note that medical interns and residents are not sufficiently supervised by specialized doctors throughout the delivery process. According to ENDESA (2013), the DR also has a high cesarean rate (56%) which is much higher than the international recommended rate (10%).
10 WDI. 2017.
developed but enforcement mechanisms appear weak and prescriptions patterns suggest that the guidelines tend not to be implemented.

6. **While more public resources are needed in the health sector to continue to enhance service quality and expand financial protection, there is room to improve efficiency and cost-effectiveness of sector spending.** The DR’s per capita public spending on health ($389) was much lower than the UMIC ($509) and LAC ($567) averages in 2014 (WDI 2016). Nevertheless, there is also room to improve the efficiency of public spending on health. In particular, sector spending is heavily skewed toward curative care and hospitals. For instance, a 2014 study by Rathe and Hernandez estimates that the MSP spent 62 percent of its recurrent budget on curative services and only 5.7 percent on primary care and health promotion in 2014. Also, it is reported that the Contributory Health Insurance and Subsidized Health Insurance Regimes spent less than one percent and 10 percent of their respective budgets for prevention and promotion activities in 2014 (SeNaSa 2014). This is also in part because the system allows people to bypass primary care centers and use hospitals for basic care. In addition, health sector financing remains, to a large extent, based on historical budgeting. While there have been advances in using results-based financing at the primary care level (in three regions with previous Bank support through the Health Sector Reform APL2 and in six regions with Inter-American Development Bank/IADB support), there is a consensus that more significant changes would need to be made in budget allocation and payment mechanisms to ensure that budgets and financing flows are better aligned with sector priorities. For example, SeNaSA’s payment mechanism would need to be restructured so it would only pay for services provided according to norms to ensure that primary care is the first point of entry or gatekeeper in the service delivery network and that the referral and counter-referral works.

7. **Government efforts to improve the quality of health services and continuity of care** are underway and these efforts need to be supported strategically by other interventions in the sector. To address quality gaps especially at the first level of care which is supposed to serve as the first point of entry or gatekeeper based on the sector’s model of care, the MSP is moving forward with the process of habilitación, by which service providers must comply with certain standards in terms of infrastructure, equipment, human resources, and others. It is reported that approximately 60 percent of primary care public units have been qualified to provide health services (Ortiz 2017 cited in Rathe 2017). In addition, under the coordination of the National Health Services (Servicios Nacionales de Salud/SNS), certain areas such as the entire Regional Health Services (Servicios Regionales de Salud/SRS) III, Barahona Province in SRS IV, and an area in the Metropolitan Region or SRS 0 have prepared Master Plans to improve service delivery. It is expected that more areas/regions would complete their situation analysis and prepare their Master Plans. Moreover, in collaboration with other Government entities such as the Social Cabinet and National Health Insurance (Seguro Nacional de Salud/SeNaSa) has been implementing the Clinical Management System (Sistema de Gestión Clínica/SGC) since 2011 to monitor primary health care staff’s compliance with established health protocols. In addition, as noted above, the health sector has also been moving away from historical budgeting toward using results-based allocation of resources. These efforts are producing positive results, including increasing the focus on outcomes, and improving registration of information and reporting. At the same time, there is a consensus in the health sector that in order to have a greater impact on outcomes, more significant, strategic efforts are needed to improve access and quality to key inputs including putting in place a system for on-the-job training of health sector staff and strengthening management of human resources, medicines and

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Continuity of care refers to the uninterrupted management of the patient who passes from one doctor/facility to another doctor/facility following health care pathway protocols to provide timely and proper service for the specific condition of the patient. Continuity of care is related to quality of care and should apply when a patient is referred from a lower level of care facility to a higher level of care facility (referral) and when the patient is referred from a higher level of care facility to a lower level of care facility (counter-referral). Under the new model of care in the DR, patients would first need to go to a primary care facility that will evaluate them and decide whether they can be treated in the primary care center itself or whether they would need to be referred to a secondary or tertiary level health facility (specialized hospital) to resolve their health problem.
medical supplies. Complementary actions in financing health services are also necessary to support the implementation of the new model of care and incentivize the proper functioning of the referral and counter-referral network.

