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Report No: PAD2357

INTERNATIONAL DEVELOPMENT ASSOCIATION

PROJECT PAPER

ON A

PROPOSED ADDITIONAL GRANT AND RESTRUCTURING

IN THE AMOUNT OF SDR 18.3 MILLION
(US$ 25 MILLION EQUIVALENT)
FROM CRISIS RESPONSE WINDOW RESOURCES

TO THE
REPUBLIC OF HAITI

FOR THE

IMPROVING MATERNAL AND CHILD HEALTH THROUGH INTEGRATED SOCIAL SERVICES PROJECT

June 1, 2017

Health, Nutrition & Population Global Practice
LATIN AMERICA AND CARIBBEAN

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CURRENCY EQUIVALENTS
(Exchange Rate Effective April 30, 2017)

Currency Unit	=	Haitian Gourdes
US$1	=	69.37 HTG
US$1	=	SDR 0.732

FISCAL YEAR
October 1 – September 30

ABBREVIATIONS AND ACRONYMS

AF	Additional Financing
BCR	Benefit-Cost Ratio
CU	Contracting Unit
CPF	Country Partnership Framework
CRW	Crisis Response Window
DHS	Demographic and Health Survey
DSA	Debt Sustainability Analysis
EHS	Environmental, Health and Safety
ESMF	Environmental and Social Management Framework
ESMP	Environmental and Social Management Plan
FAES	Economic and Social Assistance Fund (*Fonds D'Assistance Economique et Sociale*)
GoH	Government of Haiti
GRS	Grievance Redress Service
HRITF	Health and Innovation Results Trust Fund
IDA	International Development Association
IDWT	International Development Association - Crisis Response Window
LIC	Low-Income Country
MS	Moderately Satisfactory
MSPP	Ministry of Public Health and Population (*Ministère de la Santé Publique et de la Population*)
NGO	Non-Governmental Organization
PAD	Project Appraisal Document
PDO	Project Development Objective
PIU	Project Implementation Unit
PPSD	Project Procurement Strategy for Development
RAP	Resettlement Action Plans
RBF	Results-Based Financing
RPF	Resettlement Policy Framework
UGP	Project Management Unit (*Unité de Gestion de Projet)*
VSL	Value of Statistical Life
WASH	Water, Sanitation and Hygiene
WB	World Bank

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HAITI

ADDITIONAL FINANCING FOR THE IMPROVING MATERNAL AND CHILD HEALTH THROUGH INTEGRATED SOCIAL SERVICES PROJECT

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The World Bank

ADDITIONAL FINANCING DATA SHEET

Haiti

Additional Financing for the Improving Maternal and Child Health Through Integrated Social Services Project (P163313)

LATIN AMERICA AND CARIBBEAN

Health, Nutrition, and Population Global Practice

Basic Information – Parent			
Parent Project ID:	P123706	Original EA Category:	B - Partial Assessment
Current Closing Date:	31-Dec-2019		

Basic Information – Additional Financing (AF)			
Project ID:	P163313	Additional Financing Type (from AUS):	Restructuring, Scale Up
Regional Vice President:	Jorge Familiar	Proposed EA Category:	B
Country Director:	Mary A. Barton-Dock	Expected Effectiveness Date:	14-Sep-2017
Senior Global Practice Director:	Timothy Grant Evans	Expected Closing Date:	31-Dec-2019
Practice Manager/Manager:	Daniel Dulitzky	Report No:	PAD2357
Team Leader(s):	Andrew Sunil Rajkumar		

Borrower				
Organization Name	Contact	Title	Telephone	Email
Ministry of Economy and Finance	Jude Alix Patrick Salomon	Minister	50937012303	japsalomon@gmail.com

Project Financing Data - Parent (Improving Maternal and Child Health through Integrated Social Services-P123706) (in USD Million)

Key Dates

Project	Ln/Cr/TF	Status	Approval Date	Signing Date	Effectiveness Date	Original Closing Date	Revised Closing Date
P123706	IDA-H8640	Effective	21-May-2013	14-Jun-2013	12-Sep-2013	31-Dec-2018	31-Dec-2019
P123706	TF-13431	Closed	20-Apr-2013	20-Apr-2013	20-Apr-2013	31-Dec-2013	30-Jun-2014
P123706	TF-14474	Effective	14-Jun-2013	14-Jun-2013	15-Sep-2014	31-Dec-2018	31-Dec-2018

Disbursements									
Project	Ln/Cr/TF	Status	Currency	Original	Revised	Cancelled	Disbursed	Undisbursed	% Disbursed
P123706	IDA-H8640	Effective	USD	70.00	70.00	0.00	30.13	34.12	43.05
P123706	TF-13431	Closed	USD	0.85	0.82	0.03	0.82	0.00	100.00
P123706	TF-14474	Effective	USD	20.00	20.00	0.00	0.00	20.00	

Project Financing Data - Additional Financing Additional Financing for the Improving Maternal and Child Health Through Integrated Social Services Project (P163313)(in USD Million)

[ ]	Loan	[ ]	Grant	[X]	IDA Grant
[ ]	Credit	[ ]	Guarantee	[ ]	Other

Total Project Cost:	25.00	Total Bank Financing:	25.00
Financing Gap:	0.00		

Financing Source – Additional Financing (AF)	Amount
IDA Grant	0.00
IDA Grant from CRW	25.00
Total	25.00

Policy Waivers

Does the project depart from the CAS in content or in other significant respects?	No
Explanation	
Does the project require any policy waiver(s)?	Yes

Explanation: In light of Haiti's high level of debt distress and situation of urgent need following Hurricane Matthew, this Project Paper seeks the approval of the Executive Directors to provide SDR 18.3 million (US$25 million equivalent) from the IDA Crisis Response Window (CRW) for this proposed additional financing in the form of a grant, rather than on Haiti's current IDA terms. Haiti is a yellow light country, eligible for a mix of grants and credits in FY17 under its regular allocation and under any CRW allocation. However, the post-disaster Joint Debt Sustainability Analysis (DSA) for Haiti, circulated to the Executive Directors on November 16, 2016, finds the country at high risk of debt distress following Hurricane Matthew. The provision of financing in the form of all grants for the proposed operation is appropriate, as the provision of credits would further heighten Haiti's risk of debt distress at a time of urgent need. On the basis of the November 2016 DSA, in FY18, Haiti will become eligible again for 100 percent grant financing from IDA.

Has the waiver(s) been endorsed or approved by Bank Management?	Yes

Explanation

The waiver was endorsed by Bank Management on May 13, 2017 and would be considered and approved by the Executive Directors in the context of their consideration of and approval of this Board package.

Team Composition

Bank Staff				
Name	**Role**	**Title**	**Specialization**	**Unit**
Andrew Sunil Rajkumar	Team Leader (ADM Responsible)	Sr. Economist (Health)	Task Team Leader	GHN04
Rose Caline Desruisseaux-Cadet	Procurement Specialist (ADM Responsible)	Procurement Specialist	Procurement	GGO04
Aboubacar Magassouba	Procurement Specialist	Consultant	Procurement	GGO04
Fabienne Mroczka	Financial Management Specialist	Sr. Financial Management Specialist	Financial Management	GGO22
Asli Gurkan	Safeguards Specialist	Sr. Social Development Specialist	Social Development	GSU04
Victor Manuel Ordonez Conde	Team Member	Sr. Finance Officer	Disbursements	WFALA
Faly Diallo	Team Member	Finance Officer	Disbursements	WFALA
Isabella Micali Drossos	Counsel	Senior Counsel	Legal	LEGLE
Louise Estavien	Team Member	Consultant	Consultant	GHN04
Lydie Madjou	Team Member	Financial Management Specialist	Financial Management	GGO22
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Marie Isabelle Simeon	Team Member	Health Specialist	Operations	GHN04
Nicolas Antoine Robert Collin Dit De Montesson	Team Member	Consultant	Operations	GHN07
Nicolas Kotschoubey	Safeguards Specialist	Consultant	Environment	GEN04
Viviana A. Gonzalez	Team Member	Program Assistant	Operations	GHN04

Locations					
Country	**First Administrative Division**	**Location**	**Planned**	**Actual**	**Comments**
Haiti	Departement du Sud	Departement du Sud	X		
Haiti	Departement de la Grand'Anse	Departement de la Grand'Anse	X		
Haiti	Departement de Nippes	Departement de Nippes	X		
Haiti	Departement du Nord-Ouest	Departement du Nord-Ouest	X		

Institutional Data
Parent (Improving Maternal and Child Health through Integrated Social Services-P123706)
Practice Area (Lead)
Health, Nutrition & Population
Contributing Practice Areas

Additional Financing for the Improving Maternal and Child Health Through Integrated Social Services Project (P163313)
Practice Area (Lead)
Health, Nutrition & Population
Contributing Practice Areas

Consultants (Will be disclosed in the Monthly Operational Summary)
Consultants Required? Consultants will be required

I. Introduction

1. **This Project Paper seeks the approval of the Executive Directors to: (i) provide an additional IDA grant in an amount of SDR 18.3 million (US$25 million equivalent) to the Republic of Haiti for the Improving Maternal and Child Health through Integrated Social Services Project (P123706).** The proposed Additional Financing (AF) would be financed by IDA's Crisis Response Window (CRW)[1], as part of a package of a US$100 million of support from the World Bank to help the Government of Haiti recover and rebuild after Hurricane Matthew, which struck the country on October 4, 2016. This event was described and the proposed Word Bank response outlined in the CRW Paper circulated to the Executive Directors on January 22, 2017 and considered at a technical briefing held on January 26, 2017. In this context, Management underlined that funding from ongoing projects was mobilized to respond to immediate needs in the affected areas and proposed providing funding in the form of grants for the above-mentioned package, consisting of four additional financing operations in the Transport and Disaster Risk Management sectors, the Health Sector, the Water Sector, and the Agricultural Sector to be financed from the CRW. An estimated US$2.2 billion are needed for reconstruction and rehabilitation. The proposed AF would finance Hurricane response activities in the affected areas, mainly: (i) to restore the quality and supply of health services (e.g. via rehabilitation and re-equipping of health facilities damaged by the Hurricane); and (ii) to scale-up cholera prevention and response activities, to help address the new front for cholera that has opened up in Hurricane-affected areas. The AF would also fill the financing gap created under the Original Grant to finance emergency response activities immediately after Hurricane Matthew struck Haiti on October 4, 2016.

2. **Concurrently, the Project would be restructured** to: (i) revise the Project Development Objective (PDO) and Results Framework to reflect the expanded geographical coverage and emergency response objectives of the project; (ii) activate new safeguards policies: the Involuntary Resettlement Policy (OP/BP 4.12) to anticipate the possibility – although highly unlikely – of involuntary resettlement in the Hurricane-affected areas, the Physical Cultural Resources Policy (OP/BP 4.11) and the Pest Management Policy (OP/BP 4.09); and (iii) add a new disbursement category for potential compensation of affected individuals under OP/BP 4.12.

II. Background and Rationale for Additional Financing in the Amount of US$25 Million

A. Country Context

3. **Haiti remains extremely vulnerable to natural disasters with 96 percent of the population at risk.** On October 4, 2016, category 4 Hurricane Matthew struck Haiti's south-west coast, affecting over 2 million people, about 20 percent of the country's population. The Directorate of Civil Protection (Direction de la Protection Civile) of the Government of Haiti (GoH) reported 546 deaths, 128 missing, 439 injured, 175,500 people living in temporary shelters, and immediate humanitarian assistance needs for 1.4 million people (about 12.9 percent of the population). This natural catastrophe comes less than seven years after the devastating January 12, 2010 earthquake of magnitude 7.0 struck 25 km west of Port-au-Prince, Haiti's capital, killing 220,000 people and displacing 1.5 million.

[1] Management informed the Executive Directors of its intention to allocate an indicative amount of US$100 million equivalent to support Haiti's response to the impact of the Hurricane Matthew at a technical briefing on January 26, 2017. See the note entitled "IDA Crisis Response Window Support for the Republic of Haiti Emergency Recovery and Reconstruction Following the Impact of Hurricane Matthew" for additional information.

4. **Reconstruction needs were assessed at 25 percent of gross domestic product (GDP) (US$2.2 billion)**[2]. The agriculture and housing/urban sectors were the hardest hit. Up to 90 percent of crops and livestock were lost in coastal areas, including stable food crops, but also cash and tree crops such as coffee, cocoa and vetiver. Thousands of structures were damaged and 75 percent of structures in the heaviest-hit communities in Grand'Anse[3] were entirely destroyed. More than 100,000 houses were heavily damaged or destroyed, half of which were in Grand'Anse. Key roads and bridges were washed away. The area's already limited water, sanitation, and energy infrastructure was damaged. Although damages and losses appeared more modest in the education and health sectors, the population was significantly affected by the damage and destruction of schools and the interruption of services at damaged or destroyed health centers. Over 450,000 children were estimated to remain out of school, the vaccine cold chain was destroyed, and a sharp increase in suspected cholera cases has been recorded in affected departments (the number of cases has since dropped but the risk of cholera spikes remains high).

5. **In addition, the passage of Hurricane Matthew has led to a new front in the cholera epidemic.** In the southern Departments of Haiti and in the Northwest, there has been a spike in the number of cases and deaths from cholera. Total deaths in 2016 were about a third higher than in 2015. Between September and October 2016, the number of new suspected cases doubled. It has since fallen back to some extent, but the case-fatality ratio (defined as the percentage of suspected cases resulting in death) is increasing. During the first 10 weeks of 2017, the case-fatality ratio nationwide was 48 percent higher than in 2016 and 79 percent higher than in 2015 for the same period. This situation is particularly salient in Hurricane-affected Departments (see Table 1). Hurricane response efforts through mobile health clinics and increased community interventions have contributed to the provision of critical basic services. However, the combination of severely damaged infrastructure, unmet healthcare needs, a deterioration in water and sanitation conditions and new migration patterns caused by the Hurricane compounds the high risk of cholera and infectious disease outbreaks.

