Document of

**The World Bank**

**FOR OFFICIAL USE ONLY**

Report No: ICR00005403

# IMPLEMENTATION COMPLETION AND RESULTS REPORT

ON

GRANTS

H864-0-HT, D203-0-HT AND TF014474

IN THE AMOUNT OF SDR 46.70 MILLION
(US$ 70 MILLION EQUIVALENT)

IN THE AMOUNT OF SDR 18.3 MILLION
( US$ 25 MILLION EQUIVALENT)

AND A

HEALTH RESULTS INNOVATION TRUST FUND GRANT
IN THE AMOUNT OF US$20 MILLION

TO THE

REPUBLIC OF HAITI

FOR THE

IMPROVING MATERNAL AND CHILD HEALTH THROUGH INTEGRATED SOCIAL SERVICES

May 28, 2021

Health, Nutrition & Population Global Practice
Latin America and Caribbean Region

CURRENCY EQUIVALENTS

(Exchange Rate Effective January 27, 2021)

| | | |
|---|---|---|
| Currency Unit | = | Haitian Gourde - HTG |
| HTG1 | = | US$.0014 |
| US$1 | = | 75.5 HTH |

FISCAL YEAR
October 1 - September 30

| | |
|---|---|
| Regional Vice President: | Carlos Felipe Jaramillo |
| Country Director: | Tahseen Sayed Khan |
| Regional Director: | Luis Benveniste |
| Practice Manager: | Michele Gragnolati |
| Task Team Leader(s): | Andrew Sunil Rajkumar, Briana N. Wilson, Nicolas Collin Dit De Montesson |
| ICR Main Contributor: | Maria Cecilia Zanetta |

## ABBREVIATIONS AND ACRONYMS

| | |
|---|---|
| AF | Additional Financing |
| ASPIRE | The Adaptive Social Protection for Increased Resilience Project |
| BCR | Benefit-Cost Ratio |
| BSEIPH | Bureau of the Secretary of State for the Integration of Persons with Disabilities (*Bureau de la Secrétaire d'Etat a l'Intégration des Personnes Handicapées)* |
| CDAI | Departmental Supply Center (*Centre Départemental d'Approvisionnement en Intrants*) |
| CDC | Center for Disease Control |
| CDP | Departmental Steering Committee (*Comité Départemental de Pilotage)* |
| CU | Contracting Unit |
| CPF | Country Partnership Framework |
| DDS | Departmental Health Directorate *(Direction Départementale de la Santé)* |
| DELR | Epidemiology, Laboratory, and Research Directorate *(Direction d'Epidémiologie, de Laboratoires, de Recherches)* |
| DHS | Demographic and Health Survey |
| DINEPA | National Water and Sanitation Directorate (*Direction Nationale de l'Eau Potable et de l'Assainissement*) |
| DPSPE | Health and Environmental Protection Directorate *(Direction de Promotion de la Santé et de Protection de l´Environnement)* |
| EMIRA | Mobile Rapid Response Teams *(Équipes Mobiles d'intervention Rapide)* |
| ESMF | Environmental and Social Management Framework |
| FAES | Economic and Social Assistance Fund (*Fonds d'Assistance Economique et Sociale)* |
| FM | Financial Management |
| GDP | Gross Domestic Product |
| GoH | Government of Haiti |
| GRM | Grievance Redress Mechanism |
| ICR | Implementation Completion and Results Report |
| IDA | International Development Association |
| IDB | Inter-American Development Bank |
| IHSI | Haitian Institute of Statistics and Informatics (*Institute Haitien de Statistique et d'Informatique)* |
| IMF | International Monetary Fund |
| IRI | Intermediate Results Indicator |
| ISR | Implementation Status Report |
| KF | *Kore Fanmi* |
| LNSP | National Laboratory for Public Health |
| M&E | Monitoring and Evaluation |
| MAST | Ministry of Labor and Social Affairs (*Ministère des Affaires Sociales et du Travail)* |
| MCH | Maternal and Child Health |
| MSPP | Ministry of Public Health and Population (*Ministère de la Santé Publique et de la Population*) |
| NGO | Non-government Organization |
| NPV | Net Present Value |
| PAHO | Pan-American Health Organization |
| PASMISSI | Improving Maternal and Child Health Through Integrated Social Services *(Projet d'Amélioration de la Santé Maternelle et Infantile à travers des Services Sociaux Intégrés)* |
| PDI | Project Development Indicator |

| | |
|---|---|
| PDO | Project Development Objective |
| PIU | Project Implementation Unit |
| PLR | Performance and Learning Review |
| PMCHNS | Package of Maternal and Child Health and Nutrition Services |
| PNPPS | National Policy on Social Protection and Promotion *(Politique Nationale de Protection et de Promotion Sociales)* |
| PRF | Project Results Framework |
| PROSYS | Strengthening Primary Health Care and Surveillance in Haiti Project *(Projet de Renforcement des Soins de Santé Primaire et de la Surveillance en Haïti*) |
| PwDs | Persons with Disabilities |
| RBF | Results-Based Financing |
| SBR | Single Beneficiary Registry |
| SIMAST | Integrated Beneficiary Registry (*Système d'Information du MAST)* |
| SISNU | Single Sanitary Information System (*Système d'Information Sanitaire Unique)* |
| SP | Social Protection |
| SPST | Social Protection Sectoral Table |
| SSR | Single Social Registry |
| TA | Technical Assistance |
| TTL | Task Team Leader |
| UN | United Nations |
| UNICEF | United Nations Children's Fund |
| UNFPA | United Nations' Population Fund |
| USAID | United States Agency for International Development |
| WB | World Bank |
| WFP | United Nations' World Food Programme |
| WHO | World Health Organization |

TABLE OF CONTENTS

## DATA SHEET

## BASIC INFORMATION

### Product Information

| Project ID | Project Name |
|---|---|
| P123706 | Improving Maternal and Child Health through Integrated Social Services |
| **Country** | **Financing Instrument** |
| Haiti | Investment Project Financing |
| **Original EA Category** | **Revised EA Category** |
| Partial Assessment (B) | Partial Assessment (B) |

### Organizations

| Borrower | Implementing Agency |
|---|---|
| Republic of Haiti | Fonds d'Assistance Economique et Sociale (FAES), Ministry of Public Health and Population (MSPP), Institut Haïtien de Statistique et d'Informatique |

### Project Development Objective (PDO)

Original PDO

The objective of the proposed 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.

Revised PDO

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

## FINANCING

| | Original Amount (US$) | Revised Amount (US$) | Actual Disbursed (US$) |
|---|---|---|---|
| **World Bank Financing** | | | |
| TF-13431 | 850,000 | 818,530 | 818,530 |
| IDA-H8640 | 70,000,000 | 70,000,000 | 65,129,356 |
| TF-14474 | 20,000,000 | 20,000,000 | 16,235,000 |
| IDA-D2030 | 25,000,000 | 25,000,000 | 24,906,415 |
| **Total** | **115,850,000** | **115,818,530** | **107,089,301** |
| **Non-World Bank Financing** | | | |
| Borrower/Recipient | 0 | 0 | 0 |
| **Total** | **0** | **0** | **0** |
| **Total Project Cost** | **115,850,000** | **115,818,530** | **107,089,302** |

## KEY DATES

| Approval | Effectiveness | MTR Review | Original Closing | Actual Closing |
|---|---|---|---|---|
| 21-May-2013 | 20-Apr-2013 | 31-Oct-2018 | 31-Dec-2018 | 30-Sep-2020 |

## RESTRUCTURING AND/OR ADDITIONAL FINANCING

| Date(s) | Amount Disbursed (US$M) | Key Revisions |
|---|---|---|
| 29-Mar-2017 | 30.95 | Change in Implementing Agency<br>Change in Results Framework<br>Change in Components and Cost<br>Change in Loan Closing Date(s)<br>Reallocation between Disbursement Categories<br>Change in Disbursements Arrangements<br>Change in Legal Covenants<br>Change in Institutional Arrangements<br>Change in Financial Management<br>Change in Procurement<br>Change in Implementation Schedule |
| 14-Jun-2017 | 30.95 | Additional Financing<br>Change in Project Development Objectives<br>Change in Results Framework<br>Change in Components and Cost<br>Change in Disbursements Arrangements<br>Change in Safeguard Policies Triggered<br>Change in Procurement |
| 19-Dec-2019 | 97.05 | Change in Loan Closing Date(s)<br>Reallocation between Disbursement Categories |
| 24-Mar-2020 | 103.95 | Change in Loan Closing Date(s)<br>Reallocation between Disbursement Categories |

## KEY RATINGS

| Outcome | Bank Performance | M&E Quality |
|---|---|---|
| Satisfactory | Moderately Satisfactory | Substantial |

## RATINGS OF PROJECT PERFORMANCE IN ISRs

| No. | Date ISR Archived | DO Rating | IP Rating | Actual Disbursements (US$M) |
|---|---|---|---|---|
| 01 | 02-Sep-2013 | Satisfactory | Satisfactory | .40 |
| 02 | 28-Apr-2014 | Satisfactory | Moderately Satisfactory | 1.85 |
| 03 | 14-Nov-2014 | Satisfactory | Moderately Satisfactory | 3.85 |

| | | | | |
|---|---|---|---|---|
| 04 | 16-May-2015 | Moderately Satisfactory | Moderately Satisfactory | 10.00 |
| 05 | 28-Dec-2015 | Moderately Satisfactory | Moderately Satisfactory | 15.04 |
| 06 | 30-Jun-2016 | Moderately Satisfactory | Moderately Satisfactory | 19.48 |
| 07 | 28-Dec-2016 | Moderately Satisfactory | Moderately Satisfactory | 26.56 |
| 08 | 30-Jun-2017 | Moderately Satisfactory | Moderately Satisfactory | 33.70 |
| 09 | 28-Dec-2017 | Satisfactory | Moderately Satisfactory | 46.11 |
| 10 | 29-Jun-2018 | Satisfactory | Moderately Satisfactory | 56.42 |
| 11 | 31-Dec-2018 | Satisfactory | Moderately Satisfactory | 71.93 |
| 12 | 28-Jun-2019 | Satisfactory | Moderately Satisfactory | 89.30 |
| 13 | 25-Dec-2019 | Satisfactory | Moderately Satisfactory | 97.04 |
| 14 | 30-Jun-2020 | Satisfactory | Moderately Satisfactory | 105.89 |

## SECTORS AND THEMES

### Sectors

| Major Sector/Sector | (%) |
|---|---|
| **Public Administration** | **13** |
| Sub-National Government | 13 |
| **Health** | **59** |
| Public Administration - Health | 9 |
| Health | 50 |
| **Social Protection** | **50** |
| Social Protection | 50 |

### Themes

| Major Theme/ Theme (Level 2)/ Theme (Level 3) | (%) |
|---|---|

| | |
|---|---|
| **Social Development and Protection** | **20** |
| Social Protection | 20 |
| Social Safety Nets | 20 |
| **Human Development and Gender** | **0** |
| Disease Control | 0 |
| Pandemic Response | 1 |
| Health Systems and Policies | 60 |
| Reproductive and Maternal Health | 30 |
| Child Health | 30 |
| Nutrition and Food Security | 20 |
| Nutrition | 10 |
| Food Security | 10 |

## ADM STAFF

| Role | At Approval | At ICR |
|---|---|---|
| Regional Vice President: | Hasan A. Tuluy | Carlos Felipe Jaramillo |
| Country Director: | Alexandre V. Abrantes | Tahseen Sayed Khan |
| Director: | Keith E. Hansen | Luis Benveniste |
| Practice Manager: | Joana Godinho | Michele Gragnolati |
| Task Team Leader(s): | Maryanne Sharp, Francesca Lamanna | Andrew Sunil Rajkumar, Briana N. Wilson, Nicolas Antoine Robert Collin Dit De Montesson |
| ICR Contributing Author: | | Maria Cecilia Zanetta |

# I. PROJECT CONTEXT AND DEVELOPMENT OBJECTIVES

## A. CONTEXT AT APPRAISAL

### Country Context

1. **Three years after being hit by a devastating earthquake,[1] the Government of Haiti (GoH) had begun to emerge from the catastrophic aftermath and return its attention to the country's structural problems.** With a Gross Domestic Product (GDP) per capita of US$726 in 2011 and a GINI coefficient of 0.59, Haiti was one of the poorest, most unequal countries in the world. Over half of its population of 10 million was estimated to live on less than US$1 per day, 78 percent on less than US$2 per day, and 40 percent were categorized as food insecure. The country also performed poorly on the non-income dimensions of poverty, ranking 158th out of 187 in the 2011 Human Development Index.[2]

### Sectoral and Institutional Context

2. **Ten months after the earthquake hit, a severe cholera outbreak placed additional pressure on the already fragile health system, further compromising the welfare and health status of the population.** As of January 2013, nearly 650,000 cases of cholera had been reported with almost 8,000 attributable deaths, making it the largest epidemic ever recorded in a single country. Haiti's already fragile public health system was confronted with the challenge of treating patients with health workers who lacked experience in managing cholera cases. Moreover, due to separate funds for cholera prevention and treatment, parallel emergency responses systems were put into place in an unstructured manner. In response, the Ministry of Public Health and Population (*Ministère de la Sante Publique et de la Population* - MSPP) launched the National Plan for the Elimination of Cholera (*Plan d' Elimination du Cholera*), which sought to integrate cholera response activities back into the public health system to improve efficiency and sustainability and ultimately stop the secondary transmission of cholera in Haiti.

3. **Haiti also faced serious challenges ensuring access to basic health services, as reflected in its high child mortality and malnutrition rates.** While under-five mortality had decreased from 152 per 1,000 live births in the 1990s, as of 2012 the rate remained high at 87 per 1,000 live births--three times the regional average.[3] Moreover, children from the poorest households faced a mortality rate more than double that of children from the richest households. Malnutrition rates had also stagnated since 2000, with one quarter of newborns exhibiting low birth weight, nearly one-third of children under five suffering from stunted growth and three-quarters of **children** 6-24 months being anemic. The incidence of diarrheal diseases – a key contributor to child mortality – was high among children, especially those between six months and two years old (39 percent), and in rural areas (25 percent).[4]

4. **Despite the efforts of the Haitian authorities, maternal mortality was still the highest in the region at 630 per 100,000 live births (six times the regional average), and access to family planning services was low.** During childbearing years, a Haitian woman had a 1 in 37 probability of dying from maternal causes.[5] The nutritional status of women of childbearing age was of particular concern, since underweight and anemia contributed to the cycle of

[1] In January 12, 2010, a 7.0 Mw earthquake hit 25 miles of Port-au-Prince, the capital of Haiti. It caused great devastation, with over 300,000 officially reported deaths and 1.5 million people displaced.
[2] World Bank (2013), *Haiti - Improving Maternal and Child Health through Integrated Social Services*; Project Appraisal Document; Report No. 67945-HT; April 22, 2013; Washington, D.C.
[3] MSPP Haiti DHS 2012. Preliminary Report.
[4] DHS 2005/06 was the latest source of data on MCH indicators at Appraisal.
[5] DHS 2005/06.

inter-generational under-nutrition and the risk of maternal death during childbirth. Although on the decline, Haiti also had the highest fertility rate in the Americas; access to family planning services remained low.

5. **Low coverage rates of key maternal and child health (MCH) interventions played a key role in Haiti's poor MCH outcomes. On the supply side, key challenges included low access and quality of health services as well as the GoH's difficulties in coordinating service providers.** The latter challenge was compounded by the large array of organizations involved in health service provision, which resulted in a fragmented health and social system with a myriad of standards and implementation mechanisms. Within the GoH, the MSPP was the primary institutional actor in the provision of maternal and child services. Concomitantly, the Economic and Social Assistance Fund (*Fonds d'Assistance Economique et Sociale* - FAES) was implementing the *Kore Fanmi* (KF) pilot initiative,[6] which sought to improve service delivery--maternal and child care, nutrition and social services in general--through the use of polyvalent household agents. This initiative was conceived in the aftermath of the earthquake as an attempt to link households with the emergency health and social services being provided a significant number of external agencies, bilateral aid and non-government organizations (NGOs) to Haiti. While NGOs helped ensure the continuation of service delivery, they did not necessarily increase access or address existing barriers. Overcoming these issues required improving the quality and coverage of services at the institutional level, bridging the gap between families and service providers, and strengthening the GoH's stewardship through a focus on results and the efficient use of resources to improve health outcomes.

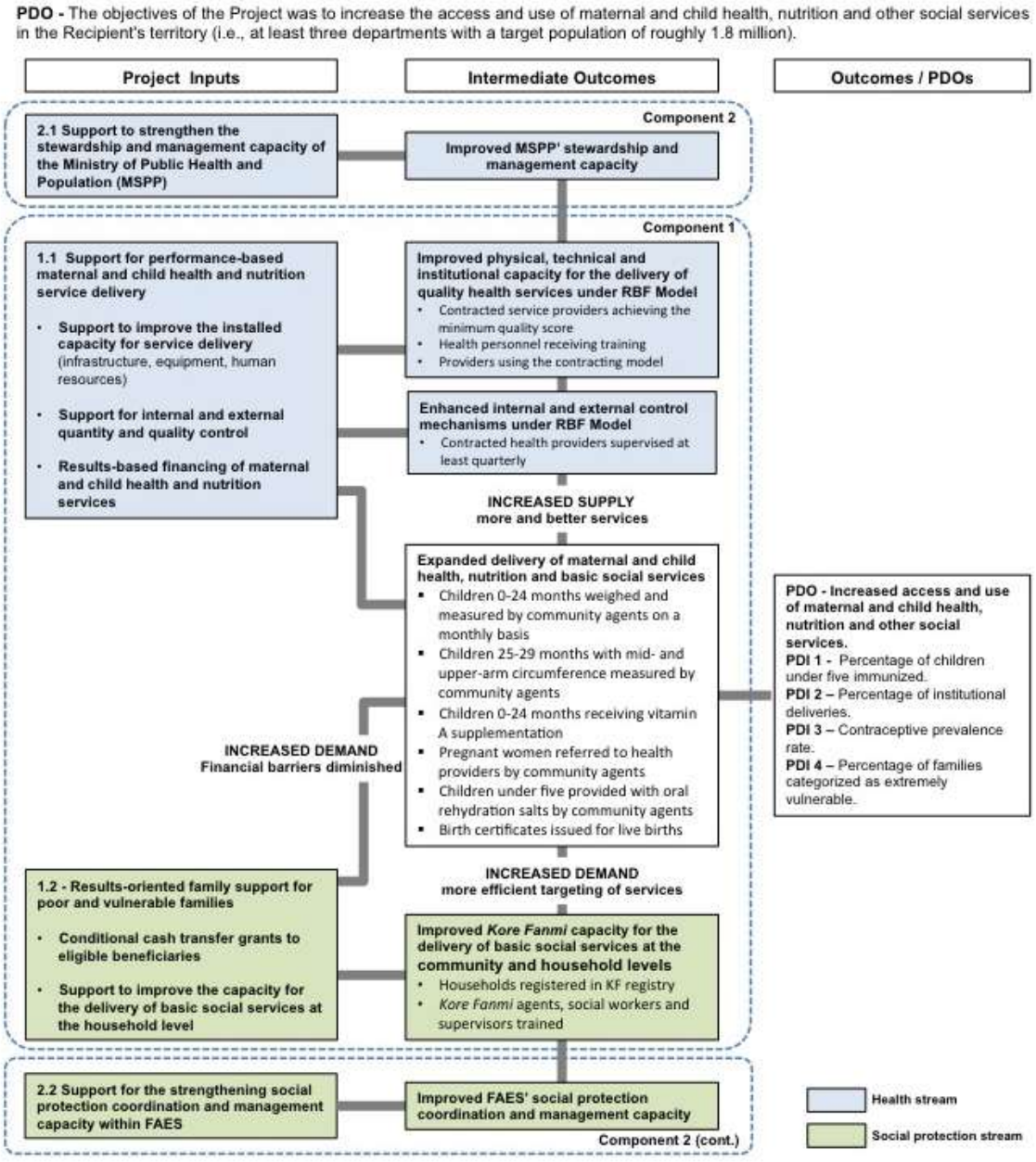
6. **On the demand side, financial constraints were one of the most important barriers to service utilization across socio-economic quintiles and particularly among women.** Of those who were seriously sick and did not seek treatment (24 percent of all those who reported being sick) in the 30 days preceding the 2005/06 Demographic Health Survey (DHS), almost half cited financial reasons and 20 percent, physical accessibility. Financial barriers posed a greater hurdle for poor women in rural areas, with eight out of ten women citing financial difficulties when seeking health care, with the proportion increasing even more among the poorest (92 percent). These demand-side barriers and social determinants of health had to be addressed at community and household level to help improve MCH outcomes, particularly for the poor.

### Theory of Change (Results Chain)

7. The operation aimed to support the GoH's efforts to reduce maternal and child mortality by improving the supply of MCH and other essential social services while simultaneously stimulating the demand. The Project supported the delivery of a package of preventative MCH and nutrition services proven to have an impact on maternal and child mortality by establishing results-based payment agreements with eligible public and non-public providers (the "health stream"). Concomitantly, the Project provided support to polyvalent community agents, called KF agents, for the delivery of health, nutrition services and other social services at the community and household levels. In addition, KF agents were expected to strengthen linkages between households (particularly the most vulnerable ones) and health and social services in order to stimulate the demand (the "social protection (SP) stream") and to provide conditional cash transfer grants to eligible beneficiaries. In addition, the operation provided support for the institutional development of the two main implementing agencies--MSPP and FAES. A more detailed mapping of the Results Chain underlying the operation is shown on Figure 1.

[6] The *KF* initiative ("family support" in Creole) was implemented under FAES under the supervision of the supervision of Haiti's Ministry of Economy and Finance.

**Figure 1. Original Project Results Chain**




**Note:** Project Outputs are indicated in bullet points under the corresponding Intermediate Outcomes. Please see below for the underlying critical assumptions.

8. There were several critical assumptions underlying the Results Chain, notably: i) the effectiveness of results-based payments to incentivize the provision of quality MCH, nutrition and social services by both health providers and KF agents; ii) adequate implementation and Monitoring and Evaluation (M&E) capacity on the part of both MSPP and FAES when complemented with the additional support envisioned under the operation; and iii) sustained commitment toward the coordinated provision and reporting of health and nutrition services on the part of MSPP and FAES.