8. To complement interventions at the service provision level, several institutional capacity building efforts are being implemented, and the Government has requested the Bank’s support to deepen/expand reforms especially in the areas of overall sector governance, coordination of the network of public services, and strategic purchasing. The GoDR took a major step in 2015 in implementing the separation of key health sector functions as envisioned in the 2001 Health Sector Reform by ratifying Law 123-15.12 This law established the National Health Services (Servicios Nacionales de Salud/SNS) as the coordinating entity for the public network of health services, which resulted in the transfer of facilities, including hospitals that were under the MSP and the Dominican Social Security Institute (IDSS). The MSP retains its functions of stewardship of the health sector and management of collective/public health services while the National Health Insurance (Seguro Nacional de Salud/SeNaSa) remains the main public purchaser of health services to improve financial protection and quality of services, especially for the poor under the Subsidized Insurance Regime. This reform is particularly significant in the case of the MSP, which in the past had focused its actions more on the provision of services than sector governance. The MSP is now expected to focus on stewardship, regulation, technology evaluation and protocol development, collective health services, epidemiological surveillance and quality control. As a result, the MSP is developing and/or revising certain tools and procedures for strengthening its stewardship role. For example, it is updating norms for quality assurance mechanisms for priority interventions) and would need assistance to effectively implement these tools and procedures through the Provincial Directorates of Public Health (Direcciones Provinciales de Salud/DPS) at local levels. The DPS would also need their capacity strengthened. In addition, the SNS has developed its strategic plan and would also need to improve its institutional capacity to coordinate the public network of health services and support the SRS and assess their compliance with MSP requirements. Similarly, the Program of Essential Medicines/Center for Logistical Support (Programa de Medicamentos Esenciales/Centro de Apoyo Logistico/PROMESE/CAL)13 is taking steps to enhance its capacity to be able to undertake a larger share of centralized procurement of medicines and medical supplies for the public sector. It would need additional support to improve its management information system and logistical management capacity. Furthermore, SeNaSa is in the process of strengthening its ability to strategically purchase services and would need support to review and reorient its provider payment system. Figure 1 illustrates the main functions of these institutions.

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12 In 2001, the Government passed two key laws as part of a major health sector reform program: the General Health Law (42-01) and the Dominican Social Security System Law (87-01). Aside from the establishment of a universal health insurance system, key provisions of these laws include changes in institutional and financial arrangements such as restructuring public provision of health services, together with progressively decentralizing regional health networks.

13 In 2012, PROMESE/CAL was being officially designated as the sole public purchaser for medicines in order to achieve economies of scale and improve the affordability of medicines.
9. The proposed Project supports the World Bank’s goals of reducing poverty and promoting shared prosperity. The Project will support the implementation of health sector strategies to improve the quality of health services in the public sector in order to reduce disparities in access to quality services across socioeconomic groups and between urban and rural areas. Improving the quality of health services in the public sector is especially important in the DR because according to the ENDESA (2013) the largest proportion of the population that uses the country’s public facilities are the poorest 40 percent for both consultations/outpatient (82 percent from the lowest income quintile and 75 percent from the second lowest income quintile) and inpatient services (87 percent of the lowest quintile and 69 percent of the second lowest quintile). The Project will also strengthen the capacity of major health sector entities to perform their respective functions, enhancing the results-orientation and efficiency of health spending especially for services used by the poor, and improving sector governance and coordination.

10. The proposed Project is consistent with the Results Area on Strengthening Social Services Delivery of the DR Country Partnership Strategy (CPS) (Report No. 49620, discussed at the Board on August 12, 2009) for the period FY15-18. In the health sector, the Project would support ongoing and proposed health reforms to further improve access and quality of health services, particularly effective coverage for the poor.

11. The proposed Project also responds to the Government’s goal of improving coverage and quality of health services, as well as improving the quality of spending (or getting “good value for money spent”) of public institutions working in the sector. In particular, it supports the achievement of the health sector related goals of the Government’s National Development Strategy 2010-2030 and the goals of the MSP’s Public Sector’s Health Multiyear Plan 2017-2020 (Plan Plurianual del Sector Público en Salud 2017-2020) related to improving physical and financial access to quality health
services through an integrated public network of health services. Thus, in line with both the CPS and the GoDR’s goals, the Project will: (a) finance rehabilitation/renovation and equipping of health facilities, with an emphasis on the first level of care; (b) contribute to improving the performance of health staff by establishing a system for on-the-job-training for health personnel; (c) strengthen local capacity for managing key health sector inputs (human resources, medicines, equipment and supplies); (d) contribute to restructuring the provider payment mechanism to promote the implementation of the new model of care which assigns the first level of care as the gatekeeper/point of entry to the health services’ network and strengthen coordination across all levels of care in the network; and (e) support activities that enhance management/administration of facilities and overall sector coordination and governance.