Table 1. Cholera Incidence and Case-Fatality Ratio in Hurricane-Affected vs. Non-Affected Departments, Haiti (January 1 – March 11 2017)

	Hurricane-Affected Departments (Grand'Anse, Nippes, South, Northwest)	**Other Departments** (North, Northeast, Artibonite, Centre, West, Southeast)
Cholera Incidence (cases per 1000 people; 1 Jan – 11 March 2017)	0.308	0.268
Case-Fatality Ratio (1 Jan – 11 March 2017)	2.52%	0.74%

Source: Ministry of Public Health and Population epidemiological data

6. **This latest disaster has compounded Haiti's pre-existing development challenges, increasing poverty and vulnerability, threatening livelihoods, and hampering already weak service delivery and human development outcomes**. It also exacerbated Haiti's underlying socio-economic drivers of poverty, such as social divisions and inequity, fragility of political mechanisms, the Government's weak capacity, risks of political instability, and persistent volatility. Almost 60 percent of Haiti's population, or 6.3 million people, remain poor,[4] and 24 percent (2.5 million) are extremely poor, with poverty highest in rural areas. The poorest regions, which are also the furthest from the capital, show extreme

[2] October 24, 2016: Rapid Damage and Loss Assessment of Hurricane Matthew, by the Government of the Republic of Haiti with joint support from the World Bank and the Inter-American Development Bank.
[3] Communities of Maniche, Camp Perrin, Chantal, Beaumont, Duchity, Moreau, and Chambellan.
[4] Under the Haitian poverty line of US$1.98 per day based on consumption.

poverty rates exceeding 40 percent and have very limited access to basic services. [5]

B. Situation of Urgent Need of Assistance or Capacity Constraint

7. **The proposed Additional Financing meets the criteria of OP 10.00 Paragraph 12 (Projects in Situations of Urgent Need of Assistance or Capacity Constraints) and was processed through condensed procedures because:** (i) Hurricane Matthew caused a national disaster and emergency; (ii) Haiti faces severe capacity constraints with under-resourced response systems in the Health sector which have limited ability to respond to all aspects of the disaster; and (iii) the shock caused by Hurricane Matthew threatens to deepen already widespread and entrenched poverty of the affected areas, among the poorest in the country.

8. **Hurricane Matthew, the first hurricane of this magnitude to make landfall in Haiti in 52 years, has caused large-scale disaster mostly in the southern part of the country.** The hurricane's high wind speeds, heavy rainfall, and devastating storm surge resulted in flooding, landslides, and extensive destruction of infrastructure and livelihoods, especially in the southern departments of Grand'Anse, Nippes, and Sud, where 80 percent, 66 percent, and 65 percent of people, respectively, are poor (under the national poverty line of US$2.41 per day) and 36 percent, 30 percent, and 26 percent, respectively, are extremely poor (under the national extreme poverty line of US$1.23 per day). Lesser damage was seen in coastal areas in other parts of the country.

9. **The GoH Damage and Loss Assessment of October 2016 estimated total losses and damages equivalent to 22 percent of the GDP (US$1.9 billion).** This figure was later evaluated to be 32 percent of GDP by the Post-Disaster Needs Assessment[6], with damages and losses specific to the health sector estimated at US$133 million. In light of the magnitude of these damages and losses as well as Matthew's impact on the GoH's already limited capacity and resources and the urgent need for support in responding to the crisis, the use of expedited procedures to prepare this proposed AF is appropriate.

C. Sectoral and Institutional Context

10. **Although Haiti has made significant progress on key health outcomes since the 1990s, it still fares worse than many low-income countries in terms of service coverage of key interventions and in providing equitable access to health.** Between 1990 and 2015, maternal and child mortality each fell by about half. Yet, the maternal mortality ratio and the under-5 mortality rate would have to decline by another 80 percent and 64 percent, respectively, by 2030 to attain the Sustainable Development Goals. Haiti has low coverage rates of basic health services relative to other low income countries, with institutional delivery rates at 37 percent (the LIC average is 70.5) and only 68 percent of children under 24 months fully vaccinated against diphtheria, tetanus, and pertussis (the LIC average is 80 percent). Service coverage is dramatically lower for the poorest, with deliveries in health care facilities eight times more frequent (76 percent) for the highest than for the lowest wealth quintile (9 percent).

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[5] "Investing in People to Fight Poverty in Haiti." World Bank, December 2014.

[6] February 6, 2017: Post-Disaster Needs Assessment, the Government of the Republic of Haiti with joint support from the European Union, the Inter-American Development Bank, the United Nations agencies, and the World Bank.

11. **The health sector is highly dependent on external financing.** Although donor assistance has enabled Haiti to expand social service delivery, it has also increased Government's reliance on such financing. This assistance peaked in 2012 following the earthquake only to fall back to pre-earthquake levels by 2016, having displaced domestic financing for health. A 2017 World Bank Health Financing Assessment underlines the correlation between diminishing external financing and increases in out-of-pocket expenditures, raising concerns about achievement of universal access to healthcare. In addition, institutional capacity in the sector remains a challenge, despite efforts to strengthen disease surveillance, financial management, procurement, and monitoring and evaluation of MSPP, including under the Original Grant.

12. **A cholera epidemic broke out in Haiti in October 2010. More than 800,000 cholera cases and more than 9,400 deaths have been recorded in the country**. An international coalition supports the Government and the MSPP in implementing a 10-year National Plan for the Elimination of Cholera (2013-2022). The plan is designed to eliminate cholera through: (i) epidemiological surveillance; (ii) medical treatment; (iii) improved water and sanitation; and (iv) health promotion. As a result of joint efforts, Haiti saw a substantial drop in the overall number of new cases and a steady decrease in the number of deaths between 2011 and 2014. However, a resurgence of the epidemic in 2015 and 2016, due in part to severe weather events, has underlined the need for continuous efforts to maintain surveillance and rapidly address localized cholera outbreaks, especially during the rainy seasons, while investing in sustainable improvements in water and sanitation infrastructure. Similarly, deaths from cholera decreased considerably from 2011 to 2015 to reach a Case Fatality Rate (CFF) of 0.89 percent in 2015, but increased in 2016 and reached an alarmingly high 1.6 percent in the first 10 weeks of 2017 following Hurricane Matthew, underlying the importance of continued robust efforts to combat cholera through health response and water and sanitation investments. [7]

D. Higher Level Objectives To Which The Project Contributes

13. **The activities under the proposed AF and restructuring are consistent with the Country Partnership Framework (CPF) and the Government's priorities.** The AF is fully aligned with the CPF for Haiti (FY16-FY19), discussed by the Board of Executive Directors on September 29, 2015 (Report No. 98132-HT). In particular, the AF would support Objectives 6 and 7 of the CPF – "Increase Access to Health Services for Mothers and Children" and "Cholera Control in Priority Communes" – within the Hurricane-affected Departments. For the cholera stream, the proposed activities are also fully aligned with the Government's "National Plan to Eliminate Cholera 2013-2022". The AF, like the Original Grant, is aligned with the Health Nutrition and Population goals of achieving Universal Health Coverage and financial protection as it contributes to increasing the access and use of health and other social services with a focus on women, children under five and vulnerable families.

E. Original Grant Background

14. **Original Grant.** The Original Grant was approved by the Board of Executive Directors on May 21, 2013, for an amount of US$70 million from IDA (Grant H864-0-HT) and an amount of US$20 million from the Health Results Innovation Trust Fund HRITF (Grant TF014474). The Project became effective on September 12, 2013.

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[7] "Profil statistique partiel du Cholera pour la 10eme semaine épidémiologique de l'année 2017", Ministry of Public Health and Population, Government of Haiti, March 2017.

15. **Project Restructuring.** A restructuring of the Original Grant was approved on March 29, 2017 to: (i) extend the closing date of the Grant by 12 months to December 21, 2019 to allow sufficient time for the satisfactory implementation and completion of Project activities to achieve the PDO pursuant to delays in implementation due to political uncertainty in 2016; and (ii) to address the need for realignment of project activities resulting from severe cuts in social protection programs. The restructuring also entailed a reallocation between categories subsequent to the adding of two new Sub-Components 1.2 ("Prevention and Treatment of Cholera and Other Diarrheal and Contagious Diseases") and 1.3 ("Contingency Emergency Response"), as well as a new Component 3 ("Piloting Vulnerability Indicators for More Targeted Social Service Delivery") for which a new Implementing Agency was also added. Finally, the Results Framework was also revised to reflect changes in the Project activities by dropping one PDO indicator and replacing it with a new one as well as dropping intermediate results indicators that were no longer relevant, adding new ones to reflect new activities, and revising the wording of some intermediate results indicators to better reflect the outcomes measured.

16. **The PDO of the Improving Maternal and Child Health through Integrated Social Services Project is "to increase the access and use of maternal and child health, nutrition and other social services in the Recipient's territory".** The Project seeks to support services in at least three Departments with a total catchment population of around 1.8 million people, targeting pregnant women, children under five, and persons susceptible to cholera (e.g. due to poor access to water and sanitation). The Project consists of four streams (the first two implemented by MSPP): (i) support for Maternal and Child Health through Results-Based Financing (RBF) and improving quality/supply of services within selected health service providers (via small-scale rehabilitation, provision of equipment and medical supplies/commodities, others); (ii) the Cholera Program; (iii) the Social Protection stream; and (iv) piloting of vulnerability indicators for more targeted social service delivery. (See Table 2; more details are given in Annex 2). Activities aimed at strengthening the stewardship and management capacity of the MSPP are embedded in the first two streams.

F. Status of Implementation

17. **The implementation of the Improving Maternal and Child Health though Integrated Social Services Project is proceeding reasonably well with both Implementation Progress and achievement of the PDO rated "Moderately Satisfactory" (MS).** The PDO rating of MS is based on satisfactory performance of the Project as measured by intermediate indicators, with 11 out of 13 intermediate indicator targets achieved for the year 2016. Data for three of the four PDO indicators measure health outcomes for the population in the Project area and are expected to become available through the 2016 Demographic and Health Survey (DHS) around mid-2017. (Data collection efforts under the DHS were delayed substantially due to the impact of the Hurricane.) However, there are strong indications of positive movement in these indicators from other sources today: (i) immunization rates for children under 1 (PDO indicator 1) have increased by 65 percent in pilot areas under the Project's RBF stream; and (ii) the percentage of institutional deliveries (PDO indicator 2) based on data from the Health Management Information System has increased in the Project areas (to be verified soon via robust data from the upcoming DHS report). Intermediate indicators for the RBF stream have achieved their targets. The fourth PDO indicator, measuring the cholera case-fatality rate, was introduced in early 2017 when the Project was restructured (see Annex 2), and the Project will aim to maintain the rate under 1 percent.

18. **Performance in Implementation Progress has improved steadily and the disbursement rate for**

the IDA grant has increased substantially in a short period of time from 27 percent at the end of FY16 to 43 percent (US$30.1 million disbursed) now. Performance regarding World Bank environmental and social safeguards aspects has overall been moderately satisfactory, and there are no outstanding legal covenants not complied with. There were initial startup challenges – for example, to find appropriate staff for the Project Implementation Unit (PIU), especially for fiduciary tasks – since this was the first Bank-financed project in many years with MSPP. Most of these have been resolved, and competent staff have been hired. Although the Project has faced financial management challenges with FAES (one of the Project implementing agencies), these are being addressed and a FAES audit report that was pending was received on May 9, 2017. To further enhance fiduciary performance, the PIU of MSPP will hire an additional accountant. There are now no outstanding audit reports for this Project, and all audit reports are satisfactory to the Bank.

19. Disbursements in the Project's initial phase since effectiveness were lower than typically observed for Bank-financed projects, due to the startup challenges mentioned above, and also because: (i) the RBF Program (which accounts for the bulk of the Project's funds) started with a small pilot by design and moved into its scale-up phase only in mid-2016, several months later than expected; and (ii) the Project's activities in 2016 and early 2017 were adversely affected by political uncertainty with a transition Government, nationwide strikes and damage to many health facilities due to the Hurricane (leading to exclusion of the South Department from the RBF scale-up phase). The transition Government period has now ended and the damaged health facilities will be rehabilitated under the AF. However, significant challenges remain in that: (i) the share of the Government's budget going to health is diminishing, as is (ii) external financing for the sector. Disbursements from the HRITF Grant TF-14474 have not yet started since, by design, these will be phased in during the RBF scale-up phase expected by July 2017. (An associated HRITF Grant of $850,000 to support preparation activities for the RBF program, TF-13431, has been fully disbursed).

20. **Response to Hurricane Matthew: To address immediate needs after the Hurricane, the Bank and MSPP agreed to reallocate US$6 million from the Original Grant's planned activities in mostly non-Hurricane Departments to support urgent activities in the southern peninsula and Northwest Department – leaving a financing gap under the Project.** These activities consist of: (i) scaled-up cholera-targeted activities (e.g. rapid response activities, treatment of cholera cases, essential medicines and supplies, quality assurance and logistics activities); (ii) small-scale health facility rehabilitation efforts, (iii) re-establishment of the vaccine cold chain; and (iv) financing of mobile health clinics. The results from these efforts will include: (i) life-saving health services for 1.5 million people in areas with limited health service delivery infrastructure; and (ii) restoration of the infrastructure for basic immunizations for 300,000 children in affected areas. This reallocation of resources from other planned activities to support the Hurricane response has left a financing gap under the Project. These immediate response efforts covered only a small part of the post-Hurricane needs and thus the AF will complement this first phase.

21. **The proposed AF would also finance gaps left by some financiers' withdrawal from responding to the cholera outbreak.** The anticipated large falls in cholera-related funding in 2017 and beyond from donors pose large risks that the results obtained through emergency interventions in the immediate aftermath of the Hurricane may not be sustained, potentially leading to a resurgence of the epidemic. Non-governmental organizations (NGOs) are already withdrawing from certain departments, creating some critical medical and Water, Sanitation and Hygiene (WASH) intervention gaps. Financing for medical and WASH inputs for community interventions and service delivery at Cholera Treatment Centers and Units is only partially covered, with expected stock outs of antibiotics and other cholera

response inputs emerging by mid-2017. The World Bank has been coordinating with MSPP and international partners to map out needs and ensure an appropriate response, particularly in Hurricane-affected Departments.

22. **Lessons Learned.** Lessons from implementation so far include**:** (i) the importance of being proactive with implementation support; (ii) the need for flexibility in design and adaptability, in light of Haiti's fragility with rapidly changing political and other circumstances; and (iii) the need for close, intensive Technical Assistance at the level of individual health facilities to make RBF a success.

G. Rationale for Additional Financing

23. **Following consultations with the Government, it was agreed that the proposed AF is the most suitable financing instrument to support the GoH in a timely manner.** Alternative approaches to the AF were considered, including a new stand-alone operation and different implementation arrangements. The proposed approach using an AF modality was found to be optimal for several reasons. First, given the urgency of the GoH request, the processing of this AF was viewed as the most expeditious way for the Bank to respond efficiently and provide urgently needed financing for critical health services and commodities to a population in dire need in the affected Departments. Second, processing AF (rather than a new Project) was assessed to be cost-effective and more practical, given limited human resources both on the Bank and Government side with many other ongoing challenges. Third, the needs created by the Hurricane in affected areas cannot be addressed with the Original Grant's resources without affecting its objectives in the rest of the country. Fourth, the implementation modalities for the Project have worked well despite the challenging country context and hence can be leveraged for expanding activities to the affected Departments under the AF.