### Project Development Objectives (PDOs)

9. The Project's development objective was to increase the access and use of MCH, nutrition and other social services in the Recipient's territory (defined as at least three Departments with a total catchment population of around 1.8 million people, targeting pregnant women, children under five and vulnerable families).

### Key Expected Outcomes and Outcome Indicators

10. PDO achievement was to be captured by the following Project Development Indicators (PDIs):

- **PDI 1 -** Children under five immunized (Percentage) - Increase in the percentage of children under five immunized from 46.22 in 2012 to 49 percent in 2018.
- **PDI 2** - Institutional deliveries (Percentage) - Increase in the percentage of institutional deliveries from 20.38 in 2012 to 22 percent in 2018.
- **PDI 3 -** Contraceptive prevalence rate (Percentage) - Increase in the percentage of contraceptive prevalence from 21.98 in 2012 to 24 percent in 2018.
- **PDI 4** - Decrease in percentage of families categorized as extremely vulnerable (Percentage) - Eight percent decrease in the percentage of families categorized as extremely vulnerable between 2012 and 2018.

### Components

11. **Component 1: Providing MCH Health, Nutrition and Social Services (US$81 million, equivalent to 90 percent of total grant proceeds).** This Component included two subcomponents:

- *Subcomponent 1.1: Performance-based MCH and Nutrition Service* Delivery (US$64 million, equivalent to 71 percent of total grant proceeds). This subcomponent provided financial support to the MSPP to carry out three sets of activities aimed at: i) improving the quality and supply of MCH services of selected public health providers; ii) maintaining and strengthening external controls (i.e., third-party verification) in terms of quantity and quality of Packages of MCH and Nutrition Services (PMCHNSs) being provided under iii); and Results-Based Financing (RBF) for the delivery of PMCHNSs[7] and supporting monitoring and supervision by departmental health authorities.
- *Subcomponent 1.2: Results-oriented Family Support for Poor and Vulnerable Families* (US$17 million, equivalent to 19 percent of total grant proceeds). This subcomponent provided financial support to FAES for the delivery of social services through family support to poor and vulnerable families by KF agents, including: i) goods, consultant services, training and operating costs to support the provision of basic social services at the household level; and ii) conditional cash transfer grants to eligible beneficiaries.

12. **Component 2: Strengthening the Stewardship and Management Capacity of Government (US$9 million, equivalent to 10 percent of total grant proceeds).** This Component included two subcomponents:

- *Subcomponent 2.1: Strengthening MSPP's Stewardship and Management Capacity* (US$5 million, equivalent to 5.6 percent of total grant proceeds). This subcomponent financed goods, TA and training with the aim of strengthening the MSPP's stewardship and management capacity.

[7] The PMCHNSs included: (i) preventative services, such as immunization, micronutrient supplementation, cholera prevention and promotion of insecticide-treated bed-nets; (ii) promotion of health services, such as increasing prevalence of exclusive breast-feeding and use of family planning; (iii) basic curative services, such as treatment of acute respiratory infections, cholera and other diarrheal diseases, other childhood illnesses, and tuberculosis; and (iv) reproductive health services, such as family planning, prenatal care, emergency obstetrical care, and post-partum care.

- *Subcomponent 2.2: Strengthening SP Coordination and Management Capacity* (US$4 million, equivalent to 4.4 percent of total grant proceeds). This subcomponent financed small works, goods, technical assistance (TA) and training with the aim of strengthening FAES's institutional capacity at the central, municipal, and community levels to enhance coordination, organization, management and social service delivery to vulnerable families.

## B. SIGNIFICANT CHANGES DURING IMPLEMENTATION

13. **There were significant changes introduced during the operation's lifetime in response to the changing implementation environment due to Hurricane Matthew, the continuous threat posed by cholera, changes in certain GoH's policies and significant fluctuations in donors' contributions.** The main changes can be summarized as follows (see also Annex 6 and Tables 1 and 2):

14. ***Level 2 restructuring - March 2017*** **- Although the PDO remained unchanged, this restructuring introduced considerable modifications to the operation's design and Project Results Framework (PRF) to reflect the country's evolving needs and priorities.** As shown in Table 2, this restructuring included significant changes to the Project components: i) the elimination of SP activities provided through the KF network under the original Subcomponent 1.2 (including cash transfers) as a result of several factors, including FAES' inadequate implementation capacity vis-à-vis the by-then obvious complexity of the integrated, cross-sectoral approach to the delivery of services envisioned under the Project; the lack of sustained commitment to cross-sectoral activities on the part of the MSPP[8]; the drastic reduction in the number of SP programs with external funding that reduced the need to coordinate social services at the household level; and reduced Government support for the KF program; ii) SP activities under Subcomponent 2.2 were modified to focus solely on the development of a Single Social Registry (SSR)[9] (which had increasing Government support); iii) activities to combat cholera previously included under Subcomponent 1.1 were given higher priority under a new Subcomponent 1.2 and strengthened in response to the heightened risk of outbreaks as a result of the flooding and destruction caused by Hurricane Matthew; iv) a new Subcomponent 1.3 was added (Contingent Emergency Response) to ensure the immediate availability of funds in the event of an emergency; and iv) a new Component 3 (Piloting Vulnerability Indicators for More Targeted Social Service Delivery) was added aimed at piloting the calculation of vulnerability indicators, a key step in targeting vulnerable households for the delivery of social services. In addition, among other changes, grant proceeds were reallocated and the PRF was significantly revised to reflect the changing priorities, including changes in PDIs (see Table 1 and Annex 6 for a more detailed description).

15. ***Additional Financing (AF) and Level 1 restructuring - June 2017*** **- An AF for US$25 million was approved on June 14, 2017 as part of a package of World Bank (WB) support to help the GoH recover and rebuild after Hurricane Matthew.** Concomitantly, the original operation was restructured and the PDO was revised to better respond to Haiti's evolving needs.[10] Specifically, the AF provided financial support for response activities in the affected areas, mainly: i) to restore the quality and supply of health services 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 in the fight against cholera that had opened up in hurricane-affected areas (see Table 2 for

[8] In particular, the MSPP favored its own Community Health Agent model (with agents focusing only on health sector activities) rather than the multi-sectoral *KF* agents.
[9] Also called the Integrated Beneficiary Registry or Information System of the Ministry of Labor and Social Affairs (MAST) or *Système d'Information du MAST* (SIMAST).
[10] The WB's response to Hurricane Matthew was financed under IDA's Crisis Response Window.

the allocation of AF funds). The AF also filled the financing gap created to support emergency response activities under the original grant immediately after Hurricane Matthew. At the same time, a Level 1 restructuring was carried out to reflect the changes made under the AF, including: i) a revision of the PDO and the PRF to reflect the expanded geographical coverage and emergency response objectives (see Section IV.A); and ii) the activation of new safeguards policies (see Section IV.B and Annex 6 for a more detailed description).

### Revised PDOs and Outcome Targets

16. As noted earlier, the operation's PDO was modified in June 2017 under a Level 1 restructuring that was carried out as part of an AF.

17. The original PDO: "to increase the access and use of MCH, nutrition and other social services in the Recipient's territory (defined as at least three Departments with a total catchment population of around 1.8 million people, targeting pregnant women, children under five and vulnerable families)" was revised in June 2017 to: "increase access and use of MCH 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."

### Revised PDO Indicators

18. **PDO indicators (PDIs) were modified to reflect the changes introduced under the two restructurings that took place in March and June 2017** (see Table 1). The main modifications under the March 2017 restructuring included: i) elimination of the original PDI 4 (i.e., families categorized as extremely vulnerable); and ii) the addition of a new PDI 4 (i.e., cholera fatality rate). The main modifications under the June 2017 AF and restructuring included: i) the addition of PDI 5 (i.e., pilot census carried out); ii) the upward revision of end targets for PDIs 2 and 3; and iii) extensions to end dates and minor modifications to the baselines for PIDs 1 through 3 (see also Annex 6).

**Table 1. Changes in PDOs and PDO Indicators (PDIs)**

| Original PDIs | Revised PDIs<br>Restructuring March 2017 | | Revised PDIs<br>AF and Restructuring June 2017 | |
|---|---|---|---|---|
| **PDI 1.** Children under five immunized | **PDI 1.** Children under five immunized | *No change* | **PDI 1.** Children under five immunized | *Slight adjustment to the baseline; end date extended.* |
| **PDI 2.** Institutional deliveries | **PDI 2.** Institutional deliveries | *No change* | **PDI 2.** Institutional deliveries | *Slight adjustment to the baseline; end date extended; end target revised upward* |
| **PDI 3.** Contraceptive prevalence rate | **PDI 3.** Contraceptive prevalence rate | *No change* | **PDI 3.** Contraceptive prevalence rate | *Slight adjustment to the baseline; end date extended; end target revised upward* |
| **PDI 4.** Families categorized as extremely vulnerable | -- | *Dropped* | -- | -- |
| | **PDI 4.** Cholera fatality rate | *Added* | **PDI 4.** Cholera fatality rate | *End date extended* |
| | | | **PDI 5.** Pilot census carried out | *Added* |

### Revised Components

19. **As described earlier, Project components were also modified under the two 2017 restructurings.** The specific changes that were introduced are summarized on Table 2 (see also Annex 6).

**Table 2. Changes in Project Components**

| Restructuring March 2017 | AF and Restructuring June 2017 |
|---|---|
| ▪ Subcomponent 1.2 (Results-oriented support for poor and vulnerable families) was eliminated due to termination of SP activities under the KF network.<br>▪ Subcomponent 2.2 (Strengthening SP coordination and management) was modified to focus solely on the development of a SSR.<br>▪ New Subcomponent 1.2 (Prevention and treatment of cholera) was added to include cholera-related activities previously under Subcomponent 1.1.<br>▪ New Subcomponent 1.3 (Contingent emergency response) was added to ensure the availability of contingency financing in case of emergency.<br>▪ New Component 3 (Piloting vulnerability Indicators) was added to support the piloting of the Fifth Housing and Population Census and vulnerability indicators. | ▪ Subcomponent 1.1 (Performance-based MCH and Nutrition Service Delivery) received an additional allocation of US$9.5 million under the AF to expand coverage to areas affected by Matthew.<br>▪ Subcomponent 1.2 (Prevention and treatment of cholera and other diarrheal diseases) received an additional allocation of US$13.5 million under the AF to expand activities in areas affected by Matthew and fill financing gap from emergency response in its immediate aftermath.<br>▪ Subcomponent 2.1 (Strengthening MSPP's Stewardship and Management Capacity) received an additional allocation of US$2 million under the AF for M&E of Project activities in areas affected by Matthew. |

### Other Changes

20. ***Level 2 Restructuring - December 2019*** **- This restructuring addressed implementation delays caused by growing social and political unrest and ensure the full utilization of the grant proceeds as well as a smooth transition to a follow-on health Project (**P167512 - Strengthening Primary Health Care and Surveillance in Haiti - *(Projet de Renforcement des Soins de Santé Primaire et de la Surveillance en Haïti*, PROSYS*)*. The specific modifications included: i) a three-month extension of the closing date from December 31, 2019 to March 31, 2020; ii) the transfer of the key health activities with continuous support under PROSYS; and iii) the reallocation of funds between disbursement categories under the Project's original International Development Association (IDA) grant (IDA-H8640) to ensure the completion of pending Project activities managed by FAES (i.e., the finalization of the National SP Strategy and the SSR) and the financing of civil works and activities supported by this operation and implemented by United Nations (UN) agencies.

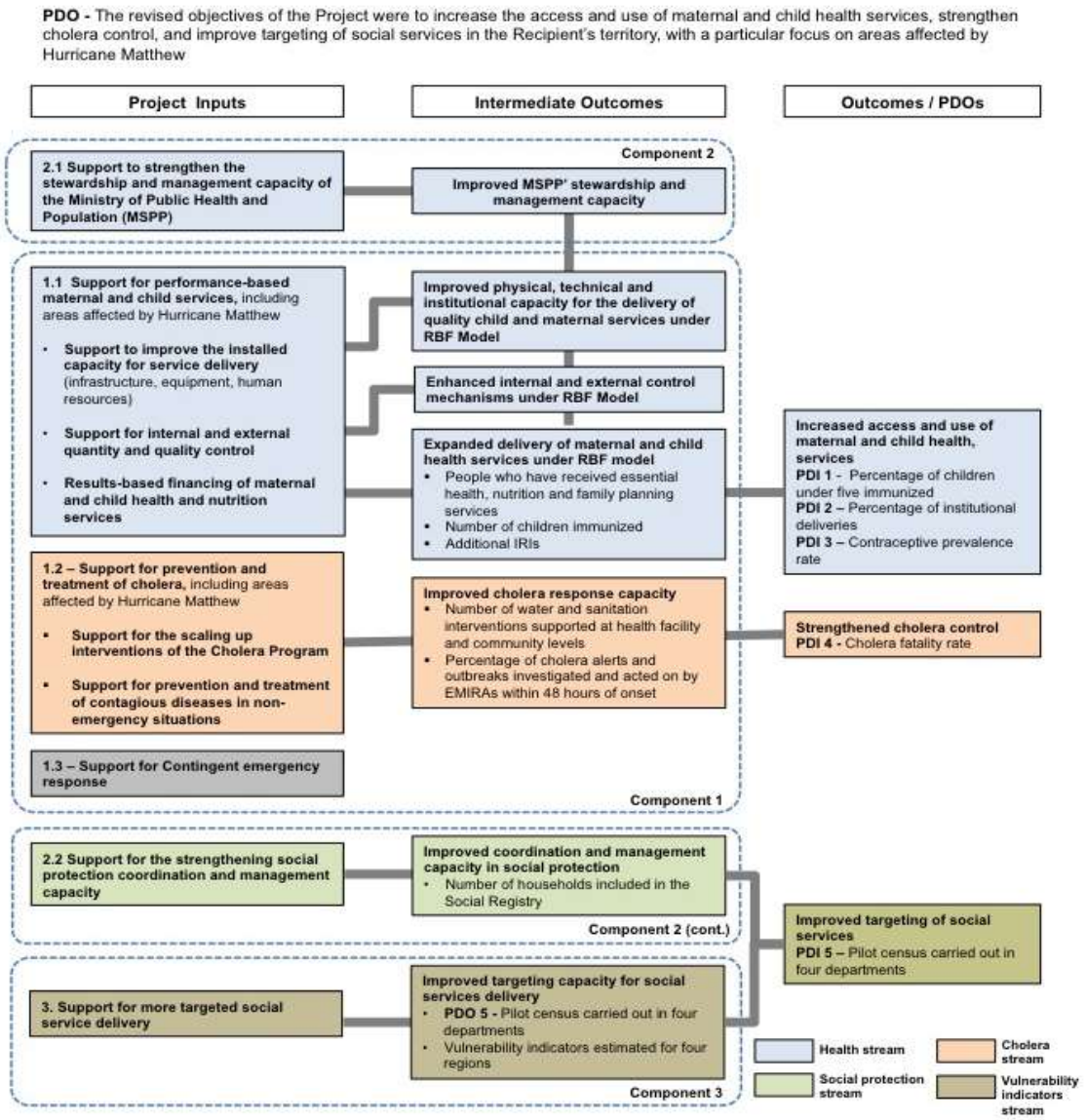
21. ***Level 2 Restructuring - March 2020*** **- This restructuring aimed to support the MSPP's efforts to address the COVID-19 pandemic.** Specific modifications included: i) a six-month extension of the closing date from March 31, 2020 to September 30, 2020; and ii) the reallocation of funds between disbursement categories to support the MSPP's capacity to address the COVID-19 pandemic.

### Rationale for Changes and their Implication on the Original Theory of Change

22. **The changes introduced in 2017 implicitly altered the original theory of change.** The operation was streamlined to focus solely on the supply side by expanding access to health services at the facility level whereas the activities intended to stimulate demand at the household and community level through the KF network were eliminated. The theory of change underlying the health stream remained largely unchanged. In response to significant shortcomings identified in the implementation of the KF initiative, the SP stream was considerably reduced, focusing solely on the development of a SSR and the development of vulnerability indicators to improve beneficiary targeting for delivery of social services (the "vulnerability indicators stream"). Finally, cholera control

gained additional importance in response to the renewed cholera outbreaks in the aftermath of Hurricane Matthew (the "cholera control stream").

**Figure 2. Revised Project Results Chain**




**Note:** Project Outputs are indicated in bullet points under the corresponding Intermediate Outcomes.

## II. OUTCOME

### A. RELEVANCE OF PDOs

#### Assessment of Relevance of PDOs and Rating

*Rating:* High (Pre-AF); High (Post-AF periods)

23. **The relevance of the operation's PDOs, both original and revised, is deemed High.** They were fully aligned with the WB's Country Partnership Framework (CPF) for the Republic of Haiti FY16-19 (Report No. 98132-HT) discussed by the Board of Directors on September 29, 2015 and the Haiti Performance and Learning Review (PLR) of the CPF (Report No. 124812-HT).[11] Specifically, the Project provided support the CPF Area of Focus 2 (Human Capital), in particular Objectives 6 (Increase Access to Health Services for Mothers and Children) and 7 (Control Cholera in Priority Communes). In addition, the revised PDO was in alignment with priorities for Haiti identified by the Systematic Country Diagnostic conducted as part of the CPF FY16-19 (i.e., better targeting in SP as a priority to protect households and individual livelihoods vulnerable to external climate and other emergencies; and better targeting of policies and programs in a context of limited resources). The Project was also consistent with the findings of the WB's 2017 Health Financing Assessment, as it focused on improving the organization of the health sector and the efficiency of the service delivery system, while increasing access and use of health care services with particular attention to women and children.

24. **Both the original and revised PDOs were also highly consistent with domestic priorities.** Specifically, they were fully aligned with the MSPP's Health Sector Development Plan 2012-2020 (*Plan Directeur de Santé* 2012-2022) and contributed toward the achievement of Sustainable Development Goals 3.1, 3.2, 3.3 and 5 (maternal mortality, child mortality, communicable diseases, and gender equality, respectively). The Project provided direct support to two components of the MSPP's Health Sector Development Plan 2012-2022 (i.e., "Organizational and Operational Strengthening of the Health System" and "Provision of Health Services and Care"). Similarly, the revised PDO was fully aligned with the GoH's 2013-2022 National Plan for the Elimination of Cholera. Finally, the revised PDO is central to the implementation of the National Policy on Social Protection and Promotion *(Politique Nationale de Protection et de Promotion Sociales, PNPPS)* that was adopted by the Council of Ministers in June 2020 and has the full support of the donor community. Specifically, better targeting of social services is a precondition for achieving the PNPPS goals for 2040: i) a reduction of poverty and inequality, ii) a reduction of economic, social, and institutional injustices, and iii) giving citizens the right to access SP and promotion as mechanisms to enhance their capacity to live better lives.

## B. ACHIEVEMENT OF PDOs (EFFICACY)

### Assessment of Achievement of Each Objective/Outcome

25. **The following considerations should be noted regarding the methodological approach adopted for this Implementation Completion and Results Report (ICR):**

- The changes introduced under the restructurings that took place in March and June 2017, respectively, called for the utilization of the split methodology.[12] However, given that there were no disbursements between March and June, for the purpose of this ICR, the evaluation is split into only two (as opposed to three) periods: the pre-AF period (effectiveness through June 2017); and post-AF (June 2017 through closing). Their relative weights reflect the disbursements during each period as a proportion of total disbursements (28.5 and 71.5 percent for the pre- and post-AF periods respectively).
- Efficacy for the pre-AF implementation period is assessed based on the original PDO, which has been "unpacked" into three different PDOs, focusing separately on MCH services (PDO 1); nutrition services

[11] The CPF period was originally set from 2015 to 2019. However, after completion of the PLR in 2018, CPF milestones were extended until 2021 while a new CPF is prepared.

[12] The May 2017 restructuring included changes in PDO indicators, and the June 2017 restructuring that was carried out in conjunction with the AF included changes in the PDO, PDO indicators, and end-project targets.

(PDO 2); and other social services (PDO 3). Efficacy performance for each of these PDOs is assessed against the original PRF targets.

- Efficacy for the post-AF implementation period is assessed based on the revised PDO, which has also been "unpacked" into three different PDOs, focusing separately on: MCH health services under the RBF model (PDO 4); cholera control (PDO 5); and targeting of social *services* (PDO 6). With regard to PDO 6, it is important to note that it encompasses actions undertaken under both the SP and Targeting streams (Subcomponent 2.2 and Component 3, respectively). Efficacy performance for each of these PDOs is assessed against the revised PRF targets.
- Thus, the operation's overall efficacy is assessed against three PDOs for the pre-AF period (i.e., PDOs 1, 2, 3) and three PDOs for the post-AF period (i.e., PDOs 4, 5, 6), each of them being assigned the same relative weight.
- Finally, although the PDO definitions refers to both "access" and "utilization" of services, further "unpacking" these two dimensions presents methodological difficulties, since in practice they are simultaneously incorporated in each of the PDIs supporting the original and revised PDOs. Hence, the two dimensions are considered to be the same for the purpose of this evaluation.

**PDO 1 -** To increase access and use of maternal and child health services.
*Rating:* Substantial (Pre-AF implementation period)

26. **Efficacy for PDO 1 is deemed Substantial.** This PDO applies to pre-AF period, when MCH services were to be provided under a two-pronged strategy: i) at the facility level under the MSPP's RBF Model; and ii) at the community and household levels by the KF network under FAES. Despite the limited contribution of the KF agents to the delivery of maternal and child services[13], there was a significant expansion in access to cost-effective preventative MCH services under the MSPP's RBF Model. One of the main innovations of the RBF Model was its reliance on results-based payments to service providers for the delivery of a package of selected health care services following pre-defined clinical and reporting protocols. Both the quantity and the quality of the services were externally verified, and payments were adjusted according. After the successful implementation of a pilot in seven health facilities in 2014, the RBF model, together with its rules and regulations, clinical and reporting protocols and M&E system, was expanded to 135 health facilities in the four target Departments[14]. The successful implementation of the RBF Model reflects the close coordination with other donors, in particular Canada and the United States Agency for International Development (USAID) and strong stewardship on the part of the MSPP.