C. Proposed Development Objective(s)

The Project will support the Government of the Dominican Republic in the implementation of the new Health Sector Strategy to improve the efficiency and quality of health services in the primary and specialized levels of care.

Key Results (From PCN)

i. SeNaSa implements a new payment system for health services with incentives for the provision of preventive services, outpatient services and services defined by facility level has been implemented (efficiency and quality).

ii. A quality control system (including technical audits) to verify compliance with clinical practice guidelines for five prevalent diseases and priority health services has been implemented (quality).

iii. PROMESE/CAL has increased to least 85% its coverage of medicines and supplies demanded: based on level of care, supply at Specialized Centers in Health Care (Centros Especializados en Atención en Salud (CEAS) and supply in People’s Pharmacies in the Southern region (efficiency).

iv. At least 5 reorganization and functional fusion schemes have been implemented in groups of 2 or 3 hospitals, based on the criteria of network integration and complementarity of services (efficiency).

v. The Program for the management of chronic diseases has been implemented in 20 municipalities (quality and efficiency).

D. Concept Description

12. The proposed Project will build on the experiences and achievements of previous projects in supporting the health sector strategy, particularly priorities that emerged from the ratification of Law 123 which concretized the separation of functions as envisioned in the Health Sector Reform Law of 87-01. It will strengthen the capacity of major health sector entities (MSP, SNS, PROMESE/CAL and SeNaSa) to perform their main functions to support the development and implementation of tools and interventions to improve the quality of health services, as well as collective/public health

14 Diabetes, heart failure, hypertension, prenatal care, cervical cancer screening and care

15 Due to increased centralized procurement, there will be benefits from economies of scale, including reducing out of pocket costs for medicines especially in People’s Pharmacies).

16 The Health Sector Reform APL1 (US$30M), implemented from 2005 to 2009, focused on strengthening health care infrastructure, reorganizing regional health systems, improving multi-year financial planning, and supporting actions to increase the number of poor enrolled under the Subsidized Health Insurance Regime. The Health Sector Reform APL2 (US$30.5M), implemented from 2010 to 2016 piloted a results-based financing mechanism in three SRS to improve access to quality primary health care services, especially for the poor and those who have no access to health insurance. It also supported the institutional strengthening of the MSP, the Executive Commission of Health Sector Reform (CERSS), PROMESE/CAL, and SeNaSa.
services that cover the entire DR population and (b). It will have two major technical components, and a management
component that will be implemented over a four-year period.

**Component 1. Institutional Strengthening and Support to the New Health Sector Strategy (USD 17 million).** This
compartment will support key health sector entities in specific areas, relevant to the implementation of the new sector
strategy. It includes three subcomponents:

A. **Strengthening the Ministry of Public Health (MSP in Spanish) and Provincial Health Directorates (Direcciones
Provinciales de Salud/DPS).** This subcomponent will support actions aimed at strengthening the capacity of the MSP and
the DPS for sector planning and management; for performing stewardship and regulatory functions that will include the
establishment of mechanisms for quality control of health services; a strategic communication program for decision
makers, health workers, and the general population; and provision of essential public health functions (salud colectiva).

B. **Strengthening critical functions to support health services:** sector coordination, centralized procurement of medicines
and medical inputs, and strategic purchasing of health services. This subcomponent would support:

i) The National Health Services (SNS) to strengthen its capacity to provide: (a) technical support to the SRS in the
formulation of their regional master plans to reorganize health services and (b) logistical support to the regional health
networks. For example, developing a team for maintenance of medical equipment, deployment of resources to respond
to medical and public health emergencies.

ii) The Program of Essential Medicines/Center for Logistical Support (PROMESE/CAL) to expand centralized procurement
and strengthen management of medicines, supplies and medical devices in order to reduce the unit cost of medicines
and other medical inputs for the public network of health services and People's Pharmacies (Farmacias del Pueblo) and
also improve the timely access to medicines of the population. The subcomponent would support the implementation of
an information system to support the management of PROMESE/CAL and, potentially, the construction and equipment
of a warehouse in the Southern Region.

iii) The National Health Insurance (SeNaSa) for the strategic purchase of services focused on generating a greater impact
on the health conditions of the affiliated population. This would include technical support for the reformulation of its
payment system for health services in order to strengthen performance and production incentives. The payment system
would function as a tool for the reorganization of the health service network, to promote the implementation of the
referral and counter-referral system and for appropriate follow-up of the target population (pregnant women, young
children, and people with chronic diseases, among others).