24. **The proposed AF would: (i) scale-up activities and target the Hurricane-affected Departments; and (ii) address a financing gap generated by Hurricane response efforts under the Project.** With the scaling-up of existing activities, the AF would cover an additional 1.5 million beneficiaries, in addition to the 1.8 million beneficiaries under the Project. The bulk of the AF resources (US$19 million) would finance: (i) activities to improve (or restore) the quality and supply of health services (via small-scale rehabilitation, equipment, medical supplies, essential health commodities, training and others); (ii) activities to fight cholera; and (iii) strengthening of MSPP's stewardship and management capacity (which is cross-cutting across both streams under MSPP). Full details are provided in Table 2. The activities to fight cholera will include the provision of medical and WASH inputs, strengthening of laboratory capacity and surveillance efforts, and financing of mobile rapid response teams to ensure an appropriate, targeted and timely response. Medical NGOs will also be contracted to treat cholera patients and to help address the spike in the cholera case-fatality ratio in the Hurricane-affected Departments.

25. **Of the above, US$200,000 would be set aside for resettlement payments.** These are payments to compensate for any potential negative impacts on the population, linked to physical resettlement, land acquisition, and/or adverse impacts on economic livelihood, resulting from the small-scale rehabilitation activities. This is in line with Involuntary Resettlement Policy (OP/BP 4.12) on Involuntary Resettlement. Given that all rehabilitations will be undertaken in already existing facilities, such negative impacts are highly unlikely and – if they occur – are expected to be very minimal.

26. **In addition, the AF will allocate US$6 million to fill the financing gap under the Original Grant –** due to the reallocation of funds away from originally planned activities to Hurricane response efforts.

Table 2 below reflects the proposed changes.

Table 2: Sub-Components, Activities and Allocations under Original Grant and Additional Financing

	Under Original Grant	Under AF
Stream, Sub-Component and Activities	**Allocation, Departments**	**Allocation, Departments**
Component 1: Maternal and Child Health stream – improving quality/supply of services within selected health service providers through small-scale rehabilitation, equipment, medical supplies, health commodities and training of, and technical assistance to health personnel (Sub-Component 1.1(a)) **Component 1: Maternal and Child Health stream** – Results-Based Financing for health facilities (Sub-Components 1.1(b) to (d))	US$2.9 m originally allocated for Northwest, Northeast, Center Departments, but US$2.5 million used on an emergency basis for Hurricane response activities[3] in South, Grand'Anse, Nippes and Northwest Departments US$19.2 m for Northwest, Northeast, Center Departments[3]	US$7 m for South, Grand'Anse, Nippes and Northwest Departments as part of Hurricane response; and $2.5 million to Northwest, Northeast, Center Departments to fill the gap left by allocating Original Grant funds for Hurricane response (see left)[2]
Component 1: Cholera Program stream – Interventions to fight cholera: (i) epidemiological surveillance; (ii) health care; (iii) promotion and prevention; and (iv) water and sanitation, including related capacity building at central, departmental and community levels. Also, support for surveillance, preventative and curative activities, and capacity building for contagious diseases overall in non-emergency situations (Sub-Component 1.2)	US$25.3 m originally allocated for Northwest, Northeast, North, Center Departments, but US$3.5 million used on an emergency basis for Hurricane response activities[3] in South, Grand'Anse, Nippes and Northwest Departments	$10 m more for South, Grand'Anse, Nippes and Northwest Departments as part of Hurricane response; and $3.5 million to Northwest, Northeast, North, Center Departments to fill the gap left by allocating Original Grant funds for Hurricane response (see left)
Component 2: Strengthening MSPP stewardship and management capacity (cross-cutting across both MSPP streams) – includes increasing the capacity of the Departmental health authorities in supervision and monitoring of health service delivery, and others (Sub-Component 2.1)	US$4.6 m for Northwest, Northeast, North, South, Center Departments	$2 m more for similar activities in South, Grand'Anse, Nippes and Northwest Departments as part of Hurricane response
Contingency Emergency Response sub-component with zero financing allocation, triggered only in cases of major health emergencies (Sub-Component 1.3)	Zero allocation; can cover any geographical area of the country if triggered	

Notes:
1. The above table only shows activities under MSPP, financed from IDA. For activities under the other implementing agencies, and financed by the HRITF, please see Annex 2.
2. The AF allocation for rehabilitation activities under Sub-Component 1.1(a) includes US$200,000 for potential resettlement payments. This was not included under the Original Grant.
3. RBF payments to health service providers under the Maternal and Child Health stream will be expanded to also include the South Department once rehabilitation activities in this Department (financed by the AF) are completed.

27. **Climate co-benefits for the proposed operation are expected to be significant at around 40 percent.** The Project emphasizes primary and preventative care, working at the level of dispensaries,

health centers and community hospitals rather than at larger hospitals. In this manner, the AF would work to reduce the demand for care at higher-level hospitals, which is resource-intensive and energy-intensive. Hence, the climate footprint of the health sector would be reduced. Furthermore, the Project is expected to have climate co-benefits by mitigating the outbreaks of cholera that are fostered by increasingly frequent and impacting climate events, and by monitoring the changing patterns in other infectious disease outbreaks among the entire population. The AF will implement some of the key priorities identified in the evaluation of the first two years of the "*Plan d'Elimination du Cholera*". Based on the expected impact of the Project's interventions in the areas of: (i) epidemiological surveillance; (ii) service delivery; (iii) promotion and prevention; (iv) water and sanitation, and (v) rehabilitation of health facilities for better climate resilience, climate co-benefits are estimated to equal 40 percent of the proposed AF.

28. **By design, the Project has a strong focus on gender, and one of its main objectives is to improve maternal health.** The AF will enhance the positive outcomes for maternal health by expanding activities to Hurricane-affected areas. The RBF scheme provides incentives to health workers to enhance the achievement of maternal health indicators, among others. Progress on maternal health is monitored through 4 indicators in the Results Framework. Also, as part of the process for updating the Environmental and Social Management Framework (ESMF) and introducing a Resettlement Policy Framework (RPF) for the AF, women's civil associations were invited to two preliminary consultations and their feedback was incorporated. A Code of Conduct will be required for contractors undertaking rehabilitation activities to sensitize construction workers on Gender-Based Violence at these sites. The PIU's Social Specialist will monitor the application and enforcement this Code of Conduct, in coordination with the MSPP.

29. **The Project will focus on various citizen engagement measures**, including: (a) engage in a pro-active communication strategy that will explain to local governments, beneficiaries and the public at large the benefits from the Project for various communities and municipalities; (b) apply clear and transparent criteria for the selection of sub-projects/investments, in particular for rehabilitation; (c) develop robust information request and grievance redress measures for the Project activities as a whole (not only for safeguards-related issues); and (d) strengthen the community satisfaction surveys already implemented under the RBF program. The community satisfaction surveys will be expanded in scope. A focal point in the PIU will be in charge of collecting the information and closing the feedback loop with the local health authorities (DSSs) as well as the central unit managing the RBF scheme (the UC) in order to take potential corrective actions to improve service delivery. An indicator has been added to the Results Framework accordingly. A dedicated social specialist will be hired under the AF, whose work program will also include citizen engagement activities.

30. **The current Monitoring and Evaluation (M&E) framework will be expanded** to include a structure for regularly monitoring progress at health facilities in the Hurricane-affected Departments that are covered by the AF activities. A standard checklist has been developed for monitoring health facilities under the Project; this will be strengthened and regularly applied for health facilities under the Original Grant as well as the AF. Specifically, the checklist will assess indicators of availability of key equipment, key staff and key medicines and supplies, state of basic infrastructure and equipment (including for water and sanitation access), and viability in terms of providing essential health services, among others. M&E of environmental and social aspects will be carried out by the current coordinator, supervisor and health engineer, with support from the departmental administration and relevant health centers, with additional support under the AF from the environmental specialist and social specialist to be recruited.

H. Policy Waiver

31. **In light of Haiti's high level of debt distress and situation of urgent need following Hurricane Matthew, this project document seeks the approval of the Executive Directors to provide IDA resources from the CRW (US$25 million equivalent) for this proposed additional financing in the form of all grants, rather than on Haiti's current IDA terms**. Haiti is a yellow light country, eligible for a mix of grants and credits in FY17 under its regular allocation and under any CRW allocation[8]. However, the post-disaster Joint Debt Sustainability Analysis (DSA)[9] for Haiti, circulated to the Executive Directors on November 16, 2016, finds the country at high risk of debt distress following Hurricane Matthew. The provision of financing in the form of all grants for the proposed operation is appropriate, as the provision of credits would further heighten Haiti's risk of debt distress at a time of urgent need. On the basis of the November 2016 DSA, in FY18, Haiti will become eligible again for 100 percent grant financing from IDA.

III. Proposed Changes

A. Proposed Changes Data Sheet

Summary of Proposed Changes

The proposed AF will scale-up the Project's existing activities to Hurricane-affected areas by: (i) financing small-scale rehabilitation, equipment, medical supplies and commodities, and other items to restore the levels of quality and service supply at health facilities damaged by the Hurricane; (ii) implementing interventions to fight cholera and other infectious diseases through activities such as epidemiological surveillance, medical treatment, promotion and prevention, and WASH; and (iii) enhancing MSPP's stewardship and management capacity. In addition, it will fill the financing gap created under the Original Grant due to the financing of immediate Hurricane response activities. The AF will also finance payments to compensate for any potential negative impacts on the population resulting from small-scale rehabilitation activities under the AF – in line with Involuntary Resettlement Policy (OP/BP 4.12) on Involuntary Resettlement, which is being triggered. The Pest Management Policy (OP/BP 4.09) will be triggered in case the management of medical waste requires the use of pesticides and other toxic products. The Physical Cultural Resources Policy (OP/BP 4.11) will also be triggered in case there is any discovery of physical cultural resources when conducting the small-scale rehabilitation activities. The restructuring will involve a revision of the PDO and the Results Framework indicators to better reflect cholera-related objectives and the new potential outcomes.

Specifically, the following changes are proposed:

Change in Implementing Agency	Yes [ ] No [X]
Change in Project's Development Objectives	Yes [X] No [ ]
Change in Results Framework	Yes [X] No [ ]
Change in Safeguard Policies Triggered	Yes [X] No [ ]
Change of EA category	Yes [ ] No [X]

[8] Under the CRW's implementation framework for IDA17, the terms of assistance for CRW financing are identical to those under which regular IDA assistance is provided to a particular country.
[9] HAITI: Joint Bank-Fund Debt Sustainability Analysis - November 7, 2016 (IDA/SecM2016-0205).

Other Changes to Safeguards	Yes [ ] No [X]
Change in Legal Covenants	Yes [ ] No [X]
Change in Loan Closing Date(s)	Yes [ ] No [X]
Cancellations Proposed	Yes [ ] No [X]
Change in Disbursement Arrangements	Yes [ ] No [X]
Reallocation between Disbursement Categories	Yes [ ] No [X]
Change in Disbursement Estimates	Yes [X] No [ ]
Change to Components and Cost	Yes [X] No [ ]
Change in Institutional Arrangements	Yes [ ] No [X]
Change in Financial Management	Yes [ ] No [X]
Change in Procurement	Yes [X] No [ ]
Change in Implementation Schedule	Yes [ ] No [X]
Other Change(s)	Yes [ ] No [X]

Development Objective/Results

Project's Development Objectives

Original PDO

The objective of the Project is to increase the access and use of maternal and child health, nutrition and other social services in the Recipient's territory. The Project will support services in at least three Departments with a total catchment population of around 1.8 million people, targeting pregnant women, children under five and vulnerable families. Progress on the objectives of the Project will be measured by the following: (i) percent of children under five immunized; (ii) percent of institutional deliveries; (iii) contraceptive prevalence rate; and (iv) decrease in percentage of families categorized as extremely vulnerable.

Change in Project's Development Objectives

Explanation:

As part of the Level 1 restructuring, a new PDO is proposed to: (i) better reflect the emphasis on cholera control activities under the Project; (ii) more accurately depict the activities under the Social Protection stream (described above) which focus on the targeting of social services and not on the delivery itself of these services; and (iii) reflect that the activities under the AF (accounting for a substantial portion of the total available funding under the Project) will mostly focus on Hurricane-affected areas.

Proposed New PDO - Additional Financing (AF)

To increase the access and use of maternal and child health services, strengthen cholera control, and improve targeting of social services in the Recipient's territory, with a particular focus on areas affected by Hurricane Matthew.

Change in Results Framework

Explanation:

The Results Framework will be revised to:

a. Upgrade the current intermediate indicator "Pilot census carried out in four Departments" to a PDO-level indicator to reflect more accurately the PDO sub-objective of improving the targeting of social services.
b. Adjust the targets and definitions of PDO indicators 1, 2, 3 and 4 and several intermediate indicators to reflect the expanded geographical coverage of the Project with the AF.
c. Include new intermediate indicators monitoring AF-related activities in the Hurricane-affected departments:

- "Number of health facilities rehabilitated and fully functioning, in Departments affected by Hurricane"
- "Percentage of health facilities assessed with adequate stocks of cholera supplies, in Departments affected by the Hurricane"
- "Number of refrigerators restored and fully functional as part of the vaccine cold chain in the Hurricane-affected Departments"

d. Include an intermediate indicator on Citizen Engagement to foster beneficiary feedback on health services:

- % of facilities under RBF that developed an action plan based on the results of community satisfaction surveys.

Compliance

Change in Safeguard Policies Triggered

Explanation:

While there has not been any issue under the Project, the proposed AF will trigger Involuntary Resettlement Policy (OP/BP 4.12) because the scaling-up of rehabilitation activities may temporarily affect the income sources and livelihood activities of households and businesses. Land acquisition leading to involuntary resettlement is not expected under this project. Preliminary consultations in two regions have taken place on April 18 and 20, 2017 with a wide range of local and national stakeholders from the government and civil society associations. Feedback from these preliminary consultations has been incorporated into the Resettlement Policy Framework (RPF) as an annex. The final RPF has been disclosed before appraisal on May 3, 2017. Consultations in the affected areas included outreach to main stakeholders and the affected communities to the extent possible, given that many sites remained unknown at the time of appraisal. Once these sites are identified, Resettlement Action Plans (RAP) or Abbreviated Resettlement Action Plans (Abbrev. RAPs) will be prepared, consulted and disclosed in accordance with the policy. Any compensation or livelihood restoration efforts that may be needed will be completed prior to commencement of the works.

The Pest Management Policy (OP/BP 4.09) will be triggered given that the project will generate medical waste that could potentially be linked to the storage and management of pesticides or other toxic products. However, the MSPP will continue to use only WHO/PAHO authorized products to ensure adequate hygiene and sanitation conditions in health facilities. The storage and manipulation of pesticides and other toxic products will be defined in the Medical Waste Management Plan.
Given the nature of project activities, the likelihood of finding physical cultural resources is low. However, as part of the small-scale rehabilitation activities, some physical, or cultural heritage resources could be

discovered and thus the Physical Cultural Resources Policy (OP/BP 4.11) will also be triggered.