27. **Overall, the operation made a significant contribution in terms of expanding and enhancing the capacity for the delivery of health care services under the RBF model, resulting not only in access to "more" but also "better" and "more homogeneous" MCH care services.[15]** Even though direct attribution cannot be readily established given the available information, these outcomes can be expected to have contributed to the decrease in neonatal, infant and child mortality during the past decade. The specific achievements under this PDO are reflected in two of three PDIs (i.e., PDI 2 - Increase in institutional deliveries; and PDI 3 - Increase in contraceptive prevalence) that amply

[13] Largely because ultimately, the MSPP did not support the *KF* program, preferring instead its own Community Health Agent program with agents dedicated to the health sector only rather than the multi-sectoral *KF* agents.
[14] At the design stage, the Project was to cover three Departments (Northeast, Northwest and Center), but this was expanded later to also include the South Department. The number of health facilities included when the RBF program was scaled up in 2014 (135) was later expanded to 188, out of a total of 276 facilities in the four Departments. The excluded facilities consist mostly of large hospitals, private for-profit facilities and facilities with low functionality.
[15] As seen from the significant increases over time in utilization of these services, as well as significant increases in the quality score, for the health facilities under the RBF program (based on data verified by the independent external verification agents).

exceeded the original targets, while the third one (PDI 1 - Increase in vaccination coverage) lagged behind original expectations (see Annex 1.A and B). These and other achievements under PDO 1 can be summarized as follows:

| **PDO 1 - To increase access and use to maternal and child health services**<br>**Level of Achievement:** Substantial (pre-AF implementation period; Original targets) |
|---|
| **Outputs** |
| ▪ RBF for the delivery of selected MCH health care services according to predefined clinical protocols, accompanied by purchase of key vaccines[16] under the Project, resulting in, among others, over 3.5 million children[17] immunized and over 47,000 deliveries attended by skilled health personnel between 2013 and 2019, amply exceeding the 660,000 and 21,000 targets, respectively.<br>▪ Upgraded health infrastructure at the primary level (e.g., small-scale rehabilitation, equipment, medical supplies, essential health commodities and training of, and TA to health personnel). |
| **Intermediate Results** |
| **Enhanced MSPP's stewardship, institutional and technical capacity for the implementation of the RBF Model**<br>▪ The percentage of contracted health providers supervised at least quarterly increased from 0 to 100 percent between 2012 and 2019, exceeding the 95 percent target.<br>▪ The percentage of contracted service providers achieving the minimum quality score (60 percent) increased from 0 percent to 93 percent between 2012 and 2019, more than twice the original target of 40 percent.<br>▪ The percentage of providers utilizing the contracting model increased from 0 to 62 percent between 2012 and 2019, exceeding the original target of 50 percent.<br>**Enhanced supply (quality and supply) of MCH services under the RBF Model**<br>▪ The number of children aged under 12 months that were completely vaccinated at health facilities under the RBF program increased by 51 percent between 2012 and 2019, amply exceeding the 13 percent target.<br>▪ The number of births at health facilities under the RBF program increased by 64 percent between 2012 and 2019, amply exceeding the 10 percent target. |
| **Outcomes** |
| **Increased access and use of MCH services**<br>▪ **PDI 1.** The percentage of children under five immunized in the four target Departments increased--albeit slightly--from 46.22 percent to 47.57 percent between 2012 and 2019, below the 49 percent target. The immunization program was adversely affected by systemic issues beyond the scope of this operation, including deficiencies in the supply chain, weaknesses in planning and management, and political instability. Expanding vaccination coverage is a main focus of the follow-on operation (PROSYS).<br>▪ **PDI 2.** The percentage of institutional deliveries in the target Departments increased significantly, from 21.26 percent to 43.92 percent between 2012 and 2019, amply exceeding the original target of 22 percent.<br>▪ **PDI 3.** The contraceptive prevalence rate in the target Departments increased significantly, from 23.37 percent to 37.49 percent between 2012 and 2019, amply exceeding the original target of 24 percent.<br><br>**Although (given the available data) it is not possible to establish direct attribution between the increased access and utilization of maternal and child services supported under the operation and MCH outcomes, trends are consistent with the Project's outcomes.[18]**<br>▪ **Continuous decline in infant and child mortality rates:** Although still at extremely high levels, the infant mortality rate (IMR) continued to decline throughout the operation's lifetime, from 56.6 to 48.2 deaths per 1,000 births between 2012 and 2019. Over the same period, the mortality rate for children under age 5 continued to decline throughout the |

[16] Under Sub-Component 1.1, which financed the purchase of key supplies to improve the quality and supply of MCH services of selected public health providers.

[17] The number of children immunized due to the Project was much larger than the target for this indicator, because the Project ultimately financed the purchase of a large number of vaccines, even though the purchase of vaccines was not anticipated at the design stage. This purchase occurred because financing from other donors for vaccines was unexpectedly reduced.

[18] World Development Indicators (12/16/2020).

operation's lifetime, from 75.9 to 64.7 deaths per 1,000 births. The operation can be expected to have contributed to these decreases via a number of pathways. neonatal mortality. For example, neonatal mortality (a component of both infant and child mortality) is largely determined by premature and low-weight births. In turn, premature and low-weight births depend largely on early detection of pregnancy risk and the adequacy of the health care facilities where births take place, which were at the center of the interventions supported under this operation (e.g., early prenatal care and the promotion of institutional births).

- **Results from similar operations also point to the impact of increased provision of MCH care services on improved infant mortality outcomes.** For example, results of an impact evaluation based on rigorous experimental controls of a similar operation in Argentina *(Plan Nacer)* showed a statistically significant relationship between participation in the program and a reduction in low birth-weight and lower in-hospital neonatal mortality.[19]

**PDO 2 -** To increase access and use of nutrition services.
*Rating:* Substantial (Pre-AF implementation period)

28. **Efficacy for PDO 2 is deemed Substantial.** This PDO applies to pre-AF period, when nutrition services were also provided under a two-pronged strategy: i) at the facility level under the MSPP's RBF Model; and ii) at the community and household levels by the KF network under FAES. As in the case of MCH services, despite the limited contribution of KF agents to the provision of nutrition services[20], there was a significant expansion in access to nutrition services under the MSPP's RBF Model. The specific achievements under PDO 2 can be summarized as follows:

| **PDO 2 - To increase access and use of nutrition services**<br>**Level of Achievement:** Substantial (pre-AF implementation period; Original targets) |
|---|
| **Outputs** |
| **RBF for the delivery of nutrition services according to predefined protocols resulted in:**<br>▪ Nutritional status measured for 5,000 children aged under five years and vitamin A delivered to 1,800 children by KF community agents.<br>▪ Over 1.5 million women and children received basic nutrition services between 2013 and 2019 under the RBF Model as well as post-Hurricane Matthew emergency response activities – almost eight times the original target of 200,000.<br>▪ Almost 1.3 million children 6-59 months old received Vitamin A supplementation under the RBF Model as well as post-Hurricane Matthew emergency response activities, amply exceeding the original target of 4,000.[21] |
| **Intermediate Results** |
| **Increased supply of nutrition services under the RBF Model**<br>▪ As of June 2018, there was a 55 percent increase over the Q3 2016 baseline in the percentage of children aged between 6 and 59 months receiving nutritional screening and follow-up under the RBF program (compared to a 12 percent target).[22] |

**PDO 3 -** To increase access and use of other social services.
*Rating:* Modest (Pre-AF implementation period)

29. **Efficacy for PDO 3 is deemed Modest.** This PDO applies to pre-AF period, during which KF agents were envisioned to function as "brokers" of social services at the household level, identifying their needs and referring

[19] Gertler, P., Giovagnoli, P., and Martinez, S. (2014), *Rewarding Performance to Enable a Healthy Start: The Impact of Plan Nacer on Birth Outcomes of Babies Born into Poverty*, Policy Research Working Paper 6884, The World Bank.
[20] Largely because, as noted above, the MSPP ultimately did not support the *KF* program.
[21] For women and children receiving basic nutrition services and the number of children receiving Vitamin A supplementation, the total numbers ultimately achieved were much higher than the targets because these numbers include beneficiaries of Project-financed post-Hurricane Matthew emergency response activities. It was not initially anticipated that the Project would finance these activities.
[22] Although end-of-Project achievement for this Indicator cannot be determined due to a change in its operational definition in 2018, the increase after 2018 can be expected to be significantly higher given that the number of nutrition services provided under the RBF Model continued to grow rapidly even under the new definition of the Indicator.

them to available social services. Families deemed extremely vulnerable were also eligible to receive cash transfers under the operation. An independent program review conducted in 2015 pointed to severe limitations in the implementation of the KF network. Even more important, with a large number of social programs being phased out due to insufficient funding[23], the objective of connecting vulnerable households to such services was no longer relevant, which led to the cancellation of the implementation of KF in December 2015.[24]

30. **While the operation did not have a direct contribution toward increasing access and use of other social services under KF as originally anticipated, it contributed indirectly to this PDO by supporting the development of tools to facilitate the identification and tracking of beneficiaries of social assistance programs.** Initially, it provided support to the development of the KF's Single Beneficiary Registry (SBR).[25] As part of the 2017 restructuring, the decision was subsequently made to eliminate the KF Beneficiary Registry and support instead the one being developed under by the Ministry of Labor and Social Affairs (*Ministère des Affaires Sociales et du Travail* - MAST)--the also-called Integrated Beneficiary Registry (*Système d'Information du MAST* - SIMAST). The scope of SIMAST goes beyond that of FAES registry, as it was conceived as a harmonized tool for the targeting of social programs at the national level, consolidating three different registries (including FAESs) into one.

31. **The SIMAST social registry has been formally established as the foundation for targeting of SP as part of the adoption of the PNPPS in June 2020.** Overall, the SIMAST now includes 473,000 households (around 2.3 million individuals). The Adaptive Social Protection for Increased Resilience Project (ASPIRE, P174111) operation will further finance its expansion to 200,000 households, as well as updates to 60,000 households, while the Promoting Inclusion of Persons with Disabilities (PwDs) in SP and Employment Programs (P145468) with the Bureau of the Secretary of State for the Integration of Persons with Disabilities (*Bureau de la Secrétaire d'Etat a l'Intégration des Personnes Handicapées* - BSEIPH[26]) supports the collection of a detailed module on disability based on the Washington Group questionnaire for 50,000 PwDs. Other donors are contributing to its expansion as well, including the European Union, the Inter-American Development Bank (IDB), USAID, and the UN (UN Development Programme, International Organization for Migration, and World Food Programme - WFP).

32. **There has been significant progress on the development of SIMAST, which is now being used to identify and tract beneficiaries of social programs supported by various donors**, such as the Promotion and Social Protection of the Southeast (PROMES) funded by the Embassy of Switzerland in Haiti,[27] and previously by the *Kore Lavi* Program funded by USAID (which ended in 2019).[28] In addition, the GoH[29] and other donors, including the United Nations'

[23] Post-earthquake, the level of aid decreased rapidly, and several sources of revenue have since depleted (for example, *PetroCaribe*) or significantly decreased (for example, special taxes on remittances and international phone calls). At the same time, limited social spending has been further squeezed by expenditures on energy subsidies. Levels of expenditures on SP in Haiti (around 1.4 percent of GDP) in 2013 were comparable to the averages for low-income countries, but well below those of other countries in Latin America and the Caribbean, and two-thirds of the budget was financed through the *PetroCaribe* fund and special taxes.

[24] Under the first Project restructuring, the funds initially allocated for *KF* activities were reallocated elsewhere, mainly to other SP activities (described above). The process of design and obtaining agreement for these new activities (involving several actors) – which was important for relevance and for subsequent performance – took just over a year, and the restructuring was finalized in March 2017.

[25] Data for FAES' SBR had two sources: a socio-economic survey and data collected at household level by *KF* agents.

[26] *Bureau du Secrétaire d'Etat pour l'Intégration des Personnes Handicapées*.

[27] Launched and implemented under the MAST, PROMES aims to reduce poverty and social inequality in the country. This first intervention consists of implementing a model focused on financial inclusion and the empowerment of families (the so-called "graduation approach"). It is expected to reach 30,000 households.

[28] The *Kore Lavi* Project was funded by USAID, and implemented in partnership with the WFP, World Vision, and Action Against Hunger. The program aimed to reduce food insecurity and prevent malnutrition. It also focuses on MCH and nutrition interventions for pregnant and lactating women and children under two years of age.

[29] A cash transfer program using SIMAST was implemented by FAES on behalf of the GoH as part of the COVID-19 response through

WFP, the IDB and the WB, have relied on SIMAST for the delivery of emergency cash transfers to address rising food insecurity and other socio-economic impacts of the COVID-19 crisis.[30] The specific achievements under PDO 3 can be summarized as follows:

| **PDO 3 - To increase access and use of other social services**<br>**Level of Achievement:** Modest (pre-AF implementation period; Original targets) |
|---|
| **Outputs** |
| ▪ A pilot of the KF initiative was conducted in three poor communes, with 150 community agents trained, 20,000 home visits to vulnerable families and families connected to other services where possible. No cash grants were issued. |
| **Intermediate Results** |
| **Provision of social services by the KF network** |
| ▪ Intermediate Results Indicators (IRIs) focusing on the delivery of social services by *KF* community agents were not met, as activities were halted in 2015. |
| **Improved institutional and technical capacity for expanding access and use of social services under the *KF* Model** |
| ▪ The number of households registered in the KF registry reached almost 34,000 beneficiaries in 2015, compared to an original target of 80,000. The decision was subsequently made to eliminate the KF beneficiary registry and focused instead on the development of SIMAST, an integrated beneficiary registry at the national level. |
| **Improved institutional and technical capacity for expanding access and use of social services at the national level** |
| ▪ Conceived as a harmonized tool for the targeting of social programs at the national level, SIMAST included 473,000 households (i.e., around 21 percent of the Haitian population) as of June 2020. |
| **Outcomes** |
| ▪ **PDI 4.** The decrease in percentage of families categorized as extremely vulnerable under the KF registry during the operation's lifetime is undetermined, as this activity was interrupted. |
| ▪ SIMAST is contributing to increasing access and use to social services under programs such as PROMES and *Kore Lavi* supported by the Swiss Embassy and USAID, respectively. |
| ▪ With support from multiple donors, the WFP has relied on SIMAST for the delivery of COVID-19 emergency cash transfers. |

**PDO 4 -** To increase access and use of MCH services, with a particular focus on areas affected by Hurricane Matthew.
*Rating*: Substantial (Post-AF implementation period)

33. **Efficacy for PDO 4 is deemed Substantial.** This PDO applies to post-AF period, with MCH services being provided solely at the facility level under the MSPP's RBF Model. To ensure the continuous provision of services, the operation also supported the rehabilitation of health facilities in areas affected by Matthew. The substantial achievement under this PDO is reflected in two of three PDIs (i.e., PDI 2 - Increase in institutional deliveries; and PDI 3 - Increase in contraceptive prevalence), which amply exceeded the revised targets. As in the case of PDO 1, achievement with respect to expanded vaccination coverage lagged behind expectations (see Annex 1A and B). In addition to those described under PDO 1, additional achievements under PDO 4 can be summarized as follows:

Digicel's mobile money platform MonCash.

[30] The WTF Covid-19 emergency cash transfer program is financed by the IDB-financed Safety Net for the Vulnerable People of the Haitian Population Affected by the Coronavirus Project (HA-L1145); the Contingent Emergency Component under the IBRD-financed Municipal Development Urban Resilience Project (P155201); with additional support from USAID and ECHO.

| PDO 4 - To increase access and use of MCH services, with a particular focus on areas affected by Hurricane Matthew<br>**Level of Achievement:** Substantial (post-AF implementation period; Revised targets) |
|---|
| **Outputs under PDO 1 plus:** |
| **Rehabilitated health infrastructure in areas affected by Hurricane Matthew**<br>▪ A total of 46 health facilities were rehabilitated and are now fully functioning between 2016 and 2020 in departments affected by Hurricane Matthew (compared to a target of 40).<br>▪ A total of 90 solar-powered refrigerators were restored between 2016 and 2020 and are now fully functional within the vaccine cold chain in the Hurricane-affected departments (compared to a target of 84). |
| **Intermediate Results under PDO 1 plus:** |
| **Enhanced MSPP's stewardship, institutional and technical capacity for the implementation of the RBF Model**<br>▪ The percentage of contracted service providers achieving the minimum quality score (60 percent) increased from 0 percent to 93 percent between 2012 and 2019, more than twice the revised target of 45 percent.<br>▪ The percentage of providers utilizing the contracting model increased from 0 to 62 percent between 2012 and 2019, exceeding the revised target of 60 percent.<br>**Enhanced access to MCH services in areas affected by Hurricane Matthew**<br>▪ 1.5 million people benefitted from the restoration of health care facilities in affected areas with limited health service delivery infrastructure<br>▪ Approximately 300,000 children benefitted from the restoration of Infrastructure for basic immunizations in affected areas. |
| **Outcomes** |
| **Increased access and use of MCH services**[31]<br>▪ **PDI 1.** The percentage of children under five immunized increased very slightly from 46.22 percent to 47.57 percent between 2012 and 2019, below the 49 percent target.<br>▪ **PDI 2.** The percentage of institutional deliveries increased significantly, from 21.26 percent to 43.92 percent between 2012 and 2019, amply exceeding the revised target of 24 percent.<br>▪ **PDI 3.** The contraceptive prevalence rate increased significantly, from 23.37 percent to 37.49 percent between 2012 and 2019, amply exceeding the revised target of 26 percent. |

**PDO 5 -** To strengthen cholera control.
*Rating*: High (Post-AF implementation period)

34. **Efficacy for PDO 5 is deemed High.** The operation's achievements in relation to cholera control were outstanding, with no cholera cases being reported since January 2019 (from over 350,000 cases in 2011), achieving the targets set in the GoH's the National Cholera Elimination Plan way ahead of time and marking the end of the epidemic phase of the disease in Haiti. As noted earlier, the epidemic was the largest ever recorded in a single country at the time (before the COVID-19 pandemic), causing more than 850,000 cases and 10,000 deaths in Haiti. In support of Haiti s National Plan for the Elimination of Cholera, the project supported: (i) strengthening of the national surveillance and laboratory network at the central and department levels; (ii) health care services for cholera cases; (iii) hygiene promotion and cholera prevention; and (iv) water and sanitation water and sanitation improvements in health facilities. Particularly effective was the implementation of Mobile Rapid Response Teams *(Équipes Mobiles d'intervention Rapide*, EMIRAs), which resulted in the systemic and fast identification and response to suspected cases of cholera, combined with a timely recollection of patient samples and laboratory confirmation.

[31] The targets for these indicators were deliberately set at a not-too-high level at the design stage due to the large uncertainties of working in a Fragile, Conflict and Violence (FCV) country like Haiti, and with a new implementation agency the MSPP (with which the Bank had not worked in many years). Given the many risks involved, the Project could easily have fallen short of these targets, with performance for them possibly even deteriorating.

The high level of achievements reflects the close alignment of Project's activities with the National Plan for the Elimination of Cholera, as well as close coordination between the GoH counterparts and other partners, including the Pan-American Health Organization (PAHO), the United Nations Children's Fund (UNICEF) and the U.S. Center for Disease Control (CDC) that ensured an integrated and well-coordinated approach. This approach was particularly effective due to its multi-sectoral nature, involving the health and water sectors. The MSPP and the National Water and Sanitation Directorate (DINEPA) developed one single national cholera response plan whose implementation was also supported in a cross sectoral by partners, including the WB, UNICEF and IDB. The specific achievements under PDO 5 can be summarized as follows (see also Annex 1.B):

| **PDO 5 - To strengthen cholera control with a particular focus on areas affected by Hurricane Matthew**<br>**Level of Achievement:** High (post-AF implementation period) |
|---|
| **Outputs** |
| ▪ A total of 141 water and sanitation interventions were supported at health facility and community levels between 2015 and 2019, amply exceeding the target of 65.<br>▪ The percentage of health facilities assessed as having adequate stocks of cholera supplies increased from 0 to 100 percent in departments affected by Hurricane Matthew, exceeding the 90 percent target. |
| **Intermediate Results** |
| ▪ Percentage of cholera alerts and outbreaks investigated and acted on EMIRAs within 48 hours of onset increased from 7 percent to 100 percent between 2015 and 2019, amply exceeding the 60 percent target. |
| **Outcomes** |
| ▪ **PDI 4.** The cholera fatality rate decreased from 0.89 percent to 0 percent between 2015 and 2019, exceeding the already ambitious 0.99 percent target.<br>▪ Most notably, there has not been any confirmed cases since January 2019. Thus, according to the World Health Organization, maintaining the cholera fatality rate below 1 percent over time indicates that the cholera epidemic has been effectively controlled. |

**PDO 6 -** To improve the targeting of social services.
*Rating*: Modest (Post-AF implementation period)

35. **Efficacy for PDO 6 is deemed Modest.** Although the operation did not have a direct, measurable impact on improving targeting of social services, it helped set the foundations in three key areas: i) the design of the overall policy framework for the country's SP strategy; ii) the implementation of a SSR at the national level, a critical tool in the implementation of such policies; and iii) collection and production of data on household vulnerability to provide evidence for the effective targeting of social programs. The first two areas of support were implemented under the SP stream. First, in coordination with other donors (most notably the WFP), the operation provided support for the development of the PNPPS that was adopted by the Council of Ministers in June 2020, representing a multisectoral effort including Disaster and Risk Management, education and health sectors. Second, it supported the development and the expansion in coverage of SIMAST. Finally, under Component 3 ("Piloting Vulnerability Indicators for More Targeted Social Service Delivery"), it provided support for inputs into the preparation of the upcoming 5$^{th}$ Housing and Population census, including the implementation of the pilot census in four departments in 2018 and the piloting of the methodology to calculate and produce estimates on vulnerability clusters using data collected under the pilot census in those four departments.

36. **Although the full impact of SIMAST as a powerful targeting tool for social services has not yet fully materialized, the GoH and multiple donors are already utilizing it to identify and track recipients of social services under their programs (see also PDO 3).** Likewise, SIMAST has facilitated the distribution of COVID-19 emergency cash transfers being implemented by the WFP and FAES. Finally, the BSEIPH is utilizing SIMAST to identify

households with PwDs.[32] The specific achievements under PDO 6 can be summarized as follows (see also Annex 1.B):

| PDO 6 - To improve the targeting of social services<br>**Level of Achievement:** Modest (post-AF implementation period) |
|---|
| **Outputs** |
| ▪ **PDO 6.** Pilots of the upcoming Fifth Housing and Population Census were carried out in four departments.<br>▪ A preliminary calculation of vulnerability clusters was carried out in the four pilot departments. |
| **Intermediate Results** |
| ▪ A Steering Committee to oversee the development of SIMAST was created in 2020 and is now operational.<br>▪ SIMAST now covers 473,000 households, or around 21 percent of the Haitian population.<br>▪ The PNPPS was adopted by the Council of Ministers in June 2020 and formalizes SIMAST's role as foundation for targeting for all programs. |
| **Outcomes** |
| ▪ SIMAST is being used for the identification of recipients of social services (such as nutrition, MCH services, productive inclusion support) and benefits under programs supported by the WB, IDB, USAID and the Swiss Embassy, including the delivery of COVID-19 emergency cash transfers being implemented by WFP.<br>▪ SIMAST is also being used for the identification and future targeting of PwDs. |

### Assessment of overall efficacy rating

*Rating*: Substantial (Pre-AF); Substantial (Post-AF)

37. **Efficacy for the pre-AF period is Substantial to reflect the Substantial achievement under PDOs 1 and 2 and the Modest level of achievement under PDO 3.[33]** Efficacy for the post-AF period is Substantial to reflect the Substantial achievement under PDOs 4, the High level of achievement under PDO 5 and the Modest level of achievement under PDO 6.