C. **Continuous training of human resources for health.** This subcomponent would support an intensive process of on-the-job-training including refresher courses and also specialized courses for human resources in clinical areas (nursing, community workers, and primary care physicians); in logistics management for technicians; in essential functions of Public Health of the MSP and DPS and PROMESE/CAL; and in management of health services including hospital administration, health and safety management, as well as medical waste management. This subcomponent would seek to develop local capacity in the health sector for implementing in-service training mechanisms.

**Component 2. Implementation and Expansion of the New Model of Health Care (USD 30 million).** This component will
support the investments needed to implement the new model of care in areas that have already completed their master
plans for reorganizing and strengthening health service delivery networks. It would also support the preparation of the
remaining master plans. It would also finance investments in rehabilitation/renovation/readjustment of first level of
care health facilities that would include development/fine-tuning of environmental management guidelines of proposed works, and equipment to expand the implementation of the new model of health care in other areas.

**Component 3. Project Management and Monitoring and Evaluation (USD 3 million).** This component will support the Project Execution Unit under the MSP that will be responsible for the overall management of the Project and each component, as well as performing fiduciary tasks, and monitoring and evaluation of the Project.

**SAFEGUARDS**

**A. Project location and salient physical characteristics relevant to the safeguard analysis (if known)**

1. The proposed Project will support the new health sector strategy, particularly priorities (improving quality and efficiency of health services) that emerged from the ratification of Law 123-15 which concretized the separation of functions of health service provision and sector stewardship as envisioned in the Health Sector Reform Law of 87-01. As part of Component 1 (Institutional Strengthening and Support to the New Health Sector Strategy), activities to strengthen environmental management related to medical wastes and construction/rehabilitation of infrastructure are recommended to be included, as well as training for implementing practices that were outlined in the Manual of Waste Management of Health Services of the Health Sector Reform Phase 1 Adaptable Lending Program (PARS1) . As part of Component 3 (Project Management and Monitoring and Evaluation) that will support the proposed Project Implementation Unit (PIU) under the Ministry of Public Health (MSP), an assessment will be undertaken to determine the type of environmental institutional/technical support that would be required by the proposed PIU and that would be financed by this component. An Environmental and Social Management Framework (ESMF) will be developed to manage the potential associated environmental impacts and risks related to the Project. This document will also include citizen engagement mechanisms including regular consultations during implementation.

2. Overall the Project does not include activities that could have significant adverse impacts on the environment and/or general population. The Project’s potential negative environmental impacts are basically of low or moderate intensity, limited to the medical facilities and work sites, and can be mitigated with standard measures. Nevertheless, some Project activities may have potential negative environmental impacts, particularly those related to construction and rehabilitation, as well as operation of health facilities. The process of implementing these works could also pose potential health and safety risks for laborers and communities and would therefore need to comply with the Environmental Safeguard OP/BP 4.01 for category B projects. An Environmental Management Plan (EMP) would need to be implemented to manage, reduce, or mitigate potential impacts. All proposed works must obtain authorization and permits from the Environmental Ministry and from Municipal Authorities where works will take place.

**B. Borrower’s Institutional Capacity for Safeguard Policies**

According to the MSP’s organogram, the Vice Ministry for Collective Health handles environmental aspects which are oriented towards environmental health of the population and for specific catastrophic events. However, the MSP does not appear to have an Institution Environmental Unit whose mandate is to implement environmental management at the institutional level, including overseeing implementation of environmental safety risks and bylaws. For the Project, it is recommended that the PIU includes an Environmental Health and Safety Specialist to assist in obtaining the environmental permits for the works to be supported by the Project, as well as to supervise the compliance of the EMP and environmental and safety clauses for works under the Project. These said clauses must include specific actions and
provisions to comply with the Environmental Safeguards OP/BP 4.01 and applicable national laws and regulations.