The Financing Agreement of the AF will include the financing of involuntary resettlement compensation (for incomes sources and livelihood activities of households and businesses being temporarily affected as described above), which may occur due to the small-scale rehabilitation works.

Current and Proposed Safeguard Policies Triggered:	Current(from Current Parent ISDS)	Proposed(from Additional Financing ISDS)
Environmental Assessment (OP) (BP 4.01)	Yes	Yes
Natural Habitats (OP) (BP 4.04)	No	No
Forests (OP) (BP 4.36)	No	No
Pest Management (OP 4.09)	No	Yes
Physical Cultural Resources (OP) (BP 4.11)	No	Yes
Indigenous Peoples (OP) (BP 4.10)	No	No
Involuntary Resettlement (OP) (BP 4.12)	No	Yes
Safety of Dams (OP) (BP 4.37)	No	No
Projects on International Waterways (OP) (BP 7.50)	No	No
Projects in Disputed Areas (OP) (BP 7.60)	No	No

Covenants - Additional Financing (Additional Financing for the Improving Maternal and Child Health Through Integrated Social Services Project - P163313)

Source of Funds	Finance Agreement Reference	Description of Covenants	Date Due	Recurrent	Frequency	Action
IDWT	Financing Agreement Schedule 2 Section I, A3	For the purpose of carrying out Component 1 and Sub-Component 2.1 of the Project, MSPP shall maintain throughout the duration of the Project a team of professionals in adequate numbers and with qualifications, experience and terms of reference satisfactory to the Association as set forth in the MSPP Operations Manual.		☒	CONTINUOUS	New
IDWT	Financing Agreement Schedule 2 Section I, D1	The Recipient shall ensure that, throughout the implementation of the Project, the Project shall be implemented in accordance with the guidelines, procedures, timetables and other specifications set forth in the Environmental and		☒	CONTINUOUS	New

		Social Management Framework and the Resettlement Policy Framework. In particular, the Recipient shall ensure: (a) that for each activity under the Project of a category for which the Environmental and Social Management Framework or the Resettlement Policy Framework provide that an Environmental and Social Management Plan or a Resettlement Action Plan shall be prepared, such Environmental and Social Management Plan or Resettlement Action Plan, in form and substance satisfactory to the Association, are effectively prepared and locally disclosed, before the implementation of such Project activity, in accordance with the provisions of the Environmental and Social Management Framework and the Resettlement Policy Framework; and (b) promptly thereafter, that the relevant activity is implemented in accordance with its Environmental and Social Management Plan or the Resettlement Action Plan.				
IDWT	Financing Agreement Schedule 2 Section I, E2 (a)(vi)	The MSPP Operations Manual shall include, *inter alia*, a detailed elaboration of the specific timeline for the preparation and adoption of the Medical Waste Management Plan (by Effectiveness).	Sept 30, 2017			New

Conditions

Source Of Fund	Name	Type
IDWT	MSPP Operations Manual has been updated and adopted by the Recipient.	Effectiveness

Description of Condition

The Recipient has updated and adopted the MSPP Operations Manual, in form and substance satisfactory to the Association (Article V, paragraph 5.01 of the Financing Agreement for the Additional Financing grant).

Source Of Fund	Name	Type

IDWT	Disbursement Condition for Category 1 in Financing Agreement.	Disbursement

Description of Condition

No withdrawal shall be made under Category 1, for Emergency Expenditures under Part A.3 of the Project (Contingent Emergency Response), unless and until the Association is satisfied, and has notified the Recipient of its satisfaction, that all of the following conditions have been met in respect of said Emergency Expenditures: (i) the Recipient has determined that an Eligible Emergency has occurred, has furnished to the Association a request to include said Eligible Emergency under Part A.3 of the Project in order to respond to said Eligible Emergency, and the Association has agreed with such determination, accepted said request and notified the Recipient thereof; (ii) the Recipient has prepared and disclosed all safeguards instruments required for said Eligible Emergency, and the Recipient has implemented any actions which are required to be taken under said instruments, all in accordance with the provisions of Section I.D of Schedule 2 to the Financing Agreement; (iii) the Coordinating Authority has adequate staff and resources, in accordance with the provisions of Section I.H of Schedule 2 to the Financing Agreement, for the purposes of said activities; and (iv) the Recipient has adopted the Emergency Response Operations Manual in form, substance and manner acceptable to the Association and the provisions of the Emergency Response Operations Manual are fully current in accordance with the provisions of Section I.H of Schedule 2 to the Financing Agreement so as to be appropriate for the inclusion and implementation Part A.3 of the Project. (Financing Agreement Schedule 2 Section IV, B1 (b)).

Source Of Fund	**Name**	**Type**
IDWT	Disbursement Condition for Category 3 in Financing Agreement.	Disbursement

Description of Condition

No withdrawal shall be made under Category 3 unless the pertinent Resettlement Action Plan has been prepared, consulted, adopted and published by the Recipient in form and substance satisfactory to the Association. (Financing Agreement Schedule 2 Section IV, B1 (c)).

Risk

Risk Category	**Rating (H, S, M, L)**
1. Political and Governance	Substantial
2. Macroeconomic	Substantial
3. Sector Strategies and Policies	Substantial
4. Technical Design of Project or Program	Moderate
5. Institutional Capacity for Implementation and Sustainability	Substantial
6. Fiduciary	Substantial
7. Environment and Social	Moderate
8. Stakeholders	Moderate
9. Other	
OVERALL	Substantial

Finance	
Loan Closing Date - Additional Financing (Additional Financing for the Improving Maternal and Child Health Through Integrated Social Services Project - P163313)	
Source of Funds	**Proposed Additional Financing Loan Closing Date**
IDA Grant from CRW	31-Dec-2019
Change in Disbursement Estimates	**(including all sources of Financing)**

Explanation:

Disbursement estimates are being revised to include the additional funds under the Project and the scaling-up of existing activities. (Note: The current amount is significantly lower than the total amount of US$90 million approved under the Original Grant because of changes in the USD-SDR exchange rate).

Expected Disbursements (in USD Million)(including all Sources of Financing)

Fiscal Year	2014	2015	2016	2017	2018	2019	2020
Annual	1.0	8.81	8.84	13.96	28.00	30.12	18.55
Cumulative	1.0	9.81	18.65	32.61	60.61	90.73	109.28

Allocations - Additional Financing (Additional Financing for the Improving Maternal and Child Health Through Integrated Social Services Project - P163313)				
Source of Fund	**Currency**	**Category of Expenditure**	**Allocation**	**Disbursement %(Type Total)**
			Proposed	**Proposed**
IDWT	USD	1. Emergency Expenditures under Part A.3 of the Project	0.00	100.00
		2. Goods, works, non-consulting services, consulting services including audit, Training and Operating Costs for Parts A.1 (a), A.2 and B.1 of the Project	24,800,000.00	100.00
		3. Resettlement compensation and assistance to Displaced Persons under Part A.1(a) of the Project	200,000.00	100.00
		Total:	25,000,000.00	100.00

Components

Change to Components and Cost

Explanation:

Component 1 (Providing Maternal and Child Health, Nutrition and Social Services): The new total cost of Component 1 is US$ 92.82 million (US$72.82 million from IDA, of which US$23 million is from this AF, and US$20 million from the Health Results and Innovation Trust Fund).

- Sub-Component 1.1(a): The AF grant will provide an additional US$9.5 million for this sub-component, with US$7 million specifically designated for areas affected by the Hurricane and the remainder going towards filling the financing gap under the Original Grant due to reallocation of funds to Hurricane response activities. Out of this additional allocation of US$9.5 million, US$200,000 will be allocated for potential resettlement payments.
- Sub-Components 1.1(b) to (d): These sub-components covering the RBF program for health facilities are financed from the Original Grant. The geographical scope of the RBF program will be expanded to also include health facilities in the South Department, once rehabilitation activities have been completed in this Department.
- Sub-Component 1.2: The AF grant will provide an additional US$13.5 million for Sub-Component 1.2, with US$10 million specifically designated for areas affected by the Hurricane and the remainder going towards filling the financing gap under the Original Grant due to reallocation of funds to Hurricane response activities.

Component 2 (Strengthening the Stewardship and Management Capacity of Government): The new total cost of Component 2 is US$11.46 million, of which US$2 million is from this AF.
The AF will provide an additional US$2 million for Sub-Component 2.1 (Increasing the capacity of the Departmental health authorities in supervision and monitoring of health service delivery, and others) for areas affected by the Hurricane.

Component 3 (Piloting Vulnerability Indicators for More Targeted Social Service Delivery):

No changes are proposed for this Component, which is not implemented by the MSPP.

Current Component Name	**Proposed Component Name**	**Current Cost (US$M)**	**Proposed Cost (US$M)**	**Action**
Component 1: Providing Maternal and Child Health, Nutrition and Social Services.	Component 1: Providing Maternal and Child Health, Nutrition and Social Services.	69.82	92.82	Revised
Component 2: Strengthening the Stewardship and Management Capacity of Government.	Component 2: Strengthening the Stewardship and Management Capacity of Government.	9.46	11.46	Revised
Component 3: Piloting Vulnerability Indicators for More Targeted Social Service Delivery	Component 3: Piloting Vulnerability Indicators for More Targeted Social Service Delivery	5.00	5.00	No Change
	Total:	84.28	109.28	

Other Change(s)		
Implementing Agency Name	**Type**	**Action**
FONDS D'ASSISTANCE ECONOMIQUE ET SOCIALE	Implementing Agency	No Change
Ministry of Public Health and Population	Implementing Agency	No Change
Institut Haïtien de Statistique et d'Informatique	Implementing Agency	No Change

Change in Procurement

Explanation:

The Project will be executed in accordance with the World Bank's (WB) Procurement Regulations for Borrowers under Investment Policy Financing (July 2016).

a. Procurement for the Project will be carried out by: The MSPP (*Unité de Gestion de Projet* - UGP). The Project will be executed in accordance with the WB's Procurement Regulations for Borrowers under Investment Policy Financing (July 2016) ("Procurement Regulations"), and the provisions stipulated in the Procurement Plan and the Operational Manual. During the last supervision mission the UGP was found to have the necessary capacity. The UGP will be responsible for all procurement and contracting related queries and processing, including management and compliance with fiduciary requirements.

b. A Project Procurement Strategy for Development was carried out and identified the appropriate selection methods, market approach and type of review by the WB. Most activities under the proposed Project will be carried out through National or International Competition. An acceptable Procurement Plan was also prepared and will be included in the new Systematic Tracking of Exchanges in Procurement system. Procurement arrangements for the Immediate Response Mechanism Component are described in the Immediate Response Mechanism Operational Manual. For International Competition, in addition to WB Standard and Sample Bidding Documents UGP will be used standard bidding documents agreed with the National Commission of Public Contracts *(Commission Nationale des Marchés Publics).*

c. MSPP (UGP) will be responsible for all procurement processes. Small improvements of devastated health facilities amounting to US$7.00 million in rehabilitation and equipment will be split into small contracts to allow national contractors to participate in the process. In principle, the aggregate amount of the works, including materials, for each health facility is estimated to be under US$200,000. For Cholera Program Stream: The program is implemented by the technical departments of the MSPP for the soft activities and the *Direction Nationale de l'Eau Potable et de l'Assainissement* (Haiti's Water and Sanitation utility DINEPA) as well as, at the departmental level, the Departmental Health Services and select non-governmental institutions for the construction and rehabilitation. Except for the equipment procurement, the remaining procurements will follow National Competition to ensure transparency. The bidding documents used by UGP have been agreed upon with the WB.

d. Experience to date under the Project shows and confirms the solid procurement capacity of the project implementation Units as confirmed by the procurement capacity assessment carried out on May 3, 2017. However, to ensure continuous satisfactory performance of procurement functions within UGP, a series of mitigation measures will be implemented. These include: (a) agreement of MSPP and WB on the required qualifications of existing procurement staff who will be appointed to support the proposed Project; and (b) inclusion of Special Procurement Provisions in the Procurement Plan. All procurement procedures are described in the Operational Manual, and approved by the WB.

IV. Appraisal Summary

Economic and Financial Analysis

Explanation:

Economic analysis was conducted for the proposed AF, including calculations of the Net Present Value (NPV) and Benefit-Cost Ratio (BCR) under different scenarios. The methodology and full results are reported in Annex 4. Despite conservative assumptions, the results show that the Project remains very cost-effective in all scenarios. In the most optimistic (base-case) scenario, the Project yields a positive Net Present Value of $90 million, with a BCR of 1.9. In contrast, the most pessimistic scenario still results in a positive NPV of $9.75 million and a BCR of 1.1. Therefore, and in spite of the highly conservative nature of many of the assumptions, the results suggest that the Project is highly cost-effective.

Technical Analysis

Explanation:

Funds for rehabilitation in Hurricane-affected areas are very much needed. Technical assessments of the state of infrastructure and capacity for health service delivery in the affected Departments show that these are very much lacking at present, and there is a large financing gap for rehabilitation efforts in the affected Departments. These assessments have been done via on-site visits to health facilities and drug warehouses at the affected Departments, using an assessment tool developed for the purpose. Information from cholera surveillance efforts also indicates that a new front for cholera has opened up in the affected Departments (see Table 1 above). Cholera remains endemic in Haiti. Even before the Hurricane, despite the results achieved by MSPP and its partners in the control of cholera, localized cholera outbreaks continued to occur throughout the country, especially during the rainy seasons (May-June and September-November). Lack of access to safe water, poor sanitation and hygienic practices, a weak and stretched health system, and insufficient funding to address these needs, contributed to a high number of cases and deaths. These factors have been exacerbated by the Hurricane, in the affected Departments. Especially alarming is the high case-fatality ratio in these Departments, and one of the goals of the AF is to keep the case-fatality ratio below 1 percent.

Social Analysis

Explanation:

Positive social impacts under the AF include improved maternal health of Project beneficiaries and temporary job creation at the construction site as local merchants would come to sell food and drinks to construction workers. Negative social impacts under the Project have been limited and activities likely to cause involuntary resettlement were excluded. The implementation experience and lessons learned from the social safeguards implementation under the Project are described in the AF ISDS. The proposed AF will trigger Involuntary Resettlement Policy (OP/BP 4.12) because the scaling-up of rehabilitation activities may temporarily affect the income sources and livelihood activities of households and businesses. Land acquisition leading to involuntary resettlement is not expected under the Project. An RPF has been prepared by the Government and preliminary consultations were held in two regions with a wide range of local and national Government and Civil Society stakeholders on April 18, 2017 (in the southern peninsula) and on April 20, 2017 (in the greater North). These preliminary consultations were followed by additional virtual consultations. The final RPF was disclosed by the Government and the Bank on May 3, 2017 (by appraisal). Upon the identification of cases of involuntary resettlement, RAP or Abbrev. RAP will be prepared consulted and disclosed by the Government in accordance with the policy. These potential resettlement impacts are expected to be avoided or minimized through the application of good construction

and management practices and with close supervision of contractor performance by field engineers and in close consultation with local communities. The current capacity for managing safeguards will be strengthened under the AF with the hiring of one environmental and one social specialists by Project effectiveness. Further details on the existing safeguards capacity of the executing agency and actions to be taken under the AF are included in the ISDS.