## C. EFFICIENCY

### Assessment of Efficiency and Rating

*Rating: Modest (Pre-AF); Substantial (Post-AF)*

38. **The operation's efficiency during the post-AF period is deemed to be Substantial to reflect its robust economic efficiency and efficient use of funds.** The operation's efficiency during the pre-AF period is deemed Modest due to the cancellation of KF activities. As mentioned earlier, pilot activities under the KF network were suspended in December 2015 based on the results of a program assessment that pointed to the shortcomings in the underlying strategy. Nevertheless, it is important to take into consideration that the decision to cancel its implementation was taken early on in the process (15 months after effectiveness), which helped minimized the use of grant resources in this area (US$2.5 million). Also, as underscored in Haiti's CPF FY16-19, it is also important to keep in mind that pilots such as this one served an important function, as they help tailor interventions to the country's needs and specificities.

39. ***Economic efficiency:*** **Based on *ex-ante* economic analysis performed at appraisal of both the original**

[32] Under the Haiti's Improving Access to Social Services & Employment Opportunities Grant (P145468), the BSEIPH is utilizing SIMAST to identify households with PwDs and conducting follow-up interviews utilizing a specific disability module. This information will allow them to assess needs and target PwDs who could benefit from the labor intermediation services as well as skills development programs supported by the grant.

[33] The rounding up to Substantial for the pre-AF period is based on two considerations. First, two out of three PDOs are rated Substantial. Second, the health intervention under the operation had significantly higher importance than the SP one (as reflected in the original allocation of grant proceeds--US$69 million vis-à-vis US$21 million, respectively).

**operation (2013) and the 2017 AF, the operation was expected to be economically efficient.** The economic analysis conducted under the AF was particularly relevant, as it closely reflects the operation's actual implementation in terms of overall costs, timetable and activities. Results indicated a Net Present Value (NPV) of about US$89 million and a Benefit-Cost Ratio (BCR) of 1.9 over a five-year period. The analysis took into consideration the economic benefits derived from reduced morbidity and mortality, including the savings in health care costs such as hospitalizations and the productivity gains resulting from avoiding premature deaths and disabilities. Specifically, the analysis focused on those benefits arising from Subcomponent 1.1 (Access and use of MCH care services) and Subcomponent 1.2 (Cholera control). With regards to costs, the analysis took into consideration the costs for the entire operation (a net investment of US$109.3 million).

40. **For the purpose of this ICR, the economic analysis conducted for the AF was updated to reflect: i) the operation's actual closing date of September 30, 2020; and ii) actual data on cholera cases for the period 2013-2020 (rather than projected ones).** Since the outcomes in terms of cholera control surpassed expectations, the results of the economic analysis are even more favorable, rendering a NPV of US$111 million and a BCR of 2.14 for the operation as a whole (see Annex 5).

41. ***Implementation efficiency:*** **Except for the cancellation of KF activities, the operation exhibited substantial implementation efficiency.** A key element that helped ensure its economic efficiency was its focus on cost-effective, low-resource interventions under the RBF Model and cholera control stream. Moreover, both interventions were implemented in close coordination with the GoH and other donors, avoiding duplications. The 2017 AF and restructurings effectively addressed the changes in the GoH's priorities and the additional needs resulting from Hurricane Matthew. The need to extend the operation's closing date twice toward the end of its lifetime arose mainly from factors beyond the orbit of the Project, in particular delays resulting from social unrest and the COVID-19 epidemic. In the case of the latter, the restructuring allowed for the continuous availability of rapid-response health teams and other key health personnel to help fight the pandemic.

## D. JUSTIFICATION OF OVERALL OUTCOME RATING

42. **The overall outcome rating for this operation is based on the split evaluation methodology (see Table 3).** Thus, outcome ratings are derived for both time periods. The outcome rating for the pre-AF period is deemed Moderately Satisfactory (i.e., High relevance; Substantial efficacy; Modest efficiency). The outcome rating for the post-AF period is deemed Satisfactory (i.e., High relevance; Substantial efficacy; Substantial efficiency). The overall outcome rating of Satisfactory is obtained by weighting the outcome ratings for the pre- and post-AF implementation periods based on their respective share of disbursements (28.3 and 71.7 percent, respectively).

**Table 3. Overall Outcome Rating - Summary of Split Evaluation Results**

| | Pre-AF | Post-AF |
|---|---|---|
| **Relevance** | **High** | **High** |
| **Efficacy** | | |
| PDO 1 | Substantial | |
| PDO 2 | Substantial | |
| PDO 3 | Modest | |
| PDO 4 | | Substantial |
| PDO 5 | | High |
| PDO 6 | | Modest |
| **Efficacy Overall** | **Substantial** | **Substantial** |
| **Efficiency** | **Modest** | **Satisfactory** |
| **Outcome Ratings** | **Moderately Satisfactory** | **Satisfactory** |
| **Numerical Score *** | **4** | **5** |
| Disbursements (US$ millions) | 30.95 | 78.33 |
| **Relative Weight** | **28.3%** | **71.7%** |
| **Weighted Score** | **1.13** | **3.58** |
| **Overall Score** | **4.72** | |
| **Overall Rating** | **Satisfactory** | |

* Highly Unsatisfactory (1); Unsatisfactory (2); Moderately Unsatisfactory (3); Moderately Satisfactory (4); Satisfactory (5); Highly Satisfactory (6)

## E. OTHER OUTCOMES AND IMPACTS

### Gender

43. **By design, the Project had a strong focus on gender, with maternal health being one its centerpieces.** Specifically, the RBF scheme provided financial incentives to health providers to enhance the achievement of maternal health indicators. Progress on the provision of health care services for women (e.g., nutrition, family planning, institutional deliveries) was monitored under the PRF. Also, women's civil associations were included in the consultation process undertaken during the preparation of the AF.

### Institutional Strengthening

44. **The RBF Model supported under this operation is a part of a national RBF program, with parallel financing from USAID and Canada, with each financier providing RBF financing for a different group of health facilities.** All health facilities under the RBF Program (regardless of who the financier is) now have the same RBF tariffs, verification system and method for determining quality payments and there has been significant progress in the development of an M&E system. This was all facilitated by a dedicated unit at the MSPP in charge of the program, the Contracting Unit (CU). In this way, the Project helped lay the foundation for a sector-wide approach in health through better donor coordination and alignment with GoH priorities. It also supported capacity building in the MSPP by strengthening stewardship and regulatory functions at the central and decentralized levels, which are key for proper oversight and implementation of a national RBF program.

45. **In the area of SP, the development of SIMAST lays a strong foundation for improving coordination across stakeholders and increasing transparency in the allocation of social transfers.** With joint support from the GoH and

the donor community, it is expected to become the entry point to determine the eligibility of households for different SP programs. Doing so will foster coordination, avoid duplication, and promote transparency and efficiency in the allocation of social transfers to poor and vulnerable households. SP actors including GoH, donors, and implementing partners are already using SIMAST and vulnerability indicators to target social assistance and reach the poorest and most vulnerable households in a more coordinated manner. As an illustration, SIMAST will be used to identify vulnerable households for the new safety net *Klere Chimen* funded by the ASPIRE (P174111) that will be managed by the MAST.

### Poverty Reduction and Shared Prosperity

46. **In terms of health, enhancing access and quality of MCH services is critical to break the vicious cycle of poverty, not just to reduce infant and maternal mortality but to also increase the opportunity to live healthy, productive lives.** Based on evidence from other projects supporting the provision of similar health services, the operation can be expected to decrease the incidence of infant mortality and low birth weight. Likewise, nutrition services provided under the operation can be expected to have both short-term and long-term positive impacts on children's immune status, cognitive function and learning ability and overall health. Likewise, high maternal morbidity and barriers to accessing reproductive health care adversely affect women's health endowments and hinder their economic opportunities. In term of SP, the newly adopted PNPPS and the implementation of SIMAST provide a solid foundation for the improved targeting and coordination of social programs to achieve greater outcomes for the poorest and most vulnerable households.

### Other Unintended Outcomes and Impacts

47. ***COVID-19* - The operation contributed to the country's ability to respond to the ongoing pandemic**. First, evidence worldwide indicates that having a well-functioning health care system is a critical determinant of a country's response capacity to the pandemic. Second, beyond the operation's overall contribution toward strengthening Haiti's health system, particularly at the primary level, the operation's contribution to the country's response to COVID-19 includes: health facilities rehabilitated after Hurricane Matthew are now operational; the expanded surveillance and lab diagnostic capacity can be used for COVID-19 testing; and the vaccines cold chain rehabilitated after Hurricane Matthew can facilitate future distribution of COVID-19 vaccines. In addition, under the 2020 restructuring, the closing date was extended six months and US$2.3 million in undisbursed IDA funds were reallocated to the COVID-19 response, which allowed extending the contracts for 500 health workers and the MSPP staff to maintain fast-mobility operational capacity for surveillance, lab capacity and treatment of patients at central and local levels.[34] Finally, SIMAST facilitated delivery of emergency cash transfers by the WFP in order to address rising food insecurity and the socio-economic impacts of the COVID-19 crisis.

## III. KEY FACTORS THAT AFFECTED IMPLEMENTATION AND OUTCOME

### A. KEY FACTORS DURING PREPARATION

48. **The operation's overall design was overly ambitious, with three areas of intervention (i.e., the RBF, the initially less visible cholera and the SP streams), each of them being implemented by a different Government counterpart and with the support of a different group of donors.** In addition, even though the three initiatives had substantial support from their respective sector authorities, in retrospect it is clear that the political will to fully

[34] The disbursement rate for IDA was 99.18% at the end of the Project. (In USD terms, total disbursements from IDA funds were significantly lower than the original USD allocation because of exchange rate losses.

integrate the RBF and the KF network was lacking, particularly on the part of the MSPP and that FAES lacked the necessary institutional capacity. Finally, while the RBF Model and the cholera stream responded to the country's structural needs, the KF initiative was primarily conceived to link households to the myriad of social services that were available in the aftermath of the earthquake.[35] These weaknesses were subsequently addressed under the AF and the two restructurings in 2017.

## B. KEY FACTORS DURING IMPLEMENTATION

### Factors under the control of implementing agencies

49. ***Implementation of the KF initiative*** **- There were significant delays in the implementation of the KF network, in large part due to FAES' weak fiduciary and implementation capacity (see also Section IV.B).** In retrospect, it is clear that the gap in capacity on the part of FAES was exacerbated by the high demands resulting from the complex strategy adopted in the original Project design. Another factor was the lack of support on the part of the MSPP for the provision of health care services by KF agents. Support for pilot activities was discontinued in December 2015, with the program being formally eliminated from the operation under the March 2017 restructuring. The decision to discontinue support was informed by the findings of a program assessment (e.g., processes, costs, and sustainability) that identified serious implementation shortcomings as well as the significant reduction in the number of social services to which vulnerable households could be referred to. The failure of this approach, which aimed to coordinate social services from the bottom up, served to increase awareness among partners of the need to adopt a longer-term development approach that builds the GoH's capacity to gradually take the lead in the delivery of SP interventions at the national level, as reflected in the 2020 PNPPS.

50. ***Implementation of the RBF Model*** **- The RBF Model faced initial implementation challenges due to lack of experience in RBF in the country, as well as a slow harmonization process across other financiers of the program (USAID and Canada), which were later overcome under the leadership of the MSPP.** There was also a steep learning curve in different aspects of implementation, from the logistical challenges of opening bank accounts for all health facilities to the fine-tuning of financial incentives to ensure their efficacy. The initial set up of the RBF Model as well as its implementation required intense capacity building at all levels of the MSPP and at the facility level, as well as the incremental development of M&E mechanisms. The role of the MSPP unit dedicated to the program, the CU, was key. The pay-off, however, goes beyond the delivery of MCH services under this operation, as it laid the foundations for a sector-wide multi-donor approach that can gradually be expanded to include other services.

51. **At the service provider level, the financial incentives under the RBF Model proved to be successful to incentivize the provision of services supported under the operation.** To ensure that providers focused on the quality of the services that they provide, the payments given to individual facilities were adjusted according to a quarterly quality score based on a broad variety of indicators such as the availability of staff and medicines, transparency measures, cleanliness and medical waste management, and the quality of recordkeeping. Individual facilities were given substantial autonomy over how to use the funds they received within some general parameters in the Operations Manual to ensure improvements in overall allocation of resources, management, governance and accountability.

52. ***Implementation of the cholera stream*** **- This operation proved critical in controlling the cholera epidemic, including the spike in cases after Hurricane Matthew, and picking up the gap in financing resulting from the sharp**

[35] Following the 2010 earthquake, the budget has benefitted from exceptional donor assistance with external grants. By 2014, more than 20 safety-net programs by six different ministries were active in Haiti, with total funding equal to 1.3 percent of GDP. However, these programs were largely funded by external resources that later dried up.

**decrease in cholera funding from other donors.** The geographic coverage of cholera-control activities expanded significantly during the operation's lifetime in response to the country's evolving needs. Specifically, cholera-related activities were originally limited to four departments (North, Northeast, Northwest, and Center) and two health facilities in the West Department. When funding from other partners came to an end, coverage was expanded to include the six other departments in the country with roughly 70 percent of all health-related cholera response activities in the country being financed under this operation from 2017 onwards. Likewise, after Hurricane Matthew battered the coasts of the South, Grand'Anse, and Northwest departments, the Improving Maternal and Child Health Through Integrated Social Services Project *(Projet d'Amélioration de la Santé Maternelle et Infantile à travers des Services Sociaux Intégrés, PASMISSI)* stepped in to help the MSPP to repair those facilities. In addition to increasing its geographical and financial support, the WB's team successfully leveraged the additional financial support to further integrate the actions of the various partners, calling, among other things, for joint Action and Investment plans.

53. ***Implementation of the SBR*** **- Initially, the SP stream provided support for the development of KF's Beneficiary Registry under FAES, while two other registries were also being implemented in parallel.** Efforts to consolidate the three registries had been gridlocked until the WB required the passage of legislation requiring their consolidation as a Prior Condition under a Policy Financing grant in 2018.[36] The MAST was subsequently designated as the institution responsible for unifying the social registries into its own SIMAST. With support under this operation as well as from other partners, SIMAST's coverage has expanded rapidly and has become a central element in the implementation of the PNPPS.

### External factors affecting implementation

54. ***Hurricane Matthew*** **- Hurricane Matthew, which hit Haiti in early October 2016, and its aftermath adversely affected implementation of the RBF Model and cholera control activities.** In terms of the RBF Model, several of the participating health facilities incurred considerable damage, which negatively affected performance. Likewise, cholera incidence spiked in the affected areas. The AF provided the resources needed to assist in the recovery efforts and mitigate the risks of a proliferation of cholera and other waterborne diseases, providing financial support for the rehabilitation of affected health facilities, the re-establishment of the vaccine cold chain and mobile health clinics. It also helped scale-up cholera rapid response efforts to respond to the spike in cases following the hurricane, intensifying epidemiological surveillance and cholera prevention and treatment interventions.

55. ***Volatile social and political environment*** **- The political instability, challenging security environment and fuel shortages during 2018 and 2019 considerably hindered Project implementation.** Specifically, restricted access to project sites due to roadblocks, attacks, and civil unrest in general delayed civil works, the installation of vaccine cold chain equipment and data collection for the impact evaluation implemented under the health stream. It also hindered supervision and verification activities under the RBF program, which, in turn caused delays in RBF payments, somewhat eroding the motivation of service providers. On the SP side, security issues slowed down the consultation processes as part of the preparation of the PNPPS and the launch of the procurement process for the expansion of SIMAST.

56. ***Uncoordinated emergency donor support*** **- Although emergency donor support in response to the earthquake ensured the continuation of services for large sectors of the population,** it could have benefited for a more coordinated approach, including the gradual and coordinated withdraw of resources. In this context, it is

[36] Haiti's Fiscal and Social Resilience Development Policy Financing (P162452; US$20 million; Approval September 2018; Report No. 129435-HT.)

noteworthy the important role the WB played in filling the resulting financial gaps and using its leverage to further coordination with other donors.

57. ***COVID-19 pandemic*** **- Given that the operation was already in its later stages of implementation, the pandemic did not hinder the completion of most Project activities. It prevented, however, supervision and certification of RBF activities during 2020.** In addition, similarly to what has been observed in countries around the world, the utilization rates of health services supported under the operation can be expected to have dropped considerably, as people have avoided contact with the health care system for fear of contagion. This is particularly the case for preventative health services such as the ones being supported under this operation.

## IV. BANK PERFORMANCE, COMPLIANCE ISSUES, AND RISK TO DEVELOPMENT OUTCOME

### A. QUALITY OF MONITORING AND EVALUATION (M&E)

#### M&E Design

58. **The operation's PRF included four PDIs--three of them focusing on the coverage of MCH services (i.e., vaccinations, institutional deliveries and reproductive health) and one of them on the identification of vulnerable households.** It also included a total of 12 IRIs--four of them focusing on the implementation of the RBF at the facility level; and eight on health services provided by KF community agents, progress in developing the beneficiary registry and training activities. Operational definitions as well as sources of data were clearly defined in the Project Appraisal Document. Baselines for the first three PDIs were calculated using the 2005/06 DHS, since data from the 2012 DHS had not yet been published.

59. **Data at the facility level was to be provided by the data collected routinely under the Haitian Institute of Statistics and Informatics (*Institute Haitien de Statistique et d'Informatique,* IHSI).** Data collected by the *KF* network at household level was to be collected under KF's Management Information System by municipal teams or directly by mobile devices and regularly updated. The accuracy of both sets, including at the household level, was to be subject to external verification.

60. **As envisioned, the SBR would include data from KF's management information system and a socio-economic household survey to be carried out by a consulting firm under FAES' supervision.** These household surveys, to be conducted every two years, were also going to be the data source to track the four PDIs.

#### M&E Implementation

61. **The strong reliance of the original PRF on sources of data from KF proved to be a challenge, as delays in its implementation affected monitoring, particularly at the PDI level.** Given that the socio-economic surveys to be conducted by FAES were delayed and eventually cancelled, data for three of the four original PDIs were based on the 2016 DHS, which, in turn, was also delayed due to the Hurricane. Nevertheless, the operation's PRF succeeded in capturing progress toward implementation through IRIs, relying mainly on data from IHSI at the facility level.

62. **The PRF was revised twice during implementation.** As mentioned earlier, the PDI focusing on the identification of vulnerable households was dropped under the March 2017 restructuring to reflect the elimination of KF activities. Other significant changes to the PRF were introduced under the March 2017 restructuring and under the June 2017 AF and restructuring as presented in Section I.B. above.

63. **The verification of results under the RBF Model, both in terms of quantity and quality, was critical to ensure**

**its successful implementation.** Specifically, verification was carried out on a quarterly basis by independent external agents to ensure the accuracy and consistency of reporting on the volume and/or quality of services provided. These agents reviewed health facility registers conducted randomly selected household surveys to verify the services they received. High turnover among verification agents was a challenge, which demanded ongoing training of new staff.

64. **Data collection for the RBF Impact Evaluation survey suffered delays due to security issues related to social unrest.** Data collection has now been completed and final results are expected to be available by mid-2021.

### M&E Utilization

65. **Particularly after the changes made in 2017, the operation's PRF was effective in tracking the operation's progress toward implementation and achievement of objectives.** It has also served to strengthen the MSPP's Single Sanitary Information System (*Système d'Information Sanitaire Unique* - SISNU), which is used sector-wide, going beyond the scope of the operation. The MSPP's directorates are using this M&E framework for their own programs, as shown by the changes in the operational definitions of two IRIs at the request of two MSPP units.

### Justification of Overall Rating of Quality of M&E

*Rating*: Substantial

66. **The quality of the operation's M&E is deemed Substantial,** as it evolved to adequately monitor implementation progress and the achievement of Project outcomes, and to contribute to the Recipient's M&E capacity.

## B. ENVIRONMENTAL, SOCIAL, AND FIDUCIARY COMPLIANCE

67. ***Environmental safeguards:*** **The original operation was classified as category B with regard to the potential environmental and social impacts, which, overall, were assessed as moderate.** The main environmental risks identified were related to medical waste management, specifically the potentially inappropriate handling, classification, transportation, disposal and elimination of medical and healthcare waste and infected materials, as well as Project-related worker occupational health and safety. To adequately manage these and other risks, an Environmental and Social Management Framework (ESMF) was prepared, which included over 40 sites screened and ESMF-mitigation measures applied. During Project implementation, several risks were observe in relation to: medical waste management; the malfunctioning of sanitation systems in some locations, especially during rainy season when flooding is common; water shortages; and inappropriate site management at some health centers leading to proliferation of vectors (mosquitoes). ESMF mitigation measures were applied to minimize any risk to the local environment. Given the extensive geographic scope of the Project and large number of sub-projects being financed, ensuring robust reporting by the Project Implementation Units (PIUs) throughout Project implementation was a challenge, resulting in an overall moderately satisfactory performance in terms of environmental safeguards.

68. ***Social safeguards:*** **While the original operation did not trigger social safeguards, the AF triggered the Involuntary Resettlement Policy (OP/BP 4.12) because the scaling-up of rehabilitation activities could temporarily affect the income sources and livelihood activities of households and businesses.** However, during implementation, the operation did not carry out activities that resulted in physical or economic displacement and, as such, did not require the preparation of any further resettlement instruments or the payment of any resettlement-related compensation. The Project suffered from some initial delays in setting up a systematic and functional grievance redress mechanism (GRM). However, after some time, a GRM was set up and functional. In the context of an issue regarding payments of workers by companies hired by the project that resulted in numerous grievances in 2019, the WB's specialists were proactive in documenting the issues and supporting their resolution.