C. Environmental and Social Safeguards Specialists on the Team

Ramon E. Anria, Social Safeguards Specialist
Francisco Xavier Geraldes Siragusa, Environmental Safeguards Specialist

D. Policies that might apply

<table>
<thead>
<tr>
<th>Safeguard Policies</th>
<th>Triggered?</th>
<th>Explanation (Optional)</th>
</tr>
</thead>
</table>
| Environmental Assessment OP/BP 4.01 | Yes        | The Project is proposed to be classified as Category B. The specific individual works to be financed under the Project will not be known until after Project approval but almost all of them will be for rehabilitation/renovation of health centers and possibly the construction of one warehouse. The potential environmental impacts associated with the type and size of works are anticipated to be relatively minor to moderate, and with appropriate standard mitigation measures the potential negative impacts would be managed appropriately. Potential risks and impacts include health worker safety, improper management from increased medical wastes and expired pharmaceuticals. Social aspects to be considered would be improving health facility accessibility (or standards for this), ensuring access to services by diverse social groups, and potential impacts of increased costs for services provided. An Environmental and Social Management Framework (ESMF) will be developed to manage the potential associated environmental impacts and risks related to the types of works to be financed under Project Sub-components: 1 B. (Strengthen critical functions in support health services; sector coordination and stewardship, centralized procurement of medicines and medical inputs, and strategic purchasing of health services; and construction and equipment of a warehouse in the Southern Region) and Component 2 (Investments in Rehabilitation/renovation/readjustment of first level of care health facilities and equipment to expand the implementation of the new model of health care in other areas). The ESMF will also incorporate the World Bank's Environmental Health Safety Guidelines for works related to health care facilities and water/sanitation infrastructure. As part of the
environmental management activities of the Project, a Medical Waste Management System will be prepared. The Project will also support capacity building efforts to promote occupational health and safety training including exposure to diseases, medical waste and use of certain equipment with radiation.

<table>
<thead>
<tr>
<th>Natural Habitats OP/BP 4.04</th>
<th>No</th>
<th>The Project will not involve any works in these areas and thus will not have significant negative impacts on natural habitats .</th>
</tr>
</thead>
<tbody>
<tr>
<td>Forests OP/BP 4.36</td>
<td>No</td>
<td>The Project will not involve any works in these areas and thus no significant negative impacts on forests.</td>
</tr>
<tr>
<td>Pest Management OP 4.09</td>
<td>No</td>
<td>The Project will not finance activities involving the use of pesticides nor will it promote their use; it is not expected to lead to an increase in the use of pesticides.</td>
</tr>
<tr>
<td>Physical Cultural Resources OP/BP 4.11</td>
<td>No</td>
<td>The Project will not involve significant impacts on physical cultural resources. A chance finds procedure will be included as part of the EMPs that will be developed under OP/BP 4.01.</td>
</tr>
<tr>
<td>Indigenous Peoples OP/BP 4.10</td>
<td>No</td>
<td>OP 4.10 should not be triggered as there are no distinct Indigenous Peoples in the Dominican Republic that fulfill the four characteristics indicated under this policy.</td>
</tr>
<tr>
<td>Involuntary Resettlement OP/BP 4.12</td>
<td>TBD</td>
<td>OP 4.12 remains as TBD until the Task Team confirms that there is no need to acquire land and/or affect squatters or informal vendors for the construction of a warehouse in the Southern region. The Government has already confirmed that health facilities to be rehabilitated under Component 2 will not require any land to be purchased nor any type of resettlement. If land is to be purchased for the warehouse in the Southern region, the Task Team will provide information as to the tenure of the land being acquired to include ownership/titling of said land.</td>
</tr>
<tr>
<td>Safety of Dams OP/BP 4.37</td>
<td>No</td>
<td>This policy should not be triggered because the Project will not affect Safety of Dams OP/BP 4.37.</td>
</tr>
<tr>
<td>Projects on International Waterways OP/BP 7.50</td>
<td>No</td>
<td>This policy should not be triggered because the Project will not affect International Waterways OP/BP 7.50.</td>
</tr>
<tr>
<td>Projects in Disputed Areas OP/BP 7.60</td>
<td>No</td>
<td>This policy should not be triggered because the proposed Project will not affect disputed areas as defined under the policy OP/BP 7.60.</td>
</tr>
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</table>
E. Safeguard Preparation Plan

Tentative target date for preparing the Appraisal Stage PID/ISDS

Oct 09, 2017

Time frame for launching and completing the safeguard-related studies that may be needed. The specific studies and their timing should be specified in the Appraisal Stage PID/ISDS

The Project will complete an Environmental and Social Management Framework (ESMF), and the EMP for known infrastructural works to be approved by the World Bank before Project appraisal in November. The Government team will undertake consultations with stakeholders including health staff and civil society and community based organizations on the design of the Project in September and October. In addition to consultations and preparation of the ESMF, the Project will also support activities to promote citizen participation such as a social oversight system coordinated by the National Health Insurance (SENASA) in collaboration with other state institutions and social and community organizations.

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