In the unlikely case of land acquisition, a potential risk (as observed in other projects in Haiti) may be delays in land acquisition and compensation due to insufficient availability of legitimate titles and complex land ownership procedures in Haiti. The Project will avoid or minimize land acquisition. The communication efforts will particularly focus on medical waste, hygiene, prevention of spread of diseases, and overall community health and safety issues. Risks linked to labor influx are expected to be limited. They will be mitigated by prioritizing local labor and ensuring clarity on where laborers coming from outside will be hosted through their stay in the host community and ensuring that contracts are consistent with ESMF and RPF provisions.

A potential social risk such as social tensions, particularly in post-Matthew context, may rise by perceived inequities in the selection of project activities. The Project will mitigate this risk by focusing on citizen engagement measures, including: (a) engage in pro-active communication strategy that will explain to local governments, beneficiaries and public at large the benefits from the Project for various communities and municipalities; (b) apply clear and transparent criteria for the selection of sub-projects/investments, (c) develop robust information request and grievance redress measures for the Project activities as a whole (not only for safeguards-related issues); and (d) strengthen the community satisfaction surveys already implemented under the RBF program. A dedicated social specialist will be hired under the AF, whose work program will also include citizen engagement activities. Training will be provided to ensure that the PIU has the awareness and capacity to share timely information with beneficiaries about project-funded activities, channel beneficiary feedback to the Project management and other decision-makers at the local and central levels, and facilitate resolution of grievances. Periodic information and consultation sessions in every locality where Project activities are going to take place will be held to allow the beneficiary population to receive information, provide feedback, clarify doubts, and express any existing grievances.

Environmental Analysis

Explanation:

Environmental impacts under the Project have been moderate, and safeguards performance has been moderately satisfactory.

The main impacts that were observed at some health facilities relate to production and mishandling of medical waste; incomplete sorting of different waste streams; malfunctioning sanitation in some cases with sewage outflows to nature (water bodies, soil, land); water shortages; and inappropriate site management at some health centers leading to proliferation of vectors (mosquitoes). Another potential impact is the environmental, health and safety (EHS) impact of construction (risk of accidents, injuries, etc.).

Under the Project, an ESMF was prepared. Safeguards issues (waste, sewage, EHS) were managed in a moderately satisfactory way. Medical waste management could have been improved through adequate sorting of waste and better disposal. Likewise for wastewater/sewage, management practices were mostly adequate but could be improved.

In order to improve management in future as part of the implementation of the AF, the preferred method is

through systematic improvement of systems through programs comprising of identification of needs followed by implementation of action plans, including training, equipping, monitoring and evaluating, rather than a piecemeal approach. This will be carried out through: (i) the continued application of the ESMF; (ii) the improvement of the management of water and sanitation issues (financed under the cholera program stream of Sub-Component 1.2); and (iii) financing an improved and project-specific healthcare waste management strategy and plan; as well as strengthening the implementation of the existing "National Strategic Plan for Medical Waste Management" and the "National Policy for Injection Safety and Healthcare Waste Management" – all through goods, consultants' services and training under component 2.1, for areas covered by the Project.

The proposed AF would largely continue current activities. The original ESMF has been updated, consulted and disclosed by the Government and the Bank on May 3, 2017. Once identification of sites is finalized during Project implementation, ESMPs and RAPs will be prepared and disclosed as needed. As described in the safeguards section, the Pest Management Policy (OP/BP 4.09) will be triggered to ensure appropriate management of pesticides and other toxic products that may be used in medical waste management processes. The Physical Cultural Resources Policy (OP/BP 4.11) is also triggered as a preventive measure in case any cultural resource is discovered during the rehabilitation activities. Thus environmental issues would be addressed using the ESMF, and on a systematic basis under Sub-Component 1.2.

The AF will maintain environmental Category B in line with the classification of the Project.

The Project does not have full time staff dedicated to environmental and social risks and impacts but this role is played by a coordinator, a supervisor and a health engineer in the Project implementation Unit, with support from the departmental administration and relevant health centers. These actors each have a primary role and contribute to Environmental and Social aspects on a part-time basis, but none has full-time responsibility for Environmental and Social issues. For the implementation of the proposed AF, the Project team at MSPP will be enhanced through the addition of a dedicated environmental specialist and a social specialist by Project effectiveness.

Risk

Explanation:

In light of improvements in the environment for implementation since the approval of the Project, the strong prior experience and successfully tested implementation mechanisms under the Project, the rating for Institutional Capacity for Implementation is downgraded from High to Substantial. The overall risk rating is also downgraded from High to Substantial. The key risks are Political and Governance, Institutional Capacity for Implementation and Fiduciary.

The impact of political uncertainties on policy decisions in the health sector, and recent declines in financing available for the sector, continue to pose potential risks for the Project – although the political environment is now more favorable. These risks would be mitigated by building in flexibility for response to unforeseen events, ensuring enough resources to deliver results within the Project scope, and continuing with current dialogue on the importance of increasing the amount and efficiency of financing for health services. Institutional Capacity remains weak, as in all Fragile States. This is mitigated by a robust program of capacity building for staff at key units of MSPP at the central, Departmental and health facility levels, and continued interaction on key issues with stakeholders. These measures have led to a downgrading of the Institutional Capacity and Implementation risk (see above), and will be continued.

The Fiduciary risk will be mitigated by adding additional fiduciary staff and continuing to provide intensive technical assistance and close, hands-on support. These efforts have already led to an improvement in the Project's fiduciary performance (see section above on Status of Implementation).

V. World Bank Grievance Redress

32. Communities and individuals who believe that they are adversely affected by a World Bank (WB) supported project may submit complaints to existing project-level grievance redress mechanisms or the WB's Grievance Redress Service (GRS). The GRS ensures that complaints received are promptly reviewed in order to address project-related concerns. Project affected communities and individuals may submit their complaint to the WB's independent Inspection Panel which determines whether harm occurred, or could occur, as a result of WB non-compliance with its policies and procedures. Complaints may be submitted at any time after concerns have been brought directly to the World Bank's attention, and Bank Management has been given an opportunity to respond. For information on how to submit complaints to the World Bank's corporate Grievance Redress Service (GRS), please visit http://www.worldbank.org/GRS. For information on how to submit complaints to the World Bank Inspection Panel, please visit www.inspectionpanel.org

Annex 1. Revised Results Framework and Monitoring Indicators

Project Name:	Additional Financing for the Improving Maternal and Child Health Through Integrated Social Services Project (P163313)			Project Stage:	Additional Financing	Status:	DRAFT
Team Leader(s):	Andrew Sunil Rajkumar	Requesting Unit:	LCC8C	Created by:	Jocelyn Haye on 28-Feb-2017		
Product Line:	IBRD/IDA	Responsible Unit:	GHN04	Modified by:	Viviana A. Gonzalez on 1-June-2017		
Country:	Haiti	Approval FY:	2017				
Region:	LATIN AMERICA AND CARIBBEAN	Lending Instrument:	Investment Project Financing				
Parent Project ID:	P123706	Parent Project Name:	Improving Maternal and Child Health through Integrated Social Services (P123706)				

Project Development Objectives

Original Project Development Objective - Parent:

The objective of the Project is to increase the access and use of maternal and child health, nutrition and other social services in the Recipient's territory. The Project will support services in at least three Departments with a total catchment population of around 1.8 million people, targeting pregnant women, children under five and vulnerable families. Progress on the objectives of the Project will be measured by the following:(i) percent of children under five immunized; (ii) percent of institutional deliveries; (iii) contraceptive prevalence rate; and (iv) decrease in percentage of families categorized as extremely vulnerable.

Proposed Project Development Objective - Additional Financing (AF):

To increase the access and use of maternal and child health services, strengthen cholera control, and improve targeting of social services in the Recipient's territory, with a particular focus on areas affected by Hurricane Matthew.

Results

Core sector indicators are considered: Yes	Results reporting level: Project Level

Project Development Objective Indicators							
Status	Indicator Name	Core	Unit of Measure		Baseline	Actual(Current)	End Target
Revised	Children under five immunized	☐	Percentage	Value	46.22	Not yet available, see comments below	49.00
				Date	31-Dec-2012	30-Apr-2017	31-Dec-2019
				Comment		Data from the 2016 DHS survey (which is much more reliable than any other source of data especially administrative data) were planned to be used to measure progress for this indicator. But data collection efforts were delayed due to the Hurricane and the results will only be ready around the third quarter of 2017.	
Revised	Institutional deliveries	☐	Percentage	Value	21.26	Not yet available, see comments below	24.00
				Date	31-Dec-2012	30-Apr-2017	31-Dec-2019
				Comment		Above comments on DHS 2016 data also apply here.	
Revised	Contraceptive prevalence rate	☐	Percentage	Value	23.37	Not yet available, see comments below	26.00

				Date	31-Dec-2012		31-Dec-2019
				Comment		Above comments on DHS 2016 data also apply here.	
Revised	Cholera Case Fatality Rate	☐	Percentage	Value	0.89	1.08	0.99
				Date	31-Dec-2015	31-Dec-2016	31-Dec-2019
				Comment			The cholera case-fatality ratio should be maintained at less than 1% in every year, and this is also the end target.
New	Pilot census carried out in four departments	☐	Yes/No	Value	No	No	Yes
				Date	31-Dec-2015	31-Dec-2016	31-Dec-2019
				Comment		This indicator is being upgraded from an Intermediate Indicator to a PDO Indicator.	
Intermediate Results Indicators							
Status	Indicator Name	Core	Unit of Measure		Baseline	Actual(Current)	End Target
Revised	Children 6-59 months old receiving Vitamin A supplementation	☐	Number	Value	0.00	6726.00	26200.00
				Date	31-Dec-2012	30-June-2016	31-Dec-2019
				Comment			
No Change	Children aged under 12 months that are	☐	Text	Value			13%
				Date			31-Dec-2019

	completely vaccinated at health facilities under the RBF program (percentage increase over baseline).			Comment	The baselines will be from externally verified RBF data for the year 2016 (which are not yet available for all relevant quarters).		(i) 13% for Northeast, Northwest and Centre Departments; (ii) 13% for South Department.
No Change	Births at health facilities under the RBF program (percentage increase over baseline).	☐	Text	Value			10%
				Date			31-Dec-2019
				Comment	The baselines will be from externally verified RBF data for the year 2016 (which are not yet available for all relevant quarters).	This is a new indicator that was introduced at the time of the restructuring (approved in early 2017).	(i) 10% for Northeast, Northwest and Centre Departments; (ii) 10% for South Department.
No Change	Utilization of modern contraceptives via health facilities under the RBF program (percentage increase over baseline).	☐	Text	Value			15%
				Date			31-Dec-2019
				Comment	The baselines will be from externally verified RBF data for the	This is a new indicator that was introduced at the time of the restructuring	(i) 15% for Northeast, Northwest and Centre Departments; (ii) 15% for South

					year 2016 (which are not yet available for all relevant quarters).	(approved in early 2017).	Department.
No Change	Children aged between 6 and 59 months receiving nutritional screening and follow up under the RBF program (percentage increase over baseline).	☐	Text	Value			12%
				Date			31-Dec-2019
				Comment	The baselines will be from externally verified RBF data for the year 2016 (which are not yet available for all relevant quarters).	This is a new indicator that was introduced at the time of the restructuring (approved in early 2017).	(i) 12% for Northeast, Northwest and Centre Departments; (ii) 12% for South Department.
No Change	Contracted service providers achieving the minimum quality score	☐	Percentage	Value	0.00	85.70	45.00
				Date	31-Dec-2012	30-Jun-2015	31-Dec-2019
				Comment			
No Change	Contracted health providers supervised at least quarterly	☐	Percentage	Value	0.00	100.00	95.00
				Date	31-Dec-2012	31-Dec-2016	31-Dec-2019
				Comment			
No Change	Health personnel receiving training	☐	Number	Value	0.00	280.00	250.00
				Date	31-Dec-2012	30-Jun-2016	31-Dec-2019
				Comment			
No Change	Providers using the	☐	Percentage	Value	0.00	39.00	50.00

	contracting model			Date	31-Dec-2012	31-Dec-2016	31-Dec-2019
				Comment			
Revised	Percentage of cholera alerts and outbreaks investigated and acted on by mobile rapid response teams (EMIRAs) within 48 hours of onset	☐	Percentage	Value	7.00	22.00	60.00
				Date	31-Dec-2014	31-Dec-2015	31-Dec-2019
				Comment			
Revised	Number of water and sanitation interventions supported at health facility and community levels	☐	Number	Value	0.00	48.00	65.00
				Date	31-Dec-2012	31-Dec-2015	31-Dec-2019
				Comment			
New	Percentage of health facilities assessed with adequate stocks of cholera supplies, in Departments affected by the Hurricane	☐	Percentage	Value			90.00
				Date			31-Dec-2019
				Comment	Baseline to be established during first quarter of effectiveness.		
New	Number of health facilities rehabilitated and fully functioning, in Departments affected by Hurricane	☐	Number	Value	0.00		40.00
				Date	31-Dec-2016		31-Dec-2019
				Comment			

New	Number of refrigerators restored and fully functional as part of the vaccine cold chain in the Hurricane-affected Departments	☐	Number	Value	0.00		84.00
				Date	31-Dec-2016		31-Dec-2019
				Comment			
Marked for Deletion	Pilot census carried out in four departments	☐	Yes/No	Value	No	No	Yes
				Date	31-Dec-2015	31-Dec-2016	31-Dec-2019
				Comment			
No Change	Preliminary calculation by the IHSI of vulnerability clusters in the four pilot departments	☐	Yes/No	Value	No	No	Yes
				Date	31-Dec-2015	31-Dec-2016	31-Dec-2019
				Comment			
No Change	Steering committee to oversee registry identified or created and operational	☐	Yes/No	Value	No	No	Yes
				Date	31-Dec-2015	31-Dec-2016	31-Dec-2019
				Comment			
New	Citizen Engagement Indicator: % of facilities under RBF that developed an action plan(s) based on the results of community satisfaction surveys	☐	Percentage	Value	0.00		50.00
				Date	31-Dec-2016		31-Dec-2019
				Comment	It is the practice to conduct community satisfaction surveys for health facilities under the RBF		

					program, but so far action plans have not been developed for health facilities based on these surveys.		
No Change	Number of households included in the social registry	☐	Number	Value	0.00	25000.00	300000.00
				Date	31-Dec-2015	31-Dec-2016	31-Dec-2019
				Comment			

Project Development Objective Indicators / Description (indicator definition etc.)		
Indicator Name	Description (indicator definition etc.)	Comments
Children under five immunized	Numerator: Number of children under five that received immunization for BCG, Polio, DTC3 and/or Pentavalent and Measles on schedule in Project interventions areas. Denominator: Estimated number of children under five in Project intervention areas.	Indicator retained from the Project Appraisal Document (PAD); it was not changed under the Restructuring. But until now this indicator only covered the Northeast, Northwest and Center Departments which were covered by the RBF Program. If the proposed AF is approved, the bulk of the health facilities in the South Department – which sustained major damage due to the Hurricane – would be rehabilitated. The RBF Program would then be expanded to also include the South Department. The baseline and target values for this indicator have been updated accordingly above, to also include the South Department. The data for this indicator will be used to measure and track the “Number of Children Immunized”, a Corporate Results Indicator.
Institutional deliveries	Numerator: Number of institutional deliveries in Project intervention areas. Denominator: Estimated number of deliveries in Project intervention areas.	As above. The data for this indicator will be used to measure and track the “Number of Deliveries Attended by Skilled Health Personnel”, a Corporate Results Indicator.
Contraceptive prevalence rate	Numerator: Number of women aged 15-49 in Project intervention areas who are practicing, or whose partners are practicing, any form of modern method contraception. Denominator: Estimated number of women aged 15-49 in Project intervention areas.	As above.