69. ***Financial Management (FM):*** **Under the original operation, FAES and MSPP were responsible for FM using arrangements acceptable to the WB.** The FM capacity of the two implementing agencies required strengthening. The MSPP had had no recent experience in the implementation of WB-financed projects both at the central and departmental levels. FAES was already implementing two WB-financed projects, but with substantial delays. FM arrangements at the MSPP were adequate and its structure included experienced FM staff with adequate capacities that were maintained throughout Project implementation. Conversely, FAES performance deteriorated during implementation due to constant turnover of staff at the fiduciary unit that prevented them to apply WB´s policies and procedures in a consistent manner. Despite hands-on support and training from the WB's team, it proved challenging to address the unit´s weaknesses.

70. ***Procurement*** **- The MSPP and FAES were responsible for the procurement aspects of the original operation, while only the MSPP was responsible for procurement under the AF.** The Project was executed in accordance with the WB's Procurement Regulations for Borrowers under Investment Policy Financing (July 2016). Project implementation units exhibited a solid procurement capacity during implementation and were able to respond to unplanned procurement needs, such as the processing of time-consuming amendments to some contracts due to the fast pace of inflation. However, procurement procedures and the execution of works contracts under the MSPP suffered several delays, largely due to the rapidly deteriorating security situation which adversely affected supervision (including on procurement aspects) of the works contracts in particular and fast-increasing inflation and depreciation of the Gourde which further added complexity for contracts management. Supervision was also affected by the pandemic situation in the last year of implementation, as well as difficulties in finding sufficient high-quality procurement staff for the PIU. Combined with a general economic slow-down that put pressure on small construction firms' cash flows, this accumulation of challenges resulted in some unfinished contracts at the end of the Project whose completion was ultimately co-financed under the PROSYS project.

## C. BANK PERFORMANCE

### Quality at Entry

*Rating*: Moderately Satisfactory

71. **The quality at entry is deemed Moderately Satisfactory, reflecting the satisfactory quality at entry under the health stream and the moderately unsatisfactory under SP.**

72. **Areas of intervention under the health stream benefited from a sound design.** The design of the RBF Model built on successful precedents from Afghanistan, Argentina, Burundi, Rwanda and others that had demonstrated the field-level effectiveness of linking performance to results. Key features as well as the lessons learned from these operations were incorporated into the design, such as tying incentives to quality scores at the facility level to ensure the quality of service delivery as well as the need to develop a strong M&E, including external verification of results. The WB's team worked closely with USAID to develop a unified sector-wide approach and provide the MSPP with the necessary technical support. The operation included adequate resources for TA. It also adopted a gradual implementation, starting with a pilot experience to test the various mechanisms and develop basic tools.

73. **Activities focusing on cholera control were aimed at supporting the GoH's National Plan for the Elimination of Cholera, which provided a sound overarching, multi-sector strategy.** They also built on the implementation experience under a preceding operation in six departments.[37] Key lessons learned were incorporated into the design, including the need for an integrated approach to facility-level treatment and community-level education and

[37] Haiti's Cholera Emergency Response Project (P120110; US$15 million; approved on 1/18/2011 and closed on 3/30/2014).

prevention campaigns and continued capacity building in all aspects of project implementation and management, including to implement integrated interventions at facility and community levels, improve coordination of service delivery, track results in real time. The cholera stream also benefited from a close working relationship with other donors actively supporting the National Plan, including the PAHO, the UNICEF and the U.S. CDC.

74. **The design of the KF initiative drew upon successful international experience in using community agents to provide services directly and to bridge the gap between the population and service providers.** It also built on the small-scale implementation of KF in three communes.[38] As noted earlier, the design exhibited two significant weaknesses. First, interventions targeted at the household level failed to address the systemic fragmentation of Haiti's SP at the peak of international assistance. Second, with the benefit of hindsight, it is now clear that FAES' implementation capacity and the MSPP's support for the shared provision and reporting of health services were overestimated, particularly vis-à-vis the complexities behind the integrated, inter-sectoral service delivery.

### Quality of Supervision

*Rating*: Satisfactory

75. **The quality of supervision is deemed Satisfactory, reflecting highly satisfactory quality of supervision under the health and cholera streams and the moderately satisfactory performance under the SP stream.** Overall, the operation required demanding supervision and coordination efforts, given Haiti's weak institutional capacity and the need to coordinate across sectors within the WB and with different counterparts and groups of donors active in each area of intervention.

76. **In the health sector, Project supervision was in-depth and permanent throughout the operation's lifetime, with regular supervision missions that included field visits and findings being recorded in detailed Aide Memoires and Implementation Status Reports (ISRs).** The WB's Task Team Leader (TTL) from the health sector, who also had accountability and decision-making responsibility, took over just after Board approval and remained on board throughout the implementation period. Communication with counterparts and partners was ongoing, with monthly supervision missions that included HQ-based team members, which helped identify and address bottlenecks in a timely manner. The team's emphasis on continuous supervision and ongoing adjustments made it less relevant to have a formal Mid-Term Review, which took place in 2018. The WB's supervision team played a highly proactive role throughout the operation's lifetime in providing labor-intensive TA in substantive topics, operational aspects and the implementation of fiduciary, environmental and social safeguards. The team also exhibited strong entrepreneurial traits, actively coordinating and brokering with other partners and donors, effectively leveraging WB financing to promote the further integration of donor activities. The stability and technical skills of the Project task team and the active role of the local WB team were important factors contributing to the Project's successful implementation. Finally, the team exhibited flexibility and the ability to respond quickly to changes in the implementation environment, as in the aftermath of Hurricane Matthew. The team's efforts to support implementation for the cholera stream, contributing to the end of the epidemic phase of the disease in Haiti, were recognized with two different Awards for Outstanding Achievement (i.e., by the Latin America and Caribbean Region and the overall Human Development Vice-Presidential Units).

77. **In the SP sector, supervision efforts were hindered by the high turnaround in WB's staff, with five different TTLs over the life of the Project, some of them for just a few months.** The short tenures, together with the

[38] Haiti's Household Development Agent Pilot Project (P121690; US$1.5 million; Approved 2/7/2011; Closed 12/31/2014). Rapid Response Social Fund - Strengthening Haiti's National SP System (US$3.2 million; April 2010; Dec. 2014)

complexity of the *KF* initiative and the plethora of government and non-government actors, undermined the supervision efforts of individual TTLs. The quality of supervision increased significantly in the last two years of implementation, when the WB's Team worked very closely with other partners as part of SIMAST Technical Committee. This had a favorable impact on implementation, as shown by the speeding up in the development of SIMAST and its adoption as a harmonized targeting tool. The WB's Team also played a key role in the MAST's SP Working Group, where it worked closely with other partners, including the International Monetary Fund (IMF), to define the country's overall SP strategy.

### Justification of Overall Rating of Bank Performance

*Rating*: Moderately Satisfactory

78. **WB's performance is rated Moderately Satisfactory to reflect the Moderately Satisfactory performance at entry and Satisfactory performance during implementation.**

## D. RISK TO DEVELOPMENT OUTCOME

*Rating*: Substantial

79. **The overall risk to the development outcomes under this operation is deemed Substantial, based on various risks ranging from Substantial to High,** as follows:

80. **At the program level, the risks are deemed Substantial for the three main development outcomes:**

- ***Access and utilization of MCH services*** - Although there has been substantial progress toward the institutionalization of the RBF Program at the national level, with all donors acting in consonance under the same operational rules defined by the MSPP, ultimately, its sustainability depends on the continuous commitment of health authorities and donor funding. In this regard, continuous WB's financial support for the BRF Program under the follow-on operation (PROSYS) helps ensure the Program's sustainability of the various components of the RBF Program (economic incentives, verification mechanisms, etc.) until the end of 2024. The COVID-19 pandemic has compounded the already significant implementation challenges of the RBF Program, as it has almost certainly reversed some of the gains toward expanding access to MCH care services. While this situation is expected to revert once the pandemic is under control, it will certainly require additional efforts.
- ***Cholera control*** - Although cholera incidence is now at zero and the risk of resurgence is low, it still exists in case of imported cases, as access to water and sanitation has not improved significantly and surveillance and response efforts are still dependent on donor funding. To safeguard and build upon the attainments of this operation, the follow-on operation (PROSYS) continues to provide support to maintain the MSPP's response capacity for cholera control while transitioning toward a more integrated approach to surveillance and response to include other diseases. Support under PROSYS is particularly important, as financing for cholera and general infectious diseases from other donors is not expected to significantly increase in the short term.
- ***Targeting of social services*** - Although there are considerable challenges still ahead, broad support from donors is an important factor contributing to sustainability of SIMAST. The European Union, IDB, WFP and USAID are among the multiple donors supporting its utilization, expansion and strengthening through their projects by identifying or registering their beneficiaries in the social registry. The ASPIRE (P174111) operation in the SP sector will continue to provide support to the development and institutionalization of the registry and access to cash transfers and accompanying measures (social services).[39] Likewise, there is growing consensus among partners, including the IMF, of the need to adopt a longer-term development approach that builds the

[39] ASPIRE (P174111).

GoH's capacity to take the lead in the delivery of SP interventions, as defined in the PNPPS and relying on SIMAST as a harmonized targeting tool. While SIMAST is currently housed at WFP, a key priority of the new WB-supported operation is to develop the necessary capacity at MAST--in terms of human resources, financing, and infrastructure--in order to fully transition SIMAST to the GoH. This will be a key step in supporting the country's capacity to manage the SP system and oversee a national social safety net, rather than fragmented efforts implemented by development partners and NGOs. Challenges ahead include the sustainability of funding of the SIMAST, but recent commitments by the Ministry of Economy and Finance to provide funds for its extension and maintenance reflect a high level of ownership and recognition by the GoH. Other challenges, including data protection, reliability of information and ease of access will have to be addressed through TA (including to support improvements in the regulatory landscape) and investments to strengthen its overall infrastructure.

81. **At the sector level, the risks are deemed Substantial.** Weak institutional and coordination capacity across different technical and administrative units combined with frequent turnover of the MSPP civil servants pose substantial sustainability risks. Likewise, Haiti's health system is heavily dependent on external financing (80 percent of non-private current health expenditure), which has been falling rapidly in recent years (i.e., on-budget external financing fell more than 80 percent since 2013).

82. **External, macroeconomic and political risks are deemed High.** As demonstrated by the tremendous devastation experienced during the past decade as a result of the earthquake, the hurricane, the cholera epidemic and ongoing pandemic, Haiti has high exposure and vulnerability to recurrent natural disasters, ranking 16th in the World Risk Report (2019).[40] Moreover, macroeconomic and political risks are also high. Recurrent episodes of institutional and political instability continue to hinder Haiti's economic and social development. GDP is estimated to have contracted by 1.4 percent in 2019 and is expected to decline by 3.1 percent in 2020 as the service sector contracted, supply chains were disrupted, and remittances fell as a result of the COVID-19 pandemic. The mounting economic losses could set back poverty reduction efforts.

## V. LESSONS AND RECOMMENDATIONS

83. Important lessons can be derived from the implementation of this operation, including:

84. **Overly complex Project design should be avoided, particularly in settings with limited institutional capacity.** In retrospect, the originally envisioned integrated approach to service delivery involving different implementing agencies was overly complex and, thus, unrealistic in the context of Haiti. This lesson has been already reflected in the follow-on operations in both the health and SP sectors.

85. **Due diligence in the selection of implementing agencies should be a priority in the Project identification and preparation stages**. As underscored by the disappointing experience of the KF initiative, sustained institutional support and robust capacity are necessary preconditions for effective implementation. In this case, the challenges of the shared provision and reporting of health services, including ensuring the sustained institutional support on the part of the MSPP, were underestimated. Likewise, FAES' lack of institutional capacity, including fiduciary, significantly hindered Project implementation.

86. **Achievements under the RBF Model underscore the effectiveness of results-based financial incentives in inducing behavioral changes among health care providers.** In the case of Haiti, these incentives served to promote the prioritization of preventative MCH care services and the homogenization of clinical and reporting protocols in a

[40] World Risk Report (2019). https://reliefweb.int/sites/reliefweb.int/files/resources/WorldRiskReport-2019_Online_english.pdf

highly decentralized and diverse landscape of public and non-public health service providers. To be effective, however, RBF incentives need to be properly fine-tuned. Haiti's experience shows that, in order to remain effective, payments need to be beyond minimum thresholds in terms of both amounts and timeliness. Ensuring reliable and consistent timing of payments was particular important during this first stage of implementation to build trust among health care providers.

87. **Effective M&E instruments are critical, particularly with projects that have results-based disbursements**. As disbursements to health care providers were directly linked to both quantity and quality of the services being provided, the development of an effective M&E system, including external controls, was critical to ensure accountability and transparency. As in the case of Haiti, the implementation of these M&E systems also offers a window of opportunity to introduce homogeneous reporting protocols and interoperable information systems that could later be the building blocks of more comprehensive health care information systems.

88. **The implementation of RBF mechanisms is particularly demanding** due to the drastic organizational changes that are required and, as such, it calls for substantial TA and supervision. The operation's design adequately identified the need for substantial TA, not just at the service provider level but also at the MSPP level to help develop robust stewardship capacity.

89. **The sector-wide adoption of homogenous program operational rules and service delivery protocols is critical for the success of the RBF Model**. In the case of Haiti, the MSPP made the decision to require all donors involved in the provision of health services to utilize the same RBF Program. This was a critical step toward ensuring the homogeneous and equitable delivery of services countrywide. It also resulted in a more coordinated approach among donors and avoided the duplication of efforts.

90. **Interventions should be designed to meet immediate needs while addressing long-term development challenges**. While it is important to capitalize on windows of opportunity and respond to unanticipated challenges in the short-term, it is also necessary to consider longer-term objectives including how interventions can fit into the broader institutional context. A bottom-up approach to SP such as the one envisioned under the *KF* initiative might be relevant in the future as a complement to a more integrated approach at the national level that brings together both humanitarian and development partners.

91. **There is a crucial need for both Government and donor-driven coordination**. The implementation experience of this operation illustrates both the best and the worse in donor coordination. The shortcomings of the *KF* initiative reflected dual challenges of poor program coordination at the local level and highly uneven flows of external funding. Conversely, the adoption of SIMAST as "the" SBR (thus, integrating the other two registries that were being developed in parallel) illustrates the positive impact that donors can have when coordinating their actions. Likewise, the implementation of the RBF within the MSPP serves as an illustration of effective leadership on the part of the GoH to establish rules of engagement with donors. Finally, the implementation of the National Plan for the Elimination of Cholera points to the effective cross coordination across donors, government agencies, levels of government and sectors.

92. **Having an existing operation in place focusing on the delivery of primary health care services offers a solid entry point for a rapid response to unanticipated health crises.** This operation, with its dual focus on the delivery of primary health care services as well as cholera control, permitted a rapid response to unanticipated needs resulting from Hurricane Matthew and the COVID-19 pandemic.

## ANNEX 1. RESULTS FRAMEWORK AND KEY OUTPUTS

### A. RESULTS INDICATORS

#### A.1 PDO Indicators

**Objective/Outcome:** To increase access and use of mater. and child health, nutrition and other Soc Serv in recipient ter

| Indicator Name | Unit of Measure | Baseline | Original Target | Formally Revised Target | Actual Achieved at Completion |
|---|---|---|---|---|---|
| Children under five immunized | Percentage | 46.22<br>31-Dec-2012 | 49.00<br>31-Dec-2018 | | 47.57<br>31-Dec-2019 |

**Comments (achievements against targets):**
*Target not achieved*: 49% level of achievement. (*Note:* The latest data available from Haiti's Health Management Information System (*Systeme d'Information Sanitaire Unique - SISNU) that* records data at the health facility level, are for the year 2019.)

| Indicator Name | Unit of Measure | Baseline | Original Target | Formally Revised Target | Actual Achieved at Completion |
|---|---|---|---|---|---|
| Institutional deliveries | Percentage | 21.26<br>31-Dec-2012 | 22.00<br>31-Dec-2018 | 24.00<br>31-Dec-2019 | 43.92<br>31-Dec-2019 |

**Comments (achievements against targets):**

*Original and revised targets exceeded.* (*Note:* The latest data available from the SISNU are for the year 2019.)

| Indicator Name | Unit of Measure | Baseline | Original Target | Formally Revised Target | Actual Achieved at Completion |
|---|---|---|---|---|---|
| Contraceptive prevalence rate | Percentage | 23.37<br>31-Dec-2012 | 24.00<br>31-Dec-2018 | 26.00<br>31-Dec-2019 | 37.49<br>31-Dec-2019 |

**Comments (achievements against targets):**
*Original and revised targets exceeded.* (*Note:* The latest data available from the SISNU are for the year 2019.)

| Indicator Name | Unit of Measure | Baseline | Original Target | Formally Revised Target | Actual Achieved at Completion |
|---|---|---|---|---|---|
| Cholera Case Fatality Rate | Percentage | 0.89<br>31-Dec-2015 | 0.99<br>31-Dec-2019 | | 0.00<br>01-Jun-2020 |

**Comments (achievements against targets):**
*Target exceeded.* The value for this indicator is currently zero since there weren't any laboratory-confirmed cases in 2020.

| Indicator Name | Unit of Measure | Baseline | Original Target | Formally Revised Target | Actual Achieved at Completion |
|---|---|---|---|---|---|
| Pilot census carried out in four departments | Yes/No | No<br>31-Dec-2015 | Y<br>31-Dec-2019 | | Yes<br>01-Jun-2020 |

**Comments (achievements against targets):**
*Target achieved.* The pilot for the Fifth Housing and Population Census was implemented in 2018.

### A.2 Intermediate Results Indicators

**Component:** Component 1: Providing Maternal and Child Health, Nutrition and Social Services.

| Indicator Name | Unit of Measure | Baseline | Original Target | Formally Revised Target | Actual Achieved at Completion |
|---|---|---|---|---|---|
| People who have received essential health, nutrition, and population (HNP) services | Number | 0.00<br>31-Jan-2013 | 881000.00<br>31-Dec-2019 | | 5,134,621.00<br>31-Dec-2019 |
| Number of children immunized | Number | 0.00<br>01-Jan-2013 | 660000.00<br>31-Dec-2019 | | 3,535,131.00<br>31-Dec-2019 |
| Number of women and | Number | 0.00 | 200000.00 | | 1,552,317.00 |

| | | | | | |
|---|---|---|---|---|---|
| children who have received basic nutrition services | | 01-Jan-2013 | 31-Dec-2019 | | 31-Dec-2019 |
| Number of deliveries attended by skilled health personnel | Number | 0.00<br>01-Jan-2013 | 21000.00<br>31-Dec-2019 | | 47,173.00<br>31-Dec-2019 |

**Comments (achievements against targets):**
*Target exceeded.*

| Indicator Name | Unit of Measure | Baseline | Original Target | Formally Revised Target | Actual Achieved at Completion |
|---|---|---|---|---|---|
| Children 6-59 months old receiving Vitamin A supplementation | Number | 0.00<br>31-Dec-2012 | 4000.00<br>31-Dec-2018 | 26,200.00<br>31-Dec-2019 | 1,291,250.00<br>31-Dec-2019 |

**Comments (achievements against targets):**
*Original and revised targets exceeded.*

| Indicator Name | Unit of Measure | Baseline | Original Target | Formally Revised Target | Actual Achieved at Completion |
|---|---|---|---|---|---|
| Children aged under 12 months that are completely | Text | 0% by definition for baseline quarter (Q3 | 13 % | | 51 % |

| | | | | | |
|---|---|---|---|---|---|
| vaccinated at health facilities under the RBF program (percentage increase over baseline). | | of 2016)<br><br>30-Sep-2016 | 31-Dec-2019 | | 30-Sep-2019 |

**Comments (achievements against targets):**
*Target exceeded.*

| Indicator Name | Unit of Measure | Baseline | Original Target | Formally Revised Target | Actual Achieved at Completion |
|---|---|---|---|---|---|
| Births at health facilities under the RBF program (percentage increase over baseline). | Text | 0% by definition for baseline quarter (Q3 of 2016)<br><br>30-Sep-2016 | 10 %<br><br>31-Dec-2019 | | 64 %<br><br>30-Sep-2019 |

**Comments (achievements against targets):**
*Target exceeded.*

| Indicator Name | Unit of Measure | Baseline | Original Target | Formally Revised Target | Actual Achieved at Completion |
|---|---|---|---|---|---|
| Utilization of modern contraceptives via health facilities under the RBF | Text | 0% by definition for baseline quarter (Q3 of 2016) | 15 % | | 13 % |

| | | | | | |
|---|---|---|---|---|---|
| program (percentage increase over baseline). | | 30-Sep-2016 | 31-Dec-2019 | | 30-Jun-2018 |

**Comments (achievements against targets):**
*Undetermined.* The operational definition of this indicator was changed in 2018 to better reflect the M&E needs of the corresponding health directorate. Thus, although expected to be even higher, more recent values comparable with the baseline are not available.

| Indicator Name | Unit of Measure | Baseline | Original Target | Formally Revised Target | Actual Achieved at Completion |
|---|---|---|---|---|---|
| Children aged between 6 and 59 months receiving nutritional screening and follow up under the RBF program (percentage increase over baseline). | Text | 0% by definition for baseline quarter (Q3 of 2016)<br>30-Sep-2016 | 12 %<br>31-Dec-2019 | | 55 %<br>30-Jun-2018 |

**Comments (achievements against targets):**
*Target exceeded as of June 2018.* The operational definition of this indicator was changed in 2018 to better reflect the M&E needs of the corresponding health directorate. Thus, although expected to be even higher, values comparable with the baseline are not available.

| Indicator Name | Unit of Measure | Baseline | Original Target | Formally Revised Target | Actual Achieved at Completion |
|---|---|---|---|---|---|
| Contracted service providers | Percentage | 0.00 | 40.00 | 45.00 | 92.93 |

| | | | | | |
|---|---|---|---|---|---|
| achieving the minimum quality score | | 31-Dec-2012 | 31-Dec-2018 | 30-Sep-2020 | 31-Dec-2019 |

**Comments (achievements against targets):**
*Original and revised targets exceeded.* (*Note*: This includes providers with a quality score of 60% or more.)

| Indicator Name | Unit of Measure | Baseline | Original Target | Formally Revised Target | Actual Achieved at Completion |
|---|---|---|---|---|---|
| Contracted health providers supervised at least quarterly | Percentage | 0.00<br>31-Dec-2012 | 95.00<br>31-Dec-2018 | | 100.00<br>29-Mar-2019 |

**Comments (achievements against targets):**
*Target exceeded.*

| Indicator Name | Unit of Measure | Baseline | Original Target | Formally Revised Target | Actual Achieved at Completion |
|---|---|---|---|---|---|
| Health personnel receiving training | Number | 0.00<br>31-Dec-2012 | 200.00<br>31-Dec-2018 | 250.00<br>31-Dec-2019 | 530.00<br>31-Oct-2016 |

**Comments (achievements against targets):**
*Original and revised targets exceeded.*

| Indicator Name | Unit of Measure | Baseline | Original Target | Formally Revised Target | Actual Achieved at Completion |
|---|---|---|---|---|---|
| Providers using the contracting model | Percentage | 0.00<br>31-Dec-2012 | 50.00<br>31-Dec-2018 | 60.00<br>30-Sep-2020 | 62.00<br>31-Dec-2019 |

**Comments (achievements against targets):**
*Original and revised targets exceeded.*

| Indicator Name | Unit of Measure | Baseline | Original Target | Formally Revised Target | Actual Achieved at Completion |
|---|---|---|---|---|---|
| Percentage of cholera alerts and outbreaks investigated and acted on by mobile rapid response teams (EMIRAs) within 48 hours of onset | Percentage | 7.00<br>31-Dec-2014 | 60.00<br>31-Dec-2019 | | 100.00<br>30-Sep-2019 |

**Comments (achievements against targets):**
*Target exceeded.* The reported achievement corresponds to the period Oct 2018 - Sept 2019.

| Indicator Name | Unit of Measure | Baseline | Original Target | Formally Revised | Actual Achieved at Completion |
|---|---|---|---|---|---|

| | | | | Target | |
|---|---|---|---|---|---|
| Number of water and sanitation interventions supported at health facility and community levels | Number | 0.00<br>31-Dec-2012 | 65.00<br>31-Dec-2019 | | 141.00<br>29-Jun-2020 |

**Comments (achievements against targets):**
*Target exceeded.*

| Indicator Name | Unit of Measure | Baseline | Original Target | Formally Revised Target | Actual Achieved at Completion |
|---|---|---|---|---|---|
| Percentage of health facilities assessed with adequate stocks of cholera supplies, in Departments affected by the Hurricane | Percentage | 0.00<br>15-Jun-2017 | 90.00<br>31-Dec-2019 | | 100.00<br>29-Mar-2019 |

**Comments (achievements against targets):**
*Target exceeded.*

| Indicator Name | Unit of Measure | Baseline | Original Target | Formally Revised Target | Actual Achieved at Completion |
|---|---|---|---|---|---|
| Number of health facilities | Number | 0.00 | 40.00 | | 46.00 |

| | | | | | |
|---|---|---|---|---|---|
| rehabilitated and fully functioning, in Departments affected by Hurricane | | 31-Dec-2016 | 31-Dec-2019 | | 29-Jun-2020 |

**Comments (achievements against targets):**
*Target exceeded.*

| Indicator Name | Unit of Measure | Baseline | Original Target | Formally Revised Target | Actual Achieved at Completion |
|---|---|---|---|---|---|
| Number of refrigerators restored and fully functional as part of the vaccine cold chain in the Hurricane-affected Departments | Number | 0.00<br>31-Dec-2016 | 84.00<br>31-Dec-2019 | | 90.00<br>01-Jun-2020 |

**Comments (achievements against targets):**
*Target exceeded.*

| Indicator Name | Unit of Measure | Baseline | Original Target | Formally Revised Target | Actual Achieved at Completion |
|---|---|---|---|---|---|
| Citizen Engagement Indicator: % of facilities under RBF that developed an action plan(s) based on the | Percentage | 0.00<br>31-Dec-2016 | 50.00<br>30-Sep-2020 | | 0.00<br>01-Jun-2020 |

| | | | | | |
|---|---|---|---|---|---|
| results of community satisfaction surveys | | | | | |

**Comments (achievements against targets):**
*Not Achieved.* The piloting of the CE and other feedback mechanisms was delayed and will be carried out under the PROSYS

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

| Indicator Name | Unit of Measure | Baseline | Original Target | Formally Revised Target | Actual Achieved at Completion |
|---|---|---|---|---|---|
| Preliminary calculation by the IHSI of vulnerability clusters in the four pilot departments | Yes/No | No<br>31-Dec-2015 | Y<br>30-Sep-2020 | | Yes<br>30-Sep-2018 |

**Comments (achievements against targets):**
*Target Achieved.*

**Component:** Component 2: Strengthening the Stewardship and Management Capacity of Government.

| Indicator Name | Unit of Measure | Baseline | Original Target | Formally Revised Target | Actual Achieved at Completion |
|---|---|---|---|---|---|
| Steering committee to | Yes/No | No | Y | | Yes |

| | | | | | |
|---|---|---|---|---|---|
| oversee registry identified or created and operational | | 31-Dec-2015 | 31-Dec-2019 | | 19-May-2020 |

**Comments (achievements against targets):**
*Target Achieved.*

| Indicator Name | Unit of Measure | Baseline | Original Target | Formally Revised Target | Actual Achieved at Completion |
|---|---|---|---|---|---|
| Number of households included in the social registry | Number | 0.00<br>31-Dec-2015 | 300000.00<br>31-Dec-2019 | | 400,000.00<br>26-Jun-2020 |

**Comments (achievements against targets):**
*Target exceeded.* The SIMAST is now covering 400,000 households, or around 19% of the Haitian population.

## B. KEY OUTPUTS BY COMPONENT

| **Objective/Outcome 1 - To increase access and use of MCH services (pre-AF implementation period; Original targets)** | |
|---|---|
| **Outcome Indicators** | ▪ **PDI 1.** The percentage of children under five immunized increased from 46.22 percent to 47.57 percent between 2012 and 2019, below the 49 percent target (49 percent level of achievement).<br>▪ **PDI 2.** The percentage of institutional deliveries increased from 21.26 percent to 43.92 percent between 2012 and 2019, amply exceeding the original target of 22 percent.<br>▪ **PDI 3.** The contraceptive prevalence rate increased from 23.37 percent to 37.49 percent between 2012 and 2019, amply exceeding the original target of 24 percent. |
| **Intermediate Results Indicators** | **Expanded delivery of MCH services**: Although the original PRF did not include any IRI focusing on the delivery of services under the RBF Model, the achievement was significant, including:<br>▪ The number of children aged under 12 months that were completely vaccinated at health facilities under the RBF program increased by 51% between 2012 and 2019 (compared to a target of 13%).<br>▪ The number of births at health facilities under the RBF program increased by 64% between 2012 and 2019 (compared to a target of 10%).<br>▪ Although the adoption of modern contraceptives was promoted in health facilities under the RBF program, the actual increase in utilization cannot be determined due to a change in the indicator's operational definition.<br>**Improved institutional and technical capacity for the delivery of quality MCH services under RBF Model**<br>▪ The percentage of contracted health providers supervised at least quarterly increased from 0 percent to 100 percent between 2012 and 2019, exceeding the 95 percent target.<br>▪ The percentage of contracted service providers achieving the minimum quality score (60 percent) increased from 0 to 93 percent between 2012 and 2019, more than twice the original target of 40 percent.<br>▪ The percentage of providers utilizing the contracting model increased from 0 to 62 percent between 2012 and 2019, exceeding the original target of 50 percent. |
| **Key Outputs by Component** | **Component 1 - Providing Maternal and Child Health, Nutrition and Social Services**<br>*MCH care services provided according to predefined protocols under the RBF Model included, among others:*<br>▪ Over 5 million people received essential health, nutrition, and population services between 2013 and 2019 (compared to target of 881,000).<br>▪ Over 3.5 million children were immunized between 2013 and 2019 (compared to target of 660,000).<br>▪ Over 47,000 deliveries were attended by skilled health personnel between 2013 and 2019 (compared to target of 21,000).<br>*Enhanced service capacity among participating health care providers*<br>▪ More motivated health staff due to salary bonuses under the RBF model. |

| | |
|---|---|
| | ▪ Upgraded health infrastructure at the primary level (e.g., small-scale rehabilitation, equipment, medical supplies, essential health commodities and training of, and TA to health personnel).<br>**Component 2 - Strengthening the Stewardship and Management Capacity of Government**<br>▪ A total of 530 health personnel received training between 2013 and 2019 (compared to the original target of 200). |
| **Objective/Outcome 2 - To increase access and use of nutrition services (pre-AF implementation period; Original targets)** | |
| **Outcome Indicators** | ▪ N.A. |
| **Intermediate Results Indicators** | **Expanded delivery of nutrition services**<br>▪ Although the original PRF did not include any IRI focusing on the delivery of services under the RBF Model, the achievement was significant, including a 55 percent increase over the Q3 2016 baseline in the percentage of children aged between 6 and 59 months receiving nutritional screening and follow-up under the RBF program as of June 2018 (compared to a 12 percent target).<br>**Enhanced service capacity among participating health care providers**<br>▪ See PDO 1. |
| **Key Outputs by Component** | **Component 1 - Providing Maternal and Child Health, Nutrition and Social Services**<br>*Nutrition services provided according to predefined protocols under the RBF Model, included:*<br>▪ Nutritional status measured for 5,000 children aged under five years and vitamin A delivered to 1,800 children by KF community agents.<br>▪ Over 1.5 million women and children received basic nutrition services between 2013 and 2019 under the RBF Model as well as post-Hurricane Matthew emergency response activities (almost eight times the original target of 200,000).<br>▪ Almost 1.3 million children 6-59 months old received Vitamin A supplementation services between 2013 and 2019 under the RBF Model as well as post-Hurricane Matthew emergency response activities (compared to the original target of 4,000).<br>**Component 2 - Strengthening the Stewardship and Management Capacity of Government**<br>▪ See PDO 1. |
| **Objective/Outcome 3 - To increase access and use of other social services (pre-AF implementation period; Original targets)** | |
| **Outcome Indicators** | ▪ **Original PDI 4.** The decrease in percentage of families categorized as extremely vulnerable in *KF* registry during the operation's lifetime is undetermined.<br>▪ SIMAST is contributing to increasing access and use to social services under programs such as PROMES and *Kore Lavi* supported by the Swiss Embassy and USAID, respectively.<br>▪ With support from multiple donors, the WFP and FAES have relied on SIMAST for the delivery of COVID-19 emergency cash transfers. |

| | |
|---|---|
| **Intermediate Results Indicators** | **Expanded delivery of other social services under the *KF* Model**<br>▪ IRIs focusing on the delivery of social services by *KF* community agents were not met, as activities were halted in 2015.<br>**Improved institutional and technical capacity for expanding access and use of social services under the *KF* Model**<br>▪ **IRI 7** - The number of households registered in the *KF* registry reached almost 34,000 beneficiaries in 2015, compared to an original target of 80,000. The decision was subsequently made to eliminate the *KF* beneficiary registry and focused instead on the development of SIMAST, an integrated beneficiary registry at the national level.<br>**Improved institutional and technical capacity for expanding access and use of social services at the national level**<br>▪ SIMAST included 400,000 households (i.e., around 19 percent of the Haitian population) as of June 2020. |
| **Key Outputs by Component** | **Component 1 - Providing Maternal and Child Health, Nutrition and Social Services**<br>▪ A pilot of the *KF* initiative was conducted in three poor communes, with 20,000 home visits to vulnerable families and connecting families with other services where possible. No cash grants were issued.<br>**Component 2 - Strengthening the Stewardship and Management Capacity of Government**<br>▪ A total of 150 *KF* agents were trained.<br>▪ Development of SIMAST, a harmonized tool for the targeting of social programs at the national level. |
| **Objective/Outcome 4 - To increase access and use of MCH services, with a particular focus on areas affected by Hurricane Matthew (Post-AF; Revised targets)** | |
| **Outcome Indicators** | ▪ **PDI 1.** The percentage of children under five immunized increased--albeit slightly--from 46.22 percent to 47.57 percent between 2012 and 2019, below the 49 percent target).<br>▪ **PDI 2.** The percentage of institutional deliveries increased significantly, from 21.26 percent to 43.92 percent between 2012 and 2019, amply exceeding the revised target of 24 percent.<br>▪ **PDI 3.** The contraceptive prevalence rate increased significantly, from 23.37 percent to 37.49 percent between 2012 and 2019, amply exceeding the revised target of 26 percent. |
| **Intermediate Results Indicators** | **Expanded delivery of MCH services under RBF Model**<br>▪ See PDO 1.<br>**Improved institutional and technical capacity for the delivery of quality MCH care services under RBF Model**<br>▪ The percentage of contracted health providers supervised at least quarterly increased from 0 percent to 100 percent between 2012 and 2019, exceeding the 95 percent target.<br>▪ The percentage of contracted service providers achieving the minimum quality score (60 percent) increased from 0 to 93 percent between 2012 and 2019, more than twice the revised target of 45 percent. |

| | |
|---|---|
| | ▪ The percentage of providers utilizing the contracting model increased from 0 to 62 percent between 2012 and 2019, exceeding the revised target of 60 percent.<br>**Reconstruction of health infrastructure in areas affected by Hurricane Matthew**<br>▪ Health care services restored, benefiting approximately 1.5 million people in affected areas with limited health service delivery infrastructure<br>▪ Infrastructure for basic immunizations restored, benefiting approximately 300,000 children in affected areas. |
| **Key Outputs by Component** | **Component 1 - Maternal and Child Health Stream**<br>*MCH care services provided according to predefined protocols under the RBF Model*<br>▪ See PDO 1.<br>*Enhanced service capacity among participating health care providers*<br>▪ See PDO 1.<br>*Rehabilitated health infrastructure in areas affected by Hurricane Matthew*<br>▪ A total of 46 health facilities were rehabilitated and fully functioning between 2016 and 2020 in Departments affected by Hurricane Matthew (compared to a target of 40).<br>▪ A total of 159 solar-powered refrigerators were procured and installed between 2016 and 2020 and are now fully functional within the vaccine cold chain in the Hurricane-affected Departments (compared to a target of 84). The WB's financing contributed to the installation of another 346 refrigerators.<br>**Component 2 - Strengthening the Stewardship and Management Capacity of Government**<br>▪ A total of 530 health personnel received training between 2013 and 2019 (compared to the revised target of 250). |
| **Objective/Outcome 5 - To strengthen cholera control with a particular focus on areas affected by Hurricane Matthew (Post-AF)** | |
| **Outcome Indicators** | ▪ **Revised PDI 4.** The cholera fatality rate decreased from 0.89% to 0% between 2015 and 2019 (compared to original target of 0.99%).<br>▪ Most notably, there have been no confirmed cases since January 2019. According to the World Health Organization, maintaining the cholera fatality rate below 1 percent over time indicates that the cholera epidemic has been effectively controlled. |
| **Intermediate Results Indicators** | ▪ The percentage of cholera alerts and outbreaks investigated and acted on by EMIRAs within 48 hours of onset increased from 7% to 100% between 2015 and 2019 (compared to 60% target).<br>▪ Approximately 1million people in the catchment areas with available cholera services (including prevention education and hygiene promotion).<br>▪ Improved access to water sources and sanitation for 220,000 and 23,000 people, respectively. |
| **Key Outputs by Component** | **Component 1 - Cholera Program Stream**<br>▪ Strengthened diagnostic capacity of national epidemiological surveillance network to analyze samples of patients suspected of cholera, including National Laboratory for Public Health (LNSP) and 19 solar-powered refrigerators installed in all the departments for patient's sample storage. |

| | |
|---|---|
| | ▪ All departments nationwide with departmental cholera/infectious disease coordinators and EMIRAs for rapid response capacity to investigate and validate cholera alerts (supported through a contract with UNICEF).<br>▪ Adequate staffing and equipment at the central level and Project Unit for activities related to cholera control, including 200 medical personnel trained.<br>▪ A total 141 water and sanitation interventions were supported at health facility and community levels between 2015 and 2019, amply exceeding the 65 percent target.<br>▪ The percentage of health facilities assessed with adequate stocks of cholera supplies increased from 0 to 100 percent in departments affected by the Hurricane Matthew, exceeding the 90 percent target. |
| **Objective/Outcome 6 - To improve targeting of social services in the Recipient's territory (Post-AF)** | |
| **Outcome Indicators** | ▪ SIMAST is being used for the identification of recipients of social services (such as nutrition, MCH services, productive inclusion support) under programs supported by the WB, IDB, USAID and the Swiss Embassy.<br>▪ SIMAST is also being used for the identification and future targeting of PwDs.<br>▪ SIMAST supported the identification of beneficiaries of COVID-19 emergency cash transfers implemented by the WFP and FAES. |
| **Intermediate Results Indicators** | ▪ A Steering Committee to oversee the Social Registry was created in 2020 and is now operational.<br>▪ SIMAST is currently covering 400,000 households, or around 19% of the Haitian population.<br>▪ The PNPPS was adopted by the Council of Ministers in June 2020. |
| **Key Outputs by Component** | **Component 2 - Strengthening the Stewardship and Management Capacity of Government**<br>▪ Development of SIMAST as a harmonized targeting tool at the national level.<br>**Component 3 - Piloting Vulnerability Indicators for More Targeted Social Service Delivery**<br>▪ **PDO 5.** Pilots of the Housing census were carried out in four departments.<br>▪ A preliminary calculation of vulnerability clusters was carried out by the IHSI in the four pilot departments. |

## ANNEX 2. BANK LENDING AND IMPLEMENTATION SUPPORT/SUPERVISION

### A. TASK TEAM MEMBERS

| Name | Role |
|---|---|
| **Preparation** | |
| Maryanne Sharp, Francesca Lamanna | Task Team Leader(s) |
| Andrew Sunil Rajkumar | Team Member |
| Prosper Nindorera | Procurement Specialist(s) |
| Josue Akre | Financial Management Specialist |
| Nyaneba E. Nkrumah | Social Specialist |
| Emmanuel Ngollo | Environmental Specialist |
| **Supervision/ICR** | |
| Andrew Sunil Rajkumar, Briana N. Wilson, Nicolas Antoine Robert Collin Dit De Montesson | Task Team Leader(s) |
| Mamata Tiendrebeogo, Aboubacar Magassouba | Procurement Specialist(s) |
| Lucas Carrer | Financial Management Specialist |
| Emeline Bredy | Financial Management Specialist |
| Nathalie Mihajloski Zivkovic | Team Member |
| Saradjine Salomon | Team Member |
| Vanessa Marin Arbelaez | Team Member |
| Louise Estavien | Team Member |
| Caroline Anne Isabelle Tassot | Team Member |
| Marie Isabelle Simeon | Team Member |
| Kevin McCall | Environmental Specialist |
| Gabriel Lara Ibarra | Team Member |
| Bruce MacPhail | Social Development Specialist |
| Ingrid Sandra Milord | Team Member |
| Viviana A. Gonzalez | Team Member |
| Asli Gurkan | Social Development Specialist |

| | |
|---|---|
| Andrianirina Michel Eric Ranjeva | Finance Officer |

## B. STAFF TIME AND COST

| Stage of Project Cycle | Staff Time and Cost | |
|---|---|---|
| | No. of staff weeks | US$ (including travel and consultant costs) |
| **Preparation** | | |
| FY11 | 0 | 6,810.22 |
| FY12 | 27.106 | 228,266.70 |
| FY13 | 78.466 | 792,249.70 |
| FY14 | 0 | 1,353.31 |
| **Total** | **105.57** | **1,028,679.93** |
| **Supervision/ICR** | | |
| FY14 | 113.798 | 582,265.15 |
| FY15 | 89.956 | 458,660.62 |
| FY16 | 46.307 | 303,571.19 |
| FY17 | 45.099 | 393,114.63 |
| FY18 | 84.942 | 574,352.73 |
| FY19 | 72.945 | 573,994.12 |
| FY20 | 51.991 | 329,850.62 |
| **Total** | **505.04** | **3,215,809.06** |

## ANNEX 3. PROJECT COST BY COMPONENT

| Components | Amount at Approval (US$M) | Actual at Project Closing (US$M) | Percentage of Approval (US$M) |
|---|---|---|---|
| Component 1: Providing Maternal and Child Health, Nutrition and Social Services. | ***81.0*** | 92.82 | 115% |
| Component 2: Strengthening the Stewardship and Management Capacity of Government. | ***9.0*** | 11.46 | 128% |
| Component 3: Piloting Vulnerability Indicators for More Targeted Social Service Delivery | | 5.00 | -- |
| **Total** | **90.00** | **109.28** | **121%** |

## ANNEX 4. EFFICIENCY ANALYSIS

1. **Results from the economic analysis indicate that the operation was highly efficient, with a robust NPV of US$111 million and a BCR of 2.14.** The operation's efficiency during the post-AF period is deemed to be Substantial to reflect both its robust economic efficiency and efficient use of funds. The operation's efficiency during the pre-AF period is deemed Modest due to the cancellation of *KF* activities in 2015. As mentioned earlier, pilot activities under the *KF* network were suspended in December 2015 based on the results of a program assessment that pointed to the shortcomings in the underlying strategy. Nevertheless, it is important to keep in mind that the decision to cancel was taken early on in the process (15 months after effectiveness) and the use of grant resources in this area of intervention was minimized (US$2.5 million). Also, as underscored in Haiti's CPF FY16-19, pilots such as this one served an important function, as they help tailor interventions to the country's needs and specificities. [41]

**Economic impact**

2. ***Ex-ante economic analysis* - According to the *ex-ante* economic analysis performed at both Appraisal (2013) and the time of preparation of the Additional Finance - AF (2017), the operation was expected to be economically efficient.** The economic analysis conducted under the AF was particularly relevant, as it reflected the operation's actual implementation in terms of overall costs, timetable and activities. The specific results indicated a NPV of about US$89 million and a BCR of 1.9 over a five-year period. The specific assumptions underlying the analysis were the following ones:

- *Benefits* - The analysis took into consideration the economic benefits derived from reduced morbidity and mortality, including the savings in health care costs including hospitalizations and the productivity gains resulting from avoiding premature deaths and disabilities. Specifically, the analysis focused on those benefits arising from Subcomponent 1.1 (Access and use of MCH care services) and Subcomponent 1.2 (Cholera control).
- *Costs* - With regards to costs, the analysis took into consideration the costs for the entire operation (a net investment of US$109.3).
- *Key Assumptions* - The temporal horizon for the accruing of benefits was the duration of the Project as envisioned at the time of the AF (October 2013 to December 2019). It was assumed that no benefits are incurred after the Project's closing, which is a highly conservative assumption as infrastructure and knowledge generated by the Project are likely to extend beyond the operation. The Project's costs and benefits were discounted at 3 percent and the Value of Statistical Life (VSL) was estimated at $33,755 for Haiti.