Cholera Case Fatality Rate	The case fatality rate (CFR) is a measure of the severity of a diseases and is defined as the proportion of cases of a specified disease or condition which are fatal within a specific time. With proper treatment, the case fatality rate should remain below 1 percent. The values for the indicator for each year are derived from dividing the total number of deaths due to cholera throughout the year by the total number of new cholera cases in the year.	This indicator was added under the Restructuring, and was meant to measure the CFR for the four Departments covered by the Cholera program – the North, Northeast, Northwest and Center Departments. The AF will finance in-depth cholera control activities in the Departments affected by the Hurricane. Given the negative externalities associated with cholera and the rapidness by which it spreads geographically, it will be important to monitor the CFR for the country as a whole. Hence, if the proposed AF is approved, the coverage of this indicator would be expanded to measure the CFR at the national level.
Pilot census carried out in four departments	The questionnaire, the equipment, and the processes are tested by collecting data in a sample of enumeration units in four departments and uploading it to the central server at IHSI.	This indicator was added at the time of the Restructuring as an Intermediate Indicator, and it is now being upgraded to be a PDO Indicator, Other than that, it will remain unchanged.
Intermediate Results Indicators/ Description (indicator definition etc.)		
Indicator Name	Description (indicator definition etc.)	
Children 6-59 months receiving Vitamin A supplementation	Number of children between the ages of 6 and 59 months receiving Vitamin A supplementation, under the Results-Based Financing program.	This Core Indicator was redefined in the recent Restructuring, and will remain unchanged under the proposed AF. However, its end target is being increased to take into account the inclusion of the South Department as an additional Department under the RBF Program.
Children aged under 12 months that are completely vaccinated at health facilities under the RBF program (percentage increase over baseline)	This indicator will be measured from externally verified data from the RBF program.	This indicator was introduced at the time of the Restructuring. Until now, this indicator only covered the Northeast, Northwest and Center Departments which were covered by the RBF Program. If the proposed AF is

		approved, the coverage of this indicator would be expanded to also include the South Department where RBF will be introduced. Most of these health facilities suffered significant damage from the Hurricane, and rehabilitation activities financed under the AF will help ensure that RBF can work properly at these facilities. The targets will be measured separately for: (i) the previously included Northeast, Northwest and Center Departments; and (ii) the South Department. Once data are available for this indicator,
Births at health facilities under the RBF program (percentage increase over baseline)	Same as for previous indicator.	Same as for previous indicator.
Utilization of modern contraceptives via health facilities under the RBF program (percentage increase over baseline)	Same as for previous indicator.	Same as for previous indicator.
Children aged between 6 and 59 months receiving nutritional screening and follow up under the RBF program (percentage increase over baseline)	Same as for previous indicator.	Same as for previous indicator.
Contracted service providers achieving the minimum quality score	Numerator: Number of contracted service providers in Project intervention areas having achieved at least 60 percent during the quality scorecard assessment undertaken by the external verification entity. The quality scorecard includes a number of indicators, for example: properly organized patient files, public posting of fees for services and source and uses of facility financing, cleanliness of	Indicator retained from original PAD. (It remained unchanged under the Restructuring.)

	facilities and management of medical waste and others. Denominator: Number of contracted service providers in Project intervention areas.	
Contracted health providers supervised at least quarterly	Numerator: Number of contracted health providers that have received a supervisory visit by the departmental health authorities at least quarterly. Denominator: Number of contracted health providers.	No change
Health personnel receiving training	Cumulative number of health personnel that have completed training sessions for activities under the Project (including on RBF and on cholera prevention and case management activities).	Indicator retained from original PAD. (It remained unchanged under the Restructuring.)
Providers using the contracting model	Numerator: Number of viable, functional providers (excluding larger hospitals) using the contracting model in Project intervention areas. Denominator: Number of viable, functional providers (excluding larger hospitals) in Project intervention areas.	Indicator retained from original PAD. (It remained unchanged under the Restructuring.)
Percentage of cholera alerts and outbreaks investigated and acted on by mobile rapid response teams (EMIRAs) within 48 hours of onset	Numerator: Number of cholera alerts/outbreaks in Project target departments investigated by mobile rapid response teams (EMIRAs) within 48 hours of onset, with action taken.	This indicator was added at the time of the Restructuring, and covered the four Departments covered by the Cholera program – the North, Northeast, Northwest and Center Departments. If the proposed restructuring is approved, the coverage of the indicator

	Denominator. Number of cholera alerts/outbreaks in Project target departments.	will be expanded to also include the South, Grand'Anse and Nippes Departments (the Departments most affected by the Hurricane, other than the Northwest Department).
Number of water and sanitation interventions supported at health facility and community levels	Cumulative number of water and sanitation infrastructure interventions completed at health facility and community levels in Project Target Departments.	This indicator was added at the time of the Restructuring, and covered the four Departments covered by the Cholera program – the North, Northeast, Northwest and Center Departments. If the proposed restructuring is approved, the coverage of the indicator will be expanded to also include the South, Grand'Anse and Nippes Departments (the Departments most affected by the Hurricane, other than the Northwest Department).
Percentage of health facilities assessed with adequate stocks of cholera supplies, in Departments affected by the Hurricane	Based on a sample of health facilities with Cholera / Diarrhea Treatment Units/Centers selected for quality assessments (each semester) in each Hurricane-affected Department.	This is a new indicator. The indicator will cover health facilities (with Cholera / Diarrhea Treatment Units/Centers) selected from the Hurricane-affected Departments (Northeast, South, Grand'Anse and Nippes Departments. The baseline is not yet available, and will be calculated based on the assessments done during the first quarter of implementation.
Number of health facilities rehabilitated and fully functioning, in Departments affected by Hurricane	These would consist of health facilities damaged by the Hurricane, that become fully functional (with adequate equipment, staff, etc.) after rehabilitation activities.	This is a new indicator. All of the health facilities would be from the Northwest, South, Grand'Anse and Nippes Departments (those affected by the Hurricane).
Number of refrigerators restored and fully functional as part of the vaccine cold chain in the Hurricane-affected Departments	The indicator will cover health facilities in the Hurricane-affected Departments that were a part of the vaccine cold chain before the Hurricane struck.	This is a new indicator. This indicator will cover Northwest, South, Grand'Anse and Nippes Departments (those affected by the Hurricane).
Preliminary calculation by the IHSI of	Calculations of vulnerability indices will be	This indicator was added at the time of the

vulnerability clusters in the four pilot departments	tested for a sample of enumeration units in four departments following the methodology agreed with the World Bank.	Restructuring, and will remain unchanged.
Steering committee to oversee registry identified or created and operational	Committee to oversee the registry identified (if an existing social protection committee can play this role) or created (if not), likely with the Prime Minister's Office holding the presidency of the committee, and the Ministry of Social Affairs and Labor the vice presidency. This committee will be considered operational if meets at least bi-annually and takes decisions on the registry.	This indicator was added at the time of the Restructuring, and will remain unchanged.
Citizen Engagement Indicator: % of facilities under RBF that developed an action plan(s) based on the results of community satisfaction surveys	Numerator: Number of health facilities under the RBF Program that developed an action plan based on the results of community satisfaction surveys Denominator: Number of health facilities under RBF Program.	This is a new indicator, a measure of citizen engagement.
Number of households included in the social registry	Number of households surveyed whose data is included in the social registry database and can be used for targeting social programs	This indicator was introduced as an Intermediate Indicator at the time of the Restructuring. It would remain unchanged.

Annex 2: More Details of Past Restructuring, Activities under Additional Financing and proposed level 1 restructuring.

A. Initial Project Approval and Restructuring

1. **The Improving Maternal and Child Health through Integrated Social Services Project (US$90 million of which US$70 from IDA and US$20 from HRITF), was approved on May 21, 2013, and its Project Development Objective (PDO) was to increase the access and use of maternal and child health, nutrition and other social services in the Recipient's territory.** The bulk of the financing (US$69 million including US$20 million from the HRITF) was for activities with the Ministry of Public Health and Population (MSPP) as the implementing agency. The remaining funds were allocated for activities under a Social Protection stream, mainly for the government's *Kore Fanmi* multi-sectoral community agents program, implemented by the *Fonds d'Assistance Economique et Sociale* (FAES). The Project became effective on September 12, 2013.

2. **A restructuring of the Project was approved in March 2017 mainly to reallocate the funds that were originally financing the government's Kore Fanmi (KF) program under the social protection stream, due to the suspension of this program.** Activities under the MSPP remained largely unchanged in nature and design. The remaining funds under the KF program (around US$20 million) were reallocated for: (a) scaling- up of ongoing activities under MSPP to combat cholera, and (b) other, new Social Protection activities that are not under MSPP. The latter consisted of: (i) support for a social registry for identification and tracking of beneficiaries and social assistance programs (with FAES remaining the implementing agency), and (ii) piloting of vulnerability indicators for more targeted social service delivery (with a new implementing agency added for these activities – the *Institut Haïtien de Statistique et d'Informatique* (IHSI). The PDO was not changed under the restructuring. There were no significant changes to the design and activities under MSPP as the implementing agency, and the implementation arrangements for these activities remained unchanged with the Contracting Unit (CU) and the *Unité de Gestion de Projet* (UGP) at MSPP taking the lead in implementation. The original closing date was extended by a year to December 31, 2019. The table below lists the activities under the three implementing agencies after the restructuring. The allocations in the table reflect changes in the USD-SDR exchange rate since the time of Board approval of the Original Grant, which has led to a reduction in the overall financing for the Project from its original total allocation of US$90 million. (The figures below reflect allocations at the latest USD-SDR exchange rate, not the exchange rate at the time of the restructuring.)

Table A2-1: Sub-Components and Activities under Current Project (After Restructuring)

Stream, Sub-Component and Activities Covered	Implementing Agency	Allocation and Financing Source
Maternal and Child Health stream – improving quality/supply of services within selected health service providers through small-scale rehabilitation, equipment, medical supplies, health commodities and training of, and technical assistance to health personnel (Sub-Component 1.1(a)) **Maternal and Child Health stream** – Results-Based Financing (RBF) payments to health facilities (Sub-	MSPP	US$2.88 million from IDA

Component 1.1(c)) **Maternal and Child Health stream** – Verification activities, Technical Assistance (TA) and knowledge generation for RBF (Sub-Components 1.1(b) and 1.1(d))	MSPP MSPP	US$18.13 million from IDA US$14 million from HRITF US$1.03 million from IDA US$6 million from HRITF
Cholera Program stream – Interventions to fight cholera: (i) epidemiological surveillance; (ii) health care; (iii) promotion and prevention; and (iv) water and sanitation, including related capacity building at central, departmental and community levels. Also, support for surveillance, preventative and curative activities, and capacity building for contagious diseases overall in non-emergency situations (Sub-Component 1.2)	MSPP	US$25.33 million from IDA
Strengthening MSPP stewardship and management capacity (cross-cutting across both MSPP streams) – includes increasing the capacity of the Departmental health authorities in supervision and monitoring of health service delivery, and others (Sub-Component 2.1)	MSPP	US$4.59 million from IDA
Contingency Emergency Response sub-component with zero financing allocation, triggered only in cases of major health emergencies (Sub-Component 1.3)	MSPP	US$0
Social Protection stream – strengthening social protection coordination and management, mainly now in support of a social registry (Sub-Component 2.2 – previously also included activities under the *Kore Fanmi* program under Sub-Component 1.2 that was closed at the time of the restructuring)	FAES	US$7.32 million from IDA (includes $2.45 million already disbursed for *Kore Fanmi* activities under Sub-Component 1.2)
Piloting vulnerability indicators for more targeted social service delivery (Component 3)	IHSI	US$5 million from IDA
TOTAL		US$64.28 million from IDA US$20 million from HRITF

B. Activities Under Additional Financing (AF)

3. The bulk of the funds under the Additional Financing (AF) would finance a scale-up of activities already eligible and already being implemented under Sub-Components 1.1(a) and 1.2 of the Project: (i) small-scale rehabilitation activities and equipment provision for health facilities damaged by the Hurricane, and (ii) prevention and response activities for cholera and other diarrheal and contagious diseases in areas affected by the Hurricane, to help address the new front for cholera that has opened up in these. (See the main part of this Project Paper for details on allocations.)

Small-Scale Rehabilitation Activities and Equipment Provision for Health Facilities Damaged by Hurricane

4. In the wake of Hurricane Matthew, most health facilities and drug warehouses in the South,

Grand'Anse, Nippes and Northwest Departments, as well as some in the North Department, suffered some damage – many to the extent that their ability to function was severely compromised. Most of these health facilities also saw substantial damage to their equipment and supplies, including for the vaccine cold chain.

5. **The existing World Bank-financed project immediately provided financing for some rehabilitation efforts, and for re-establishment of the vaccine cold chain.** Other partners also provided emergency financing for various other short term rehabilitation activities. However, given the extent of the number of health facilities that have suffered significant damages, a large number of health facilities have yet to be rehabilitated.

6. **Major health donors including the World Bank have jointly developed a plan for rehabilitation and re-equipping of the health facilities that have been affected.** The plan has been carefully developed to avoid duplication of efforts, and all parties have committed to close monitoring of the rehabilitation efforts so that the interventions are made in an appropriate way, and so that the health facilities are fully functional after the rehabilitations.

7. Under this joint plan, the rehabilitation efforts that are to be financed by World Bank financing would be supported through the proposed AF. These efforts will cover around 40 health facilities (to be financed from AF funds). A structure for close supervision of these rehabilitation efforts, and for confirming full functionality (or otherwise) of the health facilities after the rehabilitation efforts, will be set up. Rehabilitation efforts will ensure that health facilities have appropriate access to water and sanitation.

Cholera Prevention and Response Activities in Areas Affected by the Hurricane

8. **The cholera epidemic in Haiti – the worst in modern times anywhere – started in October 2010. Since then, there have been more than 800,000 cholera cases and more than 9,400 deaths in the country** – almost as many deaths as during the Ebola epidemic. Haiti's Ministry of Public Health and Population (MSSP) led a large intervention to combat the epidemic. The MSPP established Haiti's National Cholera Surveillance system (NCSS) shortly after the detection of the cholera outbreak. The system facilitates the daily collection of data about cholera cases and cholera-related deaths recorded in health facilities and cholera treatment centers across the country, and of community cases and deaths reported by community members. To complement the national cholera surveillance system, an alert and response surveillance system was established to better monitor the spread of the epidemic and guide prevention and control activities.

9. In 2012, the MSPP, in collaboration with partners, developed its 10-year National Plan for the Elimination of Cholera (2013-2022), estimated to cost $2.2 billion. The plan was designed to provide sustainable response to addressing the problems to eliminate cholera over three phases and with particular focus on four strategic areas of intervention: (i) epidemiological surveillance; (ii) medical treatment; (iii) improved water and sanitation; and (iv) health promotion. While Haiti has achieved the short term objective of less than 50,000 cases by 2015, the Plan, almost four years after its launching, remains significantly underfunded.

10. **Even before Hurricane Matthew, cholera still remained endemic in the country despite a substantial fall in the overall number of cases and deaths since the peak of the outbreak in 2011.** There had been a steady decrease in the number of cholera cases and deaths between 2011 and 2014.

In 3 years, the number of suspected cases dropped from over 350,000 cases in 2011 to 29,078 in 2014, a 90 percent decrease. However, since then, Haiti has experienced a resurgence of the epidemic in 2015 and even more so in 2016 with 41,421 cases and 447 deaths (see Table A2-2). Localized cholera outbreaks have been continuing to occur throughout the country, especially during the rainy seasons (~May-June and ~September-November). A similar trend is observed in terms of case fatality ratio (CFR). Between 2011 and 2015, the case fatality ratio declined from 2.21 percent to 0.89 percent but increased again in 2016 (even before hurricane Matthew) and reached an alarmingly high 1.6 percent in the first 10 weeks of 2017.

Table A2-2: Cumulative Cholera Cases and Deaths – March 11, 2017

Year	Total Cases	Hospital-ized Cases	Hospital Deaths	Total Deaths	Case-Fatality Ratio for Hospitalized Cases (%)	Case-Fatality Ratio for Total Cases (%)
2010 (Oct 20-Dec 31)	185,210	103,728	2,521	3,951	2.43	2.13
2011	351,839	186,673	1,950	2,918	1.04	0.83
2012	101,354	61,876	597	908	0.96	0.90
2013	58,917	37,985	400	581	1.05	0.99
2014	29,078	21,662	218	307	1.01	1.06
2015	36,045	29,642	224	322	0.75	0.89
2016	41,421	33,837	307	447	0.91	1.08
Sub-total: 2010-2016	803,864	475,403	6,217	9,434	1.31	1.17
Post-Hurricane Matthew Period 2 October – 24 December 2016	10,318**	8,531**	87	139	1.02	1.35
2017: January to March 11, 2017)	**3,585**	**2,984**	**38**	**56**	**1.27**	**1.6**

Source: MSPP National Cholera Surveillance System

** The figures for total cases since the Hurricane struck may be significantly underestimated due to underreporting and access constraints to health facilities and communities in some areas in the south.

11. **While Haiti experienced a spike in cases during the month of October 2016 compared to the same period in 2015 (almost twice as high), a steady reduction of suspected cases has been observed since the beginning of November 2016.** The number of suspected cases during the 10th epidemiological week of 2017 was almost a fourth of the one of the same week in 2015. This is the result of a combination of post-Matthew interventions:

- **Increased deployment of WASH and medical NGOs (rapid response teams) in communities with suspected cases,** with interventions targeting cholera (prevention, chlorination of water sources, and patients' treatments). After Hurricane Matthew -but before the vaccination campaign (see below) - UNICEF has added 21 additional rapid response teams in the south and country-wide. The number of rapid response teams increased to 88 (after a drop in the number of teams to below 40 earlier in the year). This deployment has a critical role in improving the mobility and responsiveness of the government's EMIRA teams to respond to cholera alerts.
- **Implementation of a vaccination campaign** targeting 759,000 people in particularly affected communities in the south (led by MSSP and supported by PAHO and health partners). It is important to note that the vaccine is not 100 percent effective, and only one dose has been

administered. The MSPP reported a coverage of 96 percent and 94 percent of the targeted population in Grand'Anse and Sud.

- **Initial rehabilitation of Cholera Treatment Centers and Units** (now called Acute Diarrhea Treatment Centers) across the country (still ongoing).

12. **However, the post-Hurricane response for cholera was enabled by the infusion of a relatively large amount of financing linked to the Hurricane, and these levels cannot be sustained in the future – implying a significant risk of a resurgence of the epidemic in the near future.** NGOs are already withdrawing from certain departments, creating some critical medical and WASH interventions gaps. The number of rapid response teams – which doubled during the few months just after the Hurricane – is already being cut. Financing for medical and WASH inputs for community intervention and service delivery in Acute Diarrhea Treatment Centers are only partially covered, with expected stock outs of antibiotics and other cholera response inputs emerging by mid-2017. Financing from key partners financing cholera response efforts such as UNICEF and CDC is likely to be fall very substantially in the near future.

13. **The case-fatality ratio in Hurricane-affected departments is 3 times higher than in the rest of the country and cholera mortality is 4 times higher in the former (see Table A2-3).** While there is no clear evidence of the epidemiological dynamic behind this, the combination of the high level of damage of health infrastructure, already lower level of service readiness, and overall lower cholera exposure before the hurricane may partly explain the difference between the departments affected by Matthew and other departments.

Table A2-3. Cholera Incidence and Case-Fatality Ratio in Hurricane-Affected vs. Non-Affected Departments, Haiti (January 1 – March 11 2017)

	Hurricane-Affected Departments (Grand'Anse, Nippes, South, Northwest)	**Other Departments** (North, Northeast, Artibonite, Centre, West, Southeast)
Cholera Incidence (cases per 1000 people; 1 Jan – 11 March 2017)	0.308	0.268
Case-Fatality Ratio (1 Jan – 11 March 2017)	2.52%	0.74%

Source: World Bank HNP team, based on MSPP epidemiological data and IHSI 2015 population data

14. **Conditions favorable to the spread of cholera remain:** lack of access to safe water, poor sanitation conditions, poor hygienic practices, generally weak functioning of an already stretched health system, and overall decline in funding, including the phasing out of humanitarian assistance were some of the key factors that were contributing to the cholera situation in the country.

15. **A portion of the funds under the AF and proposed level 1 restructuring would be used to finance prevention and response activities for cholera and other diarrheal and contagious diseases in areas affected by the Hurricane**. These will include the following, among others: (i) efforts by mobile rapid response teams; (ii) key contractual staff including departmental cholera coordinators; (iii) outbreak detection, surveillance and epidemiological monitoring activities; (iv) activities in support of diagnostics and laboratory testing; (iv) provision of essential medicines and supplies for cholera;

(v) medical treatment to persons suffering from acute diarrhea and/or persons infected by cholera; (vi) awareness raising and sensitization; (vii) information, education and referrals to facilities; (vii) chlorination supplies; (ix) household Water, Sanitation and Hygiene (WASH) activities; (x) training of health personnel and community health agents; (xi) additional cholera beds to increase capacity for treatment, and (xii) supervision, monitoring and quality assurance activities.

16. **Particular attention will be paid to the latter in the Hurricane-affected areas – supervision, monitoring and quality assurance activities – to ensure that activities being undertaken are having the desired impact on the degree and quality of the interventions supported**. For example, a reinforced quality monitoring tool and checklist will be used to regularly check the status of health facilities and Cholera Treatment Centers in the Hurricane-affected areas (e.g. verifying the availability of sufficient cholera medicines and supplies, the capacity of each facility to provide adequate services, availability of key equipment etc.).

Allocations for Sub-Components and Categories in the Financing Agreements

17. Table A2-4 below depicts the revised allocations across the different subcomponents of the Project for the two IDA grants (the original IDA grant as well as the IDA Additional Financing grant) – with only IDA allocations shown (at the latest USD-SDR exchange rate). There would be no changes in the activities under each Subcomponent, nor in Subcomponent or Component names. The only changes are the following:

- Sub-Component 1.1(a): An additional US$9.5 million (including an allocation of US$200,000 for potential resettlement payments) would be provided under the AF Grant for this sub-component, with US$7 million specifically designated for areas affected by the Hurricane.

- Sub-Component 1.2: An additional US$13.5 million would be provided under the AF Grant for this sub-component, with US$10 million specifically designated for areas affected by the Hurricane.

Table A2-4: Revised Allocations from IDA for Sub-Components and Components

Stream, Sub-Component and Activities Covered	Implementing Agency	Allocations Under the Original IDA Grant[1]	Allocations Under the AF IDA Grant
Maternal and Child Health stream – improving quality/supply of services within selected health service providers (Sub-Component 1.1(a))	MSPP	US$2.88 m	US$9.5 m (including US$200,000 for potential resettlement payments)
Maternal and Child Health stream – Results-Based Financing (RBF) payments to health facilities (Sub-Component 1.1(c))	MSPP	US$18.13 m	
Maternal and Child Health stream – Verification activities, TA and knowledge generation for RBF (Sub-Components 1.1(b) and 1.1(d))	MSPP	US$1.03 m	
Cholera Program stream – Interventions to fight cholera: (i) epidemiological surveillance; (ii) health care; (iii) promotion and prevention;	MSPP	US$25.33 m	US$13.5 m

and (iv) water and sanitation, including related capacity building at central, departmental and community levels. Also, support for surveillance, preventative and curative activities, and capacity building for contagious diseases overall in non-emergency situations (Sub-Component 1.2)			
Strengthening MSPP stewardship and management capacity (cross-cutting across both MSPP streams) – includes increasing the capacity of the Departmental health authorities in supervision and monitoring of health service delivery, and others (Sub-Component 2.1)	MSPP	US$4.59 m	US$2 m
Contingency Emergency Response sub-component with zero financing allocation, triggered only in cases of major health emergencies (Sub-Component 1.3)	MSPP	US$0	
Social Protection stream – strengthening social protection coordination and management, now mainly in support of a social registry (Sub-Component 2.2 – previously also included activities under the *Kore Fanmi* program under Sub-Component 1.2 that was closed at the time of the restructuring)	FAES	US$7.32 m (includes $2.45 m already disbursed for *Kore Fanmi* activities under Sub-Component 1.2)	
Piloting vulnerability indicators for more targeted social service delivery (Component 3)	IHSI	US$5 m	
TOTAL		US$64.28 m	US$25 m

Note:

1. All allocations (including the allocations just after the restructuring) are shown at the latest USD-SDR exchange rate, not the exchange rate at the time of the restructuring.

Under the IDA Additional Financing grant of US$25 million equivalent (18,300,000 SDR), most of the financing (US$24.8 million) would be allocated to one single Category in the Financing Agreement covering all activities mentioned in the last column on the right of the above table, with US$200,000 allocated to a new Category for resettlement payments.

Annex 3: PPSD – Executive Summary for Procurement Plan and Project Procurement Strategy for Development (PPSD)

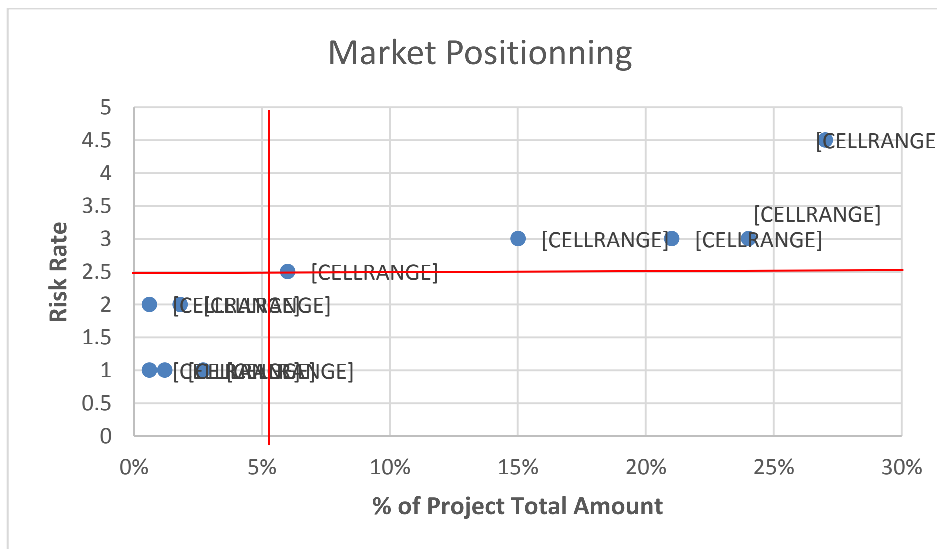
1. The Project will be executed in accordance with the WB's Procurement Regulations for Borrowers under Investment Policy Financing (July 2016).

2. Procurement for the Project will be carried out by: MSPP (UGP). The Project will be executed in accordance with the WB's Procurement Regulations for Borrowers under Investment Policy Financing (July 2016) ("Procurement Regulations"), and the provisions stipulated in the Procurement Plan and the Operational Manual. During the last supervision mission an assessment of UGP capacity found that there is a need to reinforce this unit by recruiting an assistant procurement. The UGP will be responsible for all procurement and contracting related queries and processing, including management and compliance with fiduciary requirements.

3. A Project Procurement Strategy for Development was carried out and identified the appropriate selection methods, market approach and type of review by the WB. Most activities under the Project will be carried out through National or International Competition. An acceptable Procurement Plan was also prepared and will be included in the new Systematic Tracking of Exchanges in Procurement system. Procurement arrangements for the Immediate Response Mechanism Component are described in the Immediate Response Mechanism Operational Manual. For International Competition, in addition to WB Standard and Sample Bidding Documents UGP will be using standard bidding documents agreed with the National Commission of Public Contracts (*Commission Nationale des Marchés Publics*).