3. ***Actual economic impact* - The operation was implemented as anticipated, except for the actual closing date of September 30, 2020.** In addition, since there is now actual data on cholera cases through 2020. Thus, the economic analysis was adjusted accordingly. Since the outcomes in terms of cholera control surpassed expectations, the results of the economic analysis taking into consideration the actual number of cholera cases during the operation's lifetime are even more favorable, rendering a NPV of US$111 million and a BCR of 2.14 for the operation as a whole.

[41] Haiti CPF FY16-19, Report No. 98132-HT, p. 46.

**Implementation efficiency**

4. **Except for the cancellation of *KF* activities, the operation was implemented efficiently, exhibiting substantial strengths.** Specifically, the MCH services provided under the RBF Model were selected based on their cost effectiveness. Likewise, cholera-control activities had proven to be cost effective under the preceding operation. Both interventions--RBF and cholera--were implemented in close coordination with the GoH and other donors. The 2017 AF and restructurings and AF effectively addressed to changes in the GoH's priorities and the additional needs resulting from Hurricane Matthew. Moreover, the WB's team was successful in leveraging the operation's financial contribution to help further integrate the interventions of other donors active in cholera control. The need to extend the operation's closing date twice toward the end of its lifetime arose mainly from factors beyond the orbit of the Project, in particular delays resulting from social unrest and the COVID-19 pandemic.

5. **As mentioned earlier, *KF* activities were suspended in December 2015, only 15 months after effectiveness, which helped minimize the use of grant resources in this area (US$2.5 million).** Also, the grant resources spent in this pilot served to help grow consensus over the need to develop a more comprehensive SP strategy at the national level.

## ANNEX 5. RECIPIENT, CO-FINANCIER AND OTHER PARTNER/STAKEHOLDER COMMENTS

**MINISTRY OF PUBLIC HEALTH AND POPULATION CONTRACTING UNIT**
**Improving Maternal and Child Health Through Integrated Social Services *(Projet d'Amélioration de la Santé Maternelle et Infantile à travers des Services Sociaux Intégrés,* PASMISSI)**
**Project Completion – Evaluation Document**

**Section 1. Introduction**

1. **The PASMISSI Project, financed by the WB and formalized through a memorandum of understanding between the MSPP and the FAES, consisted of support for the GoH objective of expanding access to MCH services and other essential services.** From a health standpoint, the official strategy of this project was the establishment of a results-based contracting model stipulated in the National Health Policy and implemented by the MSPP.

**Section 2. Implementation of the Strategy**

2. **The operations manual was drafted during the preparatory period. It included the management tools, the quantity and quality indicators chosen for inclusion in contracts, and the health departments, entities, and facilities selected for RBF.** This was followed by the launch of the RBF strategy through a pilot in the Northeast health department involving seven health facilities, the Departmental Health Directorate (DDS), and the Northeast Departmental Supply Center (*Centre Départemental d'Approvisionnement en Intrants*, CDAI), which was gradually extended to six additional health departments—Center, Northwest, South, Grand-Anse, Nippes, and North—bringing the total to 123 health facilities, 7 DDSs, and 7 CDAIs.

**Subsection 2.1 Achievement of Results[42]**

3. **The main results sought by the project were achieved.** More than 59,000 children between the ages of 6 and 59 months were screened for severe malnutrition compared to the projected figure of 14,000; the most recent percentage of contracted health facilities achieving the minimum quality score is close to 100 percent (99.18 percent) compared to the projected figure of 40 percent; and at least 76,298 children between the ages of 6 and 59 months are receiving vitamin A, a figure that greatly exceeds the 32,000 target. In addition, all the contracted health facilities are regularly supervised, as planned.

**Subsection 2.2. Positive Areas**

4. **Ongoing supervision led to improvements in the area of hygiene in general and the quality of care in particular.** In addition, norms and standards were applied, more careful and better documented services were provided, better leadership and collaborative skills were developed, and health information tools were used more appropriately.

5. **Implementation of the strategy also led to local support for health facilities by the Departmental Directorate (coaching) and the identification of a number of structural problems as well as solutions and progress.** For the managers of the contracted entities and facilities, results-based requirements prior to the provision of subsidies and the process linked to verification of these results serve as a support mechanism for maintaining staff morale, assessing internal results achieved, organizing constructive discussions among team members and between

[42] Reference: PASMISSI project document (targets) and CU calculations (results).

supervisors and their staff, providing stronger leadership aimed at better management of resources, and engaging in more effective planning with the ultimate aim of better performance.

6. **Changes in key indicators were positive from the first three months of the extension up to the time of availability of the most recent results, with a positive trend being noted in the quantitative results related to reproductive health and child health.**

7. **The strategy had a verifiable impact on each area listed below:**

- Supply: More careful and better documented services; implementation of innovative community outreach strategies;
- Financing: Predictable and efficient allocation of funds; institutional strengthening in terms of small investments;
- Management: Closer and more appropriate management (needs-based);
- Leadership/autonomy: Better supervision, greater empowerment (planning, management) of staff at health facilities and the DDS; emergence of a culture of team-based evaluation/analysis of joint work conducted; creation of an internal space for discussion of monthly reports prior to their transmission to the BD;
- Transparency/accountability: community involvement; information available on results and the allocation of funds;
- Inputs: better planning and more efficient use of inputs; efforts to identify strategies to curb supply chain mismanagement;
- Health information: better recording of data; increased availability of tools, etc.;
- Human resources/morale: extension of bonuses to include multi-skilled community health workers (*Agents de Santé Communautaire Polyvalents*, ASCP) and support staff; continuing education for health facility, DDS, and Central Department staff; and
- Community participation: community participation in the verification process (community verification); building/rebuilding public trust; firmer commitments from health facilities to communities and from the DDS to the health facilities (strategies; quality, etc.).

**Subsection 2.3. Achievements**

- Quantity increases
- More autonomous management
- Gradual quality improvements
- Local coaching – DDS-health facilities
- Better use of health information tools (filling in data, availability, etc.) leading to more reliable data
- Better leadership, collaborative, and decision-making skills
- Actions aligned with the Technical and Financial Partners
- Greater transparency

**Subsection 2.4. Lessons Learned**

- Bilateral and thematic meetings facilitate in-depth discussion of an area in which problems are being experienced, leading to definitive, consensus-based decisions in a short period.
- Supervision at the departmental level is rewarding and fosters fruitful discussion between the CU and the Departmental Directorates. This supervision is needed to calibrate a number of aspects of the implementation process.

- Health facility visits facilitate a closer view of the situation faced by providers and an understanding of the dynamics of care delivery. This helps maintain sound knowledge of the situation on the ground with a view to more effective work upstream.
- Departmental Steering Committee (*Comité Départemental de Pilotage, CDP*) meetings facilitate analyses, discussion, and the corrective action necessary to implement RBF at the departmental level.
- The Technical Group promotes rapport among the different operational stakeholders. This structure fosters discussion and consensus when important technical topics are being considered.
- Verification, in combination with enhanced and integrated supervision, inter alia, has led to improvements in the area of hygiene and better use of health information tools (and thus to more reliable data). Supervision is vital for supporting the performance of health facilities.
- Staff morale and engagement are critical to further improve results.

**Subsection 2.5. Challenges**

- Implementation has been greatly impacted by unanticipated and ongoing instability in the security, economic, and sociopolitical areas, especially in the last two years.
- With double-digit inflation and an overall decline of the Haitian gourde against the United States dollar, the economy has not been doing well. Added to this already bleak picture are the security crises such as the famous “locks” (barricades) and violent demonstrations and roadblocks during the anti-government, PetroCaribe, and other protests and the periods of fuel shortages leading to the repeated interruption of activities (transport of goods, persons, etc.) during this period, regardless of department or location.

**Technical Area**

- Turnover of verification staff. Although the RBF operations manual stipulates that the rotation of verification staff should be minimized as much as possible, verification staff are often moved around, a factor that compounds the problems with data interpretation and thus data validation and worsens delays.
- Responsiveness of the other ministerial directorates (Central Directorates and/or DDSs)
- Owing to the functioning of the Ministry and the volatile security situation, it remains difficult to reach a decision on a problem or constraint requiring the input of various stakeholders. Efforts to hold Technical Group meetings involving the Central Directorate have not been successful, even after invitations and reminders. While the subcommittees created to relieve the pressure on the Technical Group seem to be helpful, decisions take longer to be formalized given the more in-depth discussions held by these subcommittees.

**Financial Area**

- Communication regarding the payment process. Communication among the different stakeholders (CU, DDS, fiduciary agencies) regarding the process has been difficult. The failure to share information in a timely manner remains one of the main problems to be resolved.
- Payment delays. Several reasons account for post-verification payment delays. They include the situation in the country, problems with the availability or validity of supporting documentation, failure to share information, and not having a bank account (some health facilities).
- Use of the indicator tool and the staff evaluation tool: The use of these two tools continues to be a problem for some of the contracted entities, given that:
  a) Staff evaluations are neither rigid nor uniform, even when a single tool is used. They vary from one DDS to another, one leadership style to another, and one quarter to another.
  b) Indicator tool information is not always filled out in a timely manner (despite the fact that provision

of this information is sanctioned through verification/quality assessment grids). This has a negative impact on results and staff morale.

**Morale**

- When health facilities are contracted, staff morale is generally high. While this morale is undermined during some verification processes, in general it is quickly restored at CDP meetings where comparisons can be made.
- The involvement of staff working in an unofficial capacity at a health facility negatively impacts the morale of on-site staff, as bonuses must be shared with a greater number of persons in such instances.
- The payment of bonuses remains one of the main drivers of morale. Any delays in this regard therefore have a profoundly negative impact on staff morale.

**Subsection 2.6. Areas Requiring Improvement**

- Problems linked to traditional management practices;
- Supply chain delays;
- Lack of understanding by some managers (health facilities, Departmental Directorates, or CDAIs) of the verification process;
- Underutilization or incorrect use of SISNU tools;
- Failure to implement the recommendations agreed upon based on previous verification exercises;
- Frequent rotation of health facility staff; and
- Accounting for funds allocated.

**Section 3. Assessment of WB's Support**

8. **WB's performance in the area of support is satisfactory.**

9. **Throughout the period covered by the PASMISSI, the different[43] WB's teams provided support to the CU in particular in its discussions and work aimed at:**

a) Adjusting a number of aspects of the strategy in light of results and stakeholder feedback;
b) Identifying mechanisms and measures to reduce the bottlenecks noted;
c) Developing a large number of proposals in the context of the strategy;
d) Following the progress made with the internal activities of the CU and RBF implementation in general; and
e) Encouraging active stakeholder participation in the implementation of the strategy (Central Directorates, Departmental Directorates, and even other technical and financial partners, to mention a few).

10. **WB's support was also very helpful with the exercises related to the assessment of internal results and the implementation process.** Its consistent work and timely processing of various documents are positive factors that should be underscored.

[43] Different in terms of the composition of these teams.

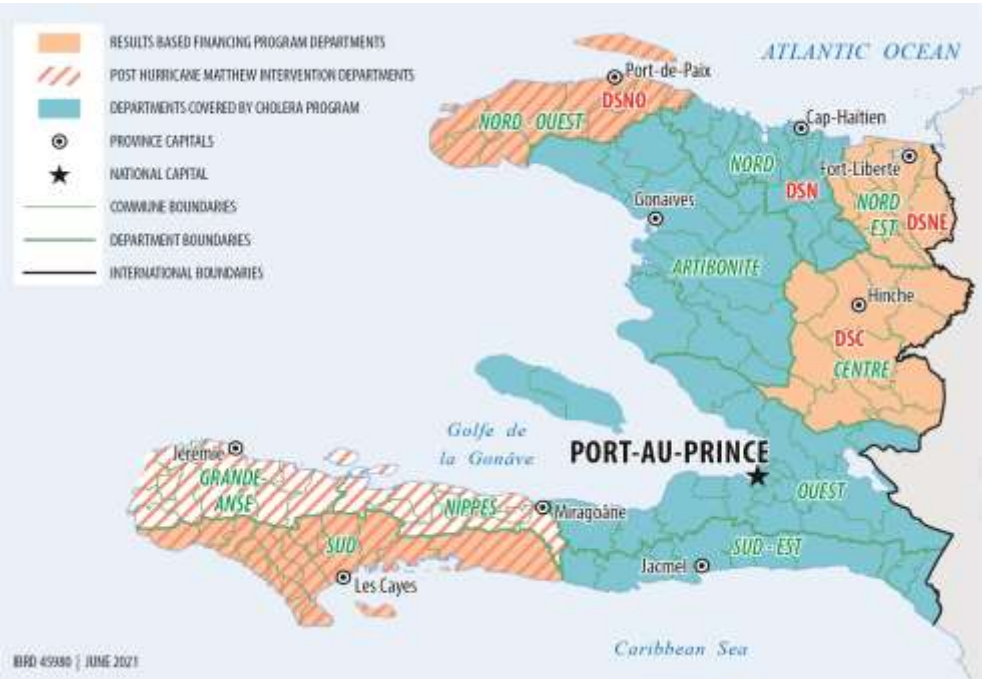
**MINISTRY OF PUBLIC HEALTH AND POPULATION**
**HEALTH SERVICES DECENTRALIZATION SUPPORT UNIT**
**NATIONAL CHOLERA COORDINATION UNIT**

# IMPROVING MATERNAL AND CHILD HEALTH THROUGH INTEGRATED SOCIAL SERVICES PROJECT (PASMISSI)

**Funded by the World Bank through**
**the fiduciary structure of the Project Management Unit (PMU)-Ministry of Public Health and Population/President's Emergency Plan for AIDS Relief (PEPFAR)/World Bank**

## PASMISSI PROJECT: FINAL REPORT
## OCTOBER 2013-SEPTEMBER 2019

**Project Intervention Areas**



## 1. BACKGROUND

1. In the wake of the devastating earthquake of January 12, 2010, Haiti witnessed the outbreak of one of the most serious cholera epidemics of modern times. The first cases in Haiti were identified in October 2010 in the Center Department. The disease then spread to Artibonite Department and, a month later, to the entire island. By February 2012, there had been a total of 543,621 cases of cholera in Haiti, with 292,283 persons hospitalized and 7,036 deaths. During that same period, the Dominican Republic reported 22,331 cases, with 16,097 hospitalizations and 338 deaths. There was therefore a risk that cholera would become endemic in Hispaniola.

2. The international community determined that the time had come to undertake short-, medium-, and long-term measures to put an end to this threat by aiding the people of Haiti and the Dominican Republic to combat this pandemic. On January 11, 2012, the two countries' presidents, together with the PAHO/World Health Organization (WHO), the UNICEF, and the U.S. CDC, called for the mobilization of major international investments in the area of water and sanitation with the aim of eliminating cholera from Hispaniola. The immediate aim of this effort was to prevent cholera from becoming endemic in the island.

3. In response to an appeal from the National Cholera Coordination Unit, the WB-financed PASMISSI, agreed to provide funding to assist the MSPP in its bid to wipe out cholera by 2022. This part of the project was launched in October 2013 in four departments (North, Northeast, Northwest, and Center) and two health facilities in the West Department (GHESKIO Centers and Foyer St. Camille). PASMISSI also supports the National Coordination Unit and, through it, two other central bodies, the Epidemiology, Laboratory, and Research Directorate *(Direction d'Epidémiologie, de Laboratoires, de Recherches, DELR)* and the Health and Environmental Protection Directorate *(Direction de Promotion de la Santé et de Protection de l´Environnement, DPSPE)*. When funding from other partners came to an end, it expanded its support to include the six other departments in the country, where it took on responsibility for paying the salaries of six infectious disease coordinators and members of their EMIRA.

4. In 2016, after Hurricane Matthew battered the coasts of the South, Grand'Anse, and Northwest departments, damaging a considerable number of health facilities, the WB, which funds PASMISSI, stepped in to help the MSPP repair those facilities.

## 2. OVERALL OBJECTIVE OF THE PROJECT

5. The project's overall objective is the same as the objective in the strategic framework for the cholera elimination plan: eliminate cholera from Hispaniola by 2022, through technical and financial support from the international community and binational coordination.

## 3. SPECIFIC OBJECTIVES

6. To prevent further death and diminish the suffering caused by the cholera epidemic, the GoH has set the following specific objectives to be achieved by 2022:

a) Strengthen epidemiological surveillance for early detection of all cholera cases and other diseases under surveillance through an improved information management system;
b) Strengthen the public health system in order to facilitate access to health care services for 80 percent of the population;
c) Step up efforts to educate the population about hygiene with a view to ensuring that by 2022 at least 75 percent of the general population in Haiti will be washing their hands after defecating and before eating;
d) Increase access to drinking water for at least 85 percent of the population, to improved sanitation

facilities, and to a better level of hygiene for at least 90 percent of the population;

e) Build capacity for coordination, M&E, oversight, and the provision of assistance to State and non-State decision-makers at all levels of the system.

## 4. EXPECTED OUTCOMES AND OBSERVATIONS

| Expected Outcomes | Observations |
|---|---|
| The incidence of cholera in the country fell from 3 per 1,000 to 0.5 per 1,000 in 2015 and to 0.1 per 1000 in 2018. It is expected to decline to 0.01 per 1,000 in 2022. | In 2019 cholera incidence averaged 0.049 per 1,000. |
| All the laboratories in the national network are in operation and are producing surveillance data. | To date, the network is not functioning. Apart from the LNSP, only the St. Marc laboratory is producing epidemiology surveillance data. |
| 80 percent of persons in the project area have access to primary health care provided by an improved health care system. | The four health districts involved in the project have received institutional capacity-building assistance. The quality of care is better and hospital deaths are down. |
| 80 percent of the population living in the project area where secondary transmission is ongoing are washing their hands after defecating and before eating. | While awaiting the KAP survey results, the population is quite well informed about cholera even though the associated practices are not yet evident. |
| 85 percent of the population has better access to drinking water and improved sanitation facilities. | Even though every effort has been made to attain this target (85 percent), it has not been met. Some community and institutional works have been carried out, including spring tapping, drilling of wells, and the repair of some water distribution networks. |
| 90 percent of the population maintains a higher level of hygiene than before. | 30 communities in which all the households have latrines have been certified. The management and proper disposal of human and biomedical waste are being conducted. Toilet blocks, incinerators, storage facilities, and wash basins have been built. |
| The programming of State and non-State actors' activities is well timed, and they work in complete synergy with one another. | Progress has been made in this direction and activities on the ground are more fully coordinated (DINEPA, UNICEF, PAHO/WHO). |

## 5. WORK CARRIED OUT

7. Following the announcement of the cholera epidemic in Haiti and the development of the first plan for combating the disease, the WB, a long-standing partner of the GoH, began to provide assistance on a large scale and set up the *Cholera Emergency Response Project (PRUC).* The DELR, as the Government body in charge of epidemiological surveillance, took part in that project aimed at helping the DELR mobilize resources to confront this new challenge in the aftermath of the earthquake of January 2010. Consensus-based planning led to the establishment of a cholera surveillance system, a review of the strategic plan, and the recruitment and training of personnel. When the PRUC ended and was replaced by PASMISSI, the cholera epidemic was still far from being brought under control, and the DELR not only had to continue its surveillance but also had to build its capacity under the strategic plan. The WB continued its support for the DELR, thereby permitting the continued implementation of the various phases of the plan for combating the disease. Thanks to this collaboration and the efforts of numerous

other partners, the downward trend observed in 2012 remained in evidence throughout the life of the project, with the number of cases falling from 5.54 to 0.02 per 1,000 persons in 2019 (the statistic available as of the time of writing). This decrease in the incidence of the disease is a fitting testimony to the hard-won success in saving millions of lives, identifying and neutralizing thousands of transmission points, and reaching communities throughout the country with information about the disease and means of prevention, which was made possible by the unstinting efforts of thousands of health professionals and personnel in related fields. With an average of between 15 and 20 suspected cases (compared to over 800) per week for the entire country and the fact that all the samples have come back negative since February 2019, it is clear that the GoH's goal of wiping out the disease is within reach. There are a number of slight discrepancies between this report and the official figures posted on the health ministry's site owing to the fact that the project is run on the basis of fiscal years whereas the ministry uses calendar years in its reports.

8. During this period the project has carried out the following work relating to each of the components of the strategy:

### *5.1 Strategy Component 1: Epidemiological Surveillance*

9. The epidemiological surveillance strategy has been improved as the continuing decline in the number of cases makes it possible to focus more on quality. Daily reporting speed has averaged 83 percent but, when converted to a weekly periodicity, rises to 98 percent, as does data completeness. The work involved in the compilation of linear case lists, active case tracking, and investigation was conducted as extensively as possible since the cholera outbreak. The proportion of patients whose samples have been subjected to laboratory testing ended up being nearly 63 percent; this rate could have been much higher if specimen transport services had been readily available on a regular basis. The need for operational research is obvious and calls for the preparation of a protocol for investigating the behavior, attitudes, and practices of the population at this point in time, eight years after the disease first made its appearance.

10. The number of cases of cholera fluctuated in 2014-2016 as a consequence of various circumstances. Nonetheless, a net decrease in cases was observed in late 2018. At the start of 2019, the incidence of cholera was at its lowest point since the beginning of the epidemic, with some departments reporting no new cases or deaths at all for the entire year. This provides further reason to expect that cholera will very soon be eliminated from the Haitian territory.

### *5.2 Strategy Component II: Response*

11. The response to the epidemic has improved as institutional capacity has been strengthened with larger numbers of qualified personnel, increased availability of inputs, and the upgrading of health care facilities. Since 2013, hospital deaths have steadily declined, falling from 2.43 percent in 2010 to 1.07 percent in 2013 and ending up at 0.48 percent in 2019. Deaths occurring in the community have also decreased as a result of the work of the EMIRA teams, which have become more operational, more experienced, and better equipped. Outbreaks are now more easily managed, investigated, and brought under control. The response package advocated by the MSPP is as follows: active search for cases of severe diarrhea, doxycycline chemoprophylaxis, the distribution of chlorinated products, decontamination, and awareness raising when areas are cordoned off for 90 percent of cases reported by treatment centers.

12. In 2016, the Northeast and Northwest departments reported fewer suspected cases of cholera than the North and Center departments. It was found that three communes within the project area were almost constantly on red

alert. These communes were therefore a cause of concern for the National Cholera Coordination Unit. Mirebalais, Hinche, and Cap-Haïtien were thus still residual hotspots in 2014-2016. Despite considerable efforts to improve the treatment provided for cases of severe diarrhea, progress fell short of expectations during those early years.

13. In the course of 2017 and 2018 and in early 2019, however, there was a vast improvement in the situation thanks to the dedicated efforts of the EMIRA teams, which worked unceasingly to carry out advocacy and preventive actions through rapid, ever-more comprehensive responses that include education/awareness raising, chemical prophylaxis, disinfection, and the distribution of water treatment supplies for use in the home. In addition to a number of events open to the public at large, a total of 104,549 institutional and community awareness-raising meetings on cholera prevention, water treatment, sanitation, and hygiene practices, have been held in the project area. These meetings were attended by 1,902,436 persons. In view of the experience acquired by the EMIRA teams, other health programs, such as initiatives for combating vector-borne diseases, would do well to make use of their services.

14. While the National Cholera Coordination Unit took charge of training staff and service providers when the epidemic began, it has since passed this responsibility on to the departments. A total of 2,364 providers have been trained or retrained, and 84 percent of the facilities in the project area have trained personnel. Cholera case management was made possible by the resources (personnel, inputs, materials, equipment, medicines, free treatment) made available to the health ministry. Infrastructure for the management of cholera cases has also been adapted and/or constructed (cholera treatment centers/cholera treatment units/centers for the treatment of severe cases of diarrhea).

### *5.3 Prevention and Health Promotion*

15. Owing to the importance and role of awareness raising in combating cholera at the end of FY2013-2014 and at the request of UADS (Health Services Decentralization Support Unit), the entity responsible for coordinating the cholera response, the DPSPE joined the epidemic coordination group. WB's support to the DPSPE thus began in October 2014, although funds did not arrive until April 2015.

16. Without a doubt, WB's support has greatly helped the DPSPE improve its operations, maintain vehicles in service, oversee departments, and carry out minimal supervision in order to remain in contact with departments.

17. This support from the project to the DPSPE aimed, inter alia, to improve infection prevention practices and waste management systems in health facilities across the country. It bears noting that our objectives for this period were ambitious, in view of the resources needed to achieve this goal. The impact of the activities conducted during this period is evident at all levels of the system.

18. Support provided by the WB, PAHO/WHO, and UNICEF to the DSPSE pertained to regulatory aspects and specific water, sanitation, and communication activities in the four departments. The recruitment of four health technicians provided considerable support to the project's four pilot departments.

### *5.4 Strategy Component IV: Water, Sanitation, and Hygiene*

19. The recruitment and assignment of a senior health technician to each of the four departments in the project area strengthened water, sanitation, and hygiene in the departments.

20. Project Management Unit (PMU) coordination of PASMISSI, which entailed TA and support to the departments and targeted health facilities including the construction of water management and improved sanitation

infrastructure in health facilities, has greatly contributed to efforts to strengthen this component. Nine resident engineers are responsible for the direct supervision of firms carrying out rehabilitation works for select facilities, while two Environmental and Social Safeguards officers, an assistant health engineer, and a health engineer conduct random supervision visits. Assistance with the construction of infrastructure in select communities served by project-supported health facilities was also provided.

21. In the area of Water, Sanitation, and Hygiene (WASH), 18 water and sanitation facilities were built in communities and 162 institutions. Access to water was established or reestablished in 153 health facilities. There were 5,296,965 beneficiaries, 1,671 cubic meters ($m^3$) of water were stored, 15 of the planned 34 wells are operational, 7 cannot be used, and 14 others are awaiting the right conditions. In addition, 23 solar pumps have already been installed while 18 are pending. A spring was tapped, two water systems were rehabilitated, and 200.5 kw of solar energy were distributed across 55 sites in seven departments.

22. With WB's support, a Water and Sanitation needs assessment in health facilities was launched, thereby providing access to reliable data on the health situation in facilities in six departments (South, Nippes, Northwest, Northeast, Center, and North). Scheduled assessments were conducted in 328 of the 414 pre-identified health facilities. To carry out this task, the project's technical team was strengthened by six engineers. Fifty-three sites were visited, with all requiring an environmental and social assessment for an Environmental and Social Impact Assessment (ESIA). These assessments facilitated the inclusion of environmental and social considerations in decision-making and in the design of the activities for the subproject, thereby paving the way for the adoption of a sustainable approach to the works. The preparation of the ESIA ensured that certain adverse impacts on communities and the environment were taken into account and that appropriate solutions were provided. Identified sensitive cases are documented.

23. In addition, the general public, beneficiaries, health personnel, and local authorities were informed of the issues of transparency, the promotion of social equity, and the promotion of environmental sustainability in the activities to be carried out.

24. In the aftermath of Hurricane Matthew, the WB provided additional funds for interventions in the health facilities damaged by the hurricane. In a bid to provide an adequate response, exploratory and assessment trips, which at times supplemented activities previously carried out by other organizations, were conducted and analyzed. The proposed responses are consistent with the WB's ESMF.

25. These visits were carried out in four of the departments hardest hit by Hurricane Matthew (South, Grande-Anse, Nippes, and Northwest). Approximately 50 of the sites identified by the departmental directorates were visited and about 40 were selected. Proposals for rehabilitation works were prepared and calls for bids launched. The Social and Environmental Safeguards officer takes part in all activities carried out in the four targeted departments. These facilities will receive equipment in order to ensure their proper functioning.

26. The contribution made by the Senior Hospital Hygiene Technicians and other health officers that provided sanitation and hygiene coaching to communities and health facilities cannot be overlooked. The following activities were conducted: training sessions on hospital hygiene for commune-level and departmental authorities; training of health facility service providers, and in particular support personnel, in hygiene and integrated waste management planning; waste management evaluation in health facilities; training of personnel responsible for water disinfection and residual chlorine monitoring, purchase of monitoring kits and disinfectant to facilitate the expansion of the Chlorine Production System; regular monitoring of the chlorine levels in the water in health facilities; Community

Approach to Total Sanitation in remote areas; certification of 30 communities where all households have latrines; and management and proper disposal of excreta.

### *5.5 Status of Disbursements*

27. The first year of the project had a protracted preliminary period marked by various difficulties relating to the establishment of the policy framework, implementation of the structure, procedures, and management tools. Funds were also very late in coming (fourth quarter of the fiscal year). In fact, few activities were actually launched; as a result, the overall execution rate of the allocated budget did not exceed 29.1 percent, even when certain recipients such as DSC (Center Health Department) and DSNE (Northeast Health Department) managed to reach or exceed the 50 percent mark for available resources. It bears noting as well that the 29 percent of the approved overall budget that was transferred corresponded to the absorption capacity of the subrecipients. A considerable amount of time was spent justifying the expenditures made from the advances received. As the project was gradually being implemented, more than half of the resources were already transferred in the second year, and 80.51 percent in the third year, with the appointment during the fiscal year of departmental accountants and an assistant financial coordinator to the PMU.

28. According to the financial department's report, the percentage of expenditures made by the project stood at roughly 93 percent as of end-September 2019.

### *5.6 Status of Contracts*

29. All purchases of goods and services under PASMISSI are subject to rules and the WB's public procurement procedures. The establishment of partnerships with service provider institutions as was the case with the GHESKIO Centers, Foyer Sainte Camille, or each of the aforementioned subrecipients, is covered under a memorandum of understanding and is subject to the same procedures. An audit is conducted by an independent external firm at the end of each fiscal year to assess management of all project resources.

## 6. CONSTRAINTS

- Lack of communication among actors at the different levels
- Lack of timely disbursements
- Repeated delays in the preparation and finalization of plans and budgets, resulting in variable delays in starting and implementing activities
- Lack of rigor displayed by departmental entities in implementing plans
- Fairly inefficient coordination and communication mechanisms
- The choice of certain firms to carry out the works contributed little to the achievement of results

## 7. LESSONS LEARNED

- The establishment of EMIRA in the 10 departments helped to effectively stem the spread of the disease and step up efforts to eliminate it. These teams can be remobilized to perform other rapid response tasks.
- The rapid response to cholera cases helped reduce the transmission and spread of the disease.
- Good communication among all partners helped pave the way for effective and efficient management of the epidemic.
- Regular monitoring of the indicators as well as recommendations improved programming to achieve the defined objectives.
- Support and supervision provided by central authorities to the departments contributed to the dynamism of the teams and the adoption of new, more effective prevention strategies.
- Greater empowerment of the DDS enhanced the effectiveness of efforts to manage the fight against cholera at the operational level.

## 8. CONCLUSION

30. After six years, PASMISSI has undoubtedly achieved a significant portion of its objectives, particularly with respect to its cholera response. The epidemiological data speak for themselves – more than 42 weeks without a confirmed case and no surge in over a year. Considerable gains have been made in the areas of water and sanitation and infrastructure has been constructed and rehabilitated. However, the project will prove meaningful to the extent that the beneficiaries value the knowledge gained and strive to preserve it. This is a learning process; one that calls for resources. RBF should offer a solution. The impact of PASMISSI, though promising, has not yet been assessed. The results of studies/surveys will either confirm or invalidate this observation.

**PROJECT: IMPROVING MATERNAL AND CHILD HEALTH THROUGH INTEGRATED SOCIAL SERVICES (PASMISSI)**


## PROJECT COMPLETION REPORT


Dr. Jean Marie Boisrond,
PASMISSI Coordinator

February 2021

## LIST OF ABBREVIATIONS AND ACRONYMS

ASEC - Communal Section Assembly
BSEIPH - Bureau of the Secretary of State for the Integration of Persons with Disabilities
CAS - Social Assistance Fund
CASEC - Administrative Council for Communal Sections
CNSA - National Coordination for Food Security
DGPC - General Directorate for Civil Protection
ECLAC - Economic Commission for Latin America and the Caribbean
FAES - Fund for Economic and Social Assistance
IDA - International Development Association
IHSI - Haitian Institute of Statistics and Informatics
MEF - Ministry of Economy and Finance
MSPP - Ministry of Public Health and the Population
ONA - National Labor Office
ONI - National Identification Office
PNPPS - National Policy on Social Protection and Promotion
UNDP - United Nations Development Program
SBR - Single Beneficiary Registry
SIMAST - Information System of the Ministry of Social Affairs and Labor
SNAS - National Social Assistance Strategy
SPST - Social Protection Sectoral Table
SSR - Single Social Registry
UNDP - United Nations Development Program
UNFPA - United Nations' Population Fund
USAID - United States Agency for International Development
WFP - World Food Programme

## 1. INTRODUCTION

1. In 2013, the WB and the IDA signed a financing agreement with the GoH through the Ministry of Economy and Finance (MEF). This was aimed at implementing the PASMISSI. This activity, led by FAES, is part of a vision to curb extreme poverty in Haiti and aims to improve access to and use of maternal, child, and nutritional health services as well as integrated social services for poor and vulnerable families.

2. PASMISSI was restructured in March 2017 which brought about changes to the project's management mechanisms by establishing three components (health, social, and support to the national census), managed respectively by three different institutions, the MSPP, FAES, and the IHSI.

3. The social component, which is of interest to us in this report, aimed to establish a SSR of beneficiaries of social projects and strengthen the GoH's coordination and management capacities, for the coordination and supervision of this registry.

4. As in other countries where SP programs are more advanced, the availability of a SSR registry is important because it provides a database on vulnerable populations in order to facilitate not only the targeting of beneficiaries of social programs, but also to ensure better coordination of actors, monitoring of interventions and better decision-making.

5. Unfortunately, implementation of the SSR could not be fully effective due to a number of problems. PASMISSI had to adapt its strategies in order to contribute towards strengthening the SIMAST, which can now be considered as the precursor of the SSR for the country.

## 2. GOAL, OBJECTIVES, EXPECTED RESULTS OF PASMISSI

6. The social component of PASMISSI aimed to strengthen social programs in Haiti by establishing a SSR and strengthening the State's management role in coordinating the registry.

The main expected results include:

- Completion of household surveys in 4 departments
- Establishment of a social registry of 300,000 households
- Coordination and monitoring committee for the social registry is operational

## 3. SINGLE SOCIAL REGISTRY (SSR)

### 3.1. *Rationale and History of the SSR in Haiti*

7. By definition, the SSR is a structured data management system that evolves and is updated constantly which identifies potential beneficiaries of SP projects and programs, describes the characteristics of their socio-economic environment (households, demographics, housing, health, education, resources, food security, etc.) and summarizes the progress of programs and projects that are implemented.

8. In order to manage the fragmentation of social programs, which leads to planning, coordination and monitoring deficits, the establishment of a SSR in Haiti would be a great contribution to the implementation of an effective social policy, as it would:

- Serve as the prime starting point for most actors involved in the implementation of SP programs (such as cash transfers, payment for work, school canteens, nutrition programs, free health services, etc.)
- Provide some indicators on ongoing projects and programs
- Constitute, for the institutions concerned, the primary source of information on registered households and their environment
- Constitute the decision-making tool relating to SP policies
- Serve as the national platform for information on SP activities, through a web portal, etc.

9. With the launch of the National Social Assistance Strategy (SNAS/EDE PEP)[44], in the course of 2012, Haitian authorities demonstrated their desire to strengthen the targeting of beneficiaries of social projects. This was through the establishment of a SBR. As outlined in the GoH's Action Plan for the Reduction of Extreme Poverty 2014-2016, the SBR initiated collaboration and consultation in 2014 between various actors and stakeholders of the sector. Some of the main actors include the WB, United Nations Development Program (UNDP), WFP, USAID, UNICEF, the European Union, the *Kore Lavi* Project, many NGOs and state institutions such as: FAES, the MAST, Ministries of Education, Health, the IHSI, National Identification Office (ONI) etc.

10. This led to the drafting of a SBR questionnaire to be used in carrying out surveys necessary for targeting beneficiaries.

[44] A final report on the SNAS/EDE PEP can be found at https://repositorio.cepal.org/bitstream/handle/11362/38232/1/S1500501_fr.pdf

11. In 2015, several partners, including the WB, UNDP and UNICEF, consolidated the SBR's position within FAES by making data available for 157,658 households in 20 communes of the country. They also provided support in the establishment of an SBR office within the institution, development of a beneficiary-targeting software as well as recruitment of a team of computer specialists to run the system. In the same vein, the PASMISSI Coordinator and a project Consultant went on a mission to Brazil, to learn about the functioning of Brazilian social programs, "*Bolsa Familia*" and "*Brasil sem Miséria*" and their social registry "*Cadastro Único*". This was with a view to implement the SBR to strengthen SP in Haiti.

### 3.2. *Obstacles and failures in developing the SBR in Haiti*

12. The conclusions of the mission report drawn up by FAES team in Brazil in 2015 foretold the failure in the implementation of the SBR in Haiti. Upon analyzing the state of Haiti's SP system compared to the Brazilian model, the authors of the report highlighted the main challenges and concluded that Haiti's SP system is weak, and in a nascent stage, characterized by:

1. Disjointed steps to promote more effective coverage of social services for the vulnerable and extremely poor population:
    - EDE PEP social assistance built the first elements to reach the population with social services, cash transfers and emergency services.
    - The KF project began to organize family support in the communes and to set up the foundation of a SBR, of which their SIIS (Integrated Social Information System) is the precursor.
    - The Ministry of Poverty Eradication (dissolved)
    - The Ministry of Peasantry (dissolved)
2. Poor governance in Haiti, resulting in the absence of:
    - A Government Roadmap for SP
    - A Government entity in charge of implementing, coordinating and steering SP
    - Strong Municipalities
    - Functional Social Services
    - A Social Registry (of vulnerable persons or beneficiaries)

13. While the EDE PEP and KF interventions were headed in the right direction, they were faced with two (2) major limitations:

- Unreliable Targeting: no baseline, which suggests that a large proportion of those vulnerable are not reached.
- No consultation or integration of actors: Interventions are still disparate and unconnected "activities", hence unsustainable once the project is over or funds used up.

## 4. RESTRUCTURING PASMISSI

14. From 2015 to 2017, interventions to implement the SSR culminated in the recruitment of the technical team, identification of service providers to develop the SSR software, and development of an operational action plan. However, the single registry could not be effective because of weaknesses associated with the poor appropriation of the process by the actors themselves and the lack of will and leadership on the part of the decision-makers at the time.

15. The reasons for restructuring PASMISSI are not clearly stated in the amendment to the Memorandum of Understanding signed between the WB and the GoH[45]. Although the poor availability of social services in the communes concerned has been mentioned, we presume that the decision to share the project components among several implementing agencies (MSPP, FAES, IHSI) could be explained by the aim to promote greater efficiency in achieving results.

16. Within the framework of the restructuring, the project has been divided into 3 components:

1. The health component managed by the PMU of the MSPP
2. The social component managed by FAES
3. The 'support to the last national census' component, managed by IHSI, via United Nations' Population Fund (UNFPA)

17. Thus, through this amendment, the changes made to the mandate of FAES aimed at establishing a SSR while strengthening the GoH's ability to manage this registry.

18. Unfortunately, following this restructuring, implementation of PASMISSI has slowed down significantly due to difficulties in integrating the SSR with other ongoing programs, particularly the SIMAST, implemented by the *Kore Lavi* project and executed by the WFP.

19. To easily remedy this situation, the WB deemed it necessary to support the project's coordination for reviewing the 2018-2019 Annual Action Plan. This was aimed at facilitating the integration of SIMAST activities into PASMISSI through two objectives: 1) Support the strengthening of SIMAST, 2) Support the drafting of the PNPPS document.

## 5. MAIN SUCCESSES OF PASMISSI

20. Despite delays in starting up, following the restructuring, some of the results achieved by PASMISSI can be considered achievements, as they contributed in strengthening of social sector governance in Haiti.

21. The first is the strengthening of SIMAST through its extension to two new communes in the North Department (Bahon, Limonade) and the use of this system by other institutions such as FAES and BSEIPH. Secondly, PASMISSI contributed to the continued operation of the MAST Social Protection Sectoral Table (SPST), a coordinating body for social sector interventions in Haiti, following the end of the *Kore Lavi* project on September 30, 2019.

22. Lastly, PASMISSI contributed greatly to the development, dissemination, and operationalization of the new PNPPS officially adopted by Haitian authorities.

[45] The Memorandum of Understanding for implementing PASMISSI was signed on June 14, 2013 and amended during the restructuring on May 3, 2017

## 6. MAIN ACHIEVEMENTS OF PASMISSI

### *6.1. Extension of SIMAST / National Coordination for Food Security (CNSA) surveys*

23. The SIMAST is the result of a series of reflections and discussions between sectoral ministries and national and international partners, all converging on the establishment of a reference database that can be used in SP and promotion interventions. Launched in 2013 as part of the "*Kore Lavi*" Food Security and Nutrition Support Program, SIMAST has received other financial support, notably from the USAID and the European Union, which have contributed enormously to its expansion and development. SIMAST was designed through household surveys conducted in 8 departments and 45 communes of the country.

24. SIMAST can be considered the precursor of the SSR because it has information on the most vulnerable households, taking into account data from the “National Vulnerability and Deprivation Index”. It is a key element for SP, as it compiles information on all households covered in the registered communes, providing the GoH and SP stakeholders with information on household vulnerability through the surveys conducted.

25. Following the Memorandum of Understanding signed with the CNSA in 2019, FAES assigned this institution with the task of conducting vulnerability surveys in 2 new communes in the country (Bahon and Limonade), thereby contributing to an increase of more than 14,042 households in SIMAST database for a total of 490,000 households. It should be noted that of the 300,000 households planned in the PASMISSI objectives, 275,000 have already been surveyed during the third year, for inclusion in SIMAST. This brings the total number of households surveyed and added to SIMAST database to 276,042.

### *6.2. Strengthening SIMAST*

#### *6.2.1. Hiring a consultant for the situational diagnosis of SIMAST*

26. With a view to ensure widespread use of SIMAST as a database to be consulted by various social actors, a consultant specialized in information technology was hired by PASMISSI to carry out a diagnostic study on how SIMAST can be extended to other institutions, particularly FAES and BSEIPH. The submitted report of the consultant highlights two important areas that need to be strengthened in order to achieve this objective. First, training staff on the use of SIMAST and second, providing institutions with the necessary computer equipment.

#### *6.2.2. Training and Capacity Building of SIMAST Staff*

27. The training of institutional staff (MAST, BSEIPH, FAES) on SIMAST was carried out in three separate sessions. The first session was held in Port-au-Prince, from March 3 to 7, 2020 and involved 20 staff. It aimed to empower staff with better knowledge on SIMAST for use at the level of these institutions. Following this training, a list of computer equipment needs was submitted to PASMISSI for distribution to 4 target institutions including the MAST, BSEIPH, FAES and the Social Assistance Fund (CAS). Table 1 below shows the computer equipment distributed to the institutions following SIMAST training.

**Table 1. Distribution of computer equipment for use by SIMAST**

| Category | MAST | BSEIPH | CAS | FAES | Total |
|---|---|---|---|---|---|
| Laptop | 8 | 3 | 0 | 15 | 26 |
| Desktop | 12 | 9 | 5 | 50 | 76 |
| Tablet | 15 | 2 | 0 | 0 | 17 |
| UPS | 12 | 9 | 5 | 34 | 60 |
| Scanner | 0 | 0 | 0 | 2 | 2 |
| USB external drive | 0 | 0 | 0 | 13 | 13 |

28. The second training session was held in Cap-Haitien from August 31 to September 2, 2020. It involved 13 computer technicians, executives of the departmental offices of the MAST in the North, Northwest, Northeast and Artibonite. The goal of the training was to strengthen the capacity of the departmental offices of the MAST to manage data on households registered in SIMAST, in order to ensure the monitoring of SP and promotion activities. This helped these executives to understand the functionalities of SIMAST for its optimal use. At the end of the training, a practical session on survey techniques for data collection on vulnerable households was held for them, in order to ensure that SIMAST database in their respective zones will be updated.

29. The third training session took place in Port-au-Prince from September 7 to 9, 2020 with the same objectives. It reached 20 technical staff from the departmental offices of the MAST in the West, South, Grande Anse, Southeast and Nippes.

#### *6.2.3. WFP technical support*

30. The role of the WFP in establishing and operating SIMAST remains crucial because this institution is one of the precursors of this system through the *Kore Lavi* project. Through a Memorandum of Understanding signed with WFP in January 2020, WFP carried out a series of interventions under PASMISSI to help the GoH