4. Following the market analysis, risks identified, and contract amounts it was determined that the most important activities under the Project will be carried out through International or National Competition and Direct Selection. These activities represent 93 percent of the AF total amount, and they are comprised of: (i) Works (US$4.50 millions); and (ii) Goods (US$11.0 million). Works will be procured through one request for quotation at national level. This procurement concerned small improvement of devastated health facilities. Goods will be procured through the following methods: (i) two requests for bid (open and international competition) for procuring small health facilities equipment amounting US$2.5 million and for procuring three spectrometers amounting US$1.00 million. Presently there is no national enterprise which can provide these items; and (ii) two direct selection contracts with UN Agencies (such as UNICEF, WHO/PAHO/AMRO, etc.) for the procurement of medicals and drug supplies amounting each US$2.00 million.

No.	Contract	Contract Amount (US$)	% Project Total Amount	Risk Rate
1	Small equipment for 40 renovated health facilities	2500000	0.14	4.5
2	Medical Equipment for National Laboratories (3 spectrometers)	1,000,000	0.06	2.5
3	Medical supply +WASH supply for comminatory interventions	4,000,000	0.23	3
4	Logistic for community interventions (vehicles)	450,000	0.03	1
5	Pilot for cholera management	100,000	0.01	1
6	Consultant for crisis management and emergency planning	150,000	0.01	1
7	Consultant for support to MSPP at central level (1 international + 4 local consultants)	300,000	0.02	2
8	Effective action taken against cholera in four zones	3,500,000	0.20	1
9	Engineer /Consultants	300,000	0.02	2
10	Rehabilitation of 40 health facilities	5,000,000	0.29	4.5
	TOTAL	17,300,000	1	



5. A series of mitigation measures will be implemented to ensure the satisfactory performance of procurement functions within UGP-MSPP. These include: (i) assessment of procurement capability of UGP; (ii) supervision of procurement/selection transactions carried out by UGP; and (iii) inclusion of Special Procurement Provisions in the Procurement Plan. All procurement procedures are described in the Operational Manual which would be updated to reflect the above activities.

Major contracts and selection methods from the PPSD

Contract Title, Description and Category	Bank Oversight	Procurement Approach	Selection Methode	Evaluation Method
Small equipment for 40 renovated health facilities	Yes	· International · Open	Request for bids	Lowest Evaluated Cost
Medical supply	Yes	· Direct ·	Direct Selection	Lowest Evaluated Cost
WASH supply for comminatory interventions	Yes	· Direct ·	Direct Selection	Lowest Evaluated Cost
Rehabilitation of 40 health facilities	Yes	· National · Open	Request for quotation	Lowest Evaluated Cost

Annex 4. Economic and Financial Analysis

1. **Methodology:** The economic impact of the Improving Maternal and Child Health through Integrated Social Services Project, including the proposed additional Financing was estimated based on the updated cost-benefit analysis conducted for the recent restructuring. This analysis estimated the Project's Net Present Value and Benefit-Cost Ratio (BCR) using estimates for the total costs and health benefits, where the Net Present Value represents the stream of benefits minus costs discounted for the time value of money. The benefits reflect primarily the deaths avoided due to strengthened primary care provision and cholera interventions, where one death averted is equivalent to the value of one Statistical Life (VSL), which has been calculated for Haiti based on a standardized methodology. Sensitivity analyses analyze the robustness of the estimates to various assumptions about the effectiveness of primary care and cholera interventions.

2. **Program costs:** The cost figures for the analysis consist of project costs, financed from IDA as well as from the HRITF. These costs are portrayed in the below table, in USD terms. The costs presented refer to financing allocations after the proposed Additional Financing. (The costs of stewardship and capacity building for MSPP have been "apportioned out" proportionally to the Primary Care and Cholera streams.)

Table A4.1: Total Project Costs (Including AF), USD

Item	Sub-item	USD Million
Primary Care	Maternal and Child Health (MCH) mostly via Results-Based Financing or RBF (from IDA)	$34.5
	RBF (from HRITF)	$20.00
	Subtotal Primary Care	***$54.5***
Cholera	Cholera + other infectious diseases	**$42.5**
Social Protection	Activities on Social Protection and census	***$12.3***
	Total Project	**$109.3**

3. **Program benefits**: Benefits have been calculated separately for the primary care and cholera streams. The first are based on the maternal and infant deaths that would be reduced due to the Project's primary care interventions. The international literature[10,11,12] has long demonstrated that strengthened primary care has substantial impacts on health outcomes. Further, Bhutta et al.[13] estimate that the implementation of a primary care package akin to the Project's Results-Based Financing interventions (i.e. family planning, antenatal care and others) can reduce up to 30 percent of

[10] Macinko, James, et al. "Going to scale with community-based primary care: an analysis of the family health program and infant mortality in Brazil, 1999–2004." *Social Science & Medicine* 65.10 (2007): 2070-2080.

[11] Macinko, James, Barbara Starfield, and Leiyu Shi. "The contribution of primary care systems to health outcomes within Organization for Economic Cooperation and Development (OECD) countries, 1970–1998." *Health services research* 38.3 (2003): 831-865.

[12] Kruk, Margaret Elizabeth, et al. "The contribution of primary care to health and health systems in low-and middle-income countries: a critical review of major primary care initiatives." *Social Science & Medicine* 70.6 (2010): 904-911.

[13] Bhutta, Zulfiqar A., et al. "Interventions to address maternal, newborn, and child survival: what difference can integrated primary health care strategies make?" *The Lancet* 372.9642 (2008): 972-989.

maternal and child mortality in Uganda and Pakistan, whose socioeconomic conditions are similar to Haiti's in several relevant aspects. Additional studies have demonstrated similar effects in other low-income countries where similar types of RBF packages have been implemented. The benefits of the Project's primary care component were thus estimated under the assumption of a progressive reduction of mother-child deaths reaching 30 percent by the end of the Project.[14] These averted deaths are then multiplied by the VSL for Haiti, which has been set at $33,755 after standard calculations (see below). The benefits for the cholera stream reflects the deaths, treatments and productivity losses (due to time off work during treatment) avoided due to the Project's interventions. Note that the Bank finances high-impact cholera interventions such as cholera surveillance, rapid response teams, and diagnostics/treatment. The Bank provides approximately 50 percent of major donor spending on key cholera interventions, so it would be reasonable to assume that a similar proportion of all cholera cases (as well as deaths etc.) are attributable to the Bank's financing (via this Project). Yet for the purposes of being conservative in our estimates, it is assumed that only 38 percent (=50 percent *75 percent) of all cholera deaths, productivity losses, and treatments avoided (see calculations below) can be attributed to the Project.

4. **Our estimated benefits are very likely to underestimate the true benefits from the Project**. This is because of the conservative nature of our calculations. First, the benefits from community agents and other infectious disease activities have not been estimated, because: (i) in spite of its demonstrated potential in low-income countries[15,16], there is a high degree of uncertainty about the specific impact of community agents on health outcomes in the context of Haiti; and (ii) the category "other infectious diseases" is too unspecific to allow reasonable benefit estimates to be calculated. For similar reasons, the benefits from the social protection activities have not been estimated. Therefore, the calculations in this exercise assume that the benefits from all of these activities are zero. This is done, again, for the purposes of being conservative in our estimates. In addition, the RBF benefits take into account only mortality reductions; they therefore disregard important benefits such as benefits from morbidity and disability reductions. If all these benefits—due to reduced morbidity/disability resulting from the RBF interventions, as well as benefits from community-level, "other infectious diseases" and social protection activities—were taken into account, the BCR and Net Present Value estimates would be considerably higher.

Key Assumptions

Other than the assumptions mentioned above, the following additional assumptions were made for the analysis:

- **Temporal horizon:** The Net Present Value and BCR are estimated over the duration of the Project (October 2013 to December 2019). Therefore, it is assumed that no benefits are incurred after the Project's closing. As much of the infrastructure and knowledge generated by the Project are likely to remain after 2019, this assumption is a highly conservative one.

[14] And incorporating the assumption of progressive rollout of the RBF activities as planned under the Project, with the number of covered individuals increasing from 76,633 in October 2013 to 2.3 million in 2019.

[15] Perry, Henry B., Rose Zulliger, and Michael M. Rogers. "Community health workers in low-, middle-, and high-income countries: an overview of their history, recent evolution, and current effectiveness." *Annual Review of Public Health* 35 (2014): 399-421.

[16] Theodoratou, Evropi, et al. "The effect of case management on childhood pneumonia mortality in developing countries." *International Journal of Epidemiology* 39.suppl 1 (2010): i155-i171.

- **Discount rate:** In the baseline scenario, the Project's costs and benefits are discounted at 3 percent, for the time value of money (of 3 percent).
- **Sensitivity analysis:** The calculations were made under the following alternative scenarios: (a) the effectiveness of primary care interventions was reduced from its base-case value of 30 percent (for reduction of maternal and child deaths) to 15 percent in an alternative scenario; and (b) the percentage of all reductions in cholera cases (and deaths etc.) attributable to the Bank's financing were assumed in an alternative scenario to be 19 percent rather than 38 percent as assumed in the base-case scenario. The Net Present Value and BCR were estimated for all these alternative scenarios.
- **Value of Statistical Life (VSL):** The current evaluation uses an assumed VSL value of $33,755 for Haiti. This amount is based on the benefits transfer formula proposed by Ozawa[17], whereby $VSL_j = VSL_{USA} \times (GNI_j/GNI_{USA})$ ^ ξ. In this formula, the subscript j refers to the country of study (i.e. Haiti), and the VSL value for the United States for 2011 is $6.2 million[18]. The variable ξ denotes the percentage change of VSL in terms of GNI; based on Ozawa's contribution[19], the current evaluation uses a 1.5 income elasticity of VSL in the United States compared to that of developing countries. Hence ξ=1.5.

Costs

- **Annual costs:** As noted in the above table, total Project costs add up to $107 million, with allocations for the different streams (and sub-streams) also provided in the table.

Benefits

The Project benefits were calculated as follows (and incorporating the assumptions mentioned above):

- **Counterfactual:**
  - **Primary care**: in Haiti, department-specific death rates are currently unavailable. Therefore, our calculations assume the national death rates as the counterfactual. Based on UNICEF data[20], there is (without the intervention) a 0.0019 probability of death per child under five years old, and a 0.00029 probability of death per woman due to maternal causes. These rates are assumed to stay constant over time under the counterfactual (i.e. if the intervention did not take place).
  - **Cholera**: The counterfactual for the cholera analysis comprises the totality of nation-wide cholera cases (deaths, inpatient, and outpatient) during 2013. According to MSPP,[21] in 2013

[17] Ozawa S, Stack ML, Bishai DM, et al. "During the "decade of vaccines," the lives of 6.4 million children valued at $231 billion could be saved:. *Health Aff (Millwood).* 2011;30:1010–1020.
[18] Trottenberg, P.; Rivkin R.. "Treatment of the Economic Value of a Statistical Life in Departmental Analyses". July, 2011.
[19] Ozawa S, Stack ML, Bishai DM, et al. "During the "decade of vaccines," the lives of 6.4 million children valued at $231 billion could be saved:. *Health Aff (Millwood).* 2011;30:1010–1020.
[20] Unicef. "Haiti Statistics". Available: http://www.unicef.org/infobycountry/haiti_statistics.html. Last updated December 2013.
[21] Ministry of Health and Population – Direction de l'Épidemiologie, Laboratoires et la Recherche (DELR). «Update-Haiti Cholera: May 2016 ».

there were 581 deaths, 37,895 hospitalizations and 20,983 outpatient episodes due to cholera. Therefore, the numbers of cases for each year thereafter (2014-2019) were subtracted from the 2013 baseline, to obtain the total number of cases that were assumed to be averted in each of the years 2014 to 2019 due to interventions against cholera. These calculations are thus based on the counterfactual assumption that the epidemic would revert back to 2013 levels if cholera interventions were not implemented. As mentioned above, 38 percent of the cases assumed to be averted in each year (deaths, etc.) were attributed to Project interventions (in the base-case scenario). Note that our counterfactual assumption is likely very conservative, because there are indications that an absence of interventions could well lead to numbers of cholera cases, deaths etc., reverting back to levels in 2012, 2011 etc. And the levels of cholera cases, deaths etc. in 2012, 2011 etc. were much higher than in 2013. Our counterfactual regarding cholera interventions thus likely, again, results in a substantial underestimate of the Project's benefits under its cholera stream.

- **Benefit calculations:**

  - **Primary care stream:** The number of deaths averted due to the primary care stream is the sum of the deaths averted for children and mothers over the Project's lifetime. These have been calculated using the general formula: Deaths Averted = Population Covered * Death $Rate_{Group}$ * Reduction $Coefficient_{Group}$, where the Reduction Coefficient expresses the percentage of deaths reduced by the Project's primary care component, which increases yearly to finally reach 15 percent or 30 percent, depending on the effectiveness scenario. The total number of deaths averted is then valued using the VSL methodology, whereby the value of one death averted is equal to the estimated VSL.

  - **Cholera stream:** The benefits of this stream incorporate the benefits due to cholera deaths, treatments, and productivity losses avoided due to the Project. As mentioned above, the number of cases averted is based on the assumption of the 2013 level as the counterfactual. The value of each death averted is valued using the VSL methodology, as noted above (1 death averted = $33,755). Treatment costs cover both inpatient and outpatient costs. Based on an assumed treatment duration of five days, and WHO-CHOICE treatment costs for high cholera mortality countries in the Americas Region[22], the cost per hospitalization was determined at $253, and per outpatient case at $48. Finally, the productivity losses take into account the time off work for those treated, under the assumption that each case treated (whether outpatient or inpatient) results in five days spent away from work. Assuming an annual GDP per capita of $810 in 2013, the productivity loss per case amounts to $23.

Results

The results of the analysis are given in the below table, which shows that the Project remains very cost-effective in all scenarios. In the most optimistic (base-case) scenario, the Project yields a Net Present Value of $90 million, with a benefit to cost ratio of 1.9. In contrast, the most pessimistic scenario (lower effectiveness of primary care interventions, and lower percentage of all reductions in cholera cases,

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[22] World Health Organization. "Cost-Effectiveness Analysis and Strategic Planning (WHO-CHOICE). Available: http://www.who.int/choice/en/

deaths etc. attributable to the Project) still results in a positive Net Present Value of $9.75 million and a BCR of 1.1. Therefore, and in spite of the highly conservative nature of many of the assumptions used for the analysis, the results suggest that the Project is highly cost-effective.

Table A4.2. Net Present Value and Cost-Benefit Ratio for the Project, 2013-2019

	Percentage of reductions in cholera cases, deaths etc. attributable to Project higher (38%)		Percentage of reductions in cholera cases, deaths etc. attributable to Project lower (16%)	
	Net Present Value	**Benefit-Cost Ratio**	**Net Present Value**	**Benefit-Cost Ratio**
Primary Care / RBF effectiveness higher (30%)	$89,986,186	1.9	$71,236,112	1.7
Primary Care / RBF effectiveness lower (15%)	$28,251,019	1.3	$9,750,946	1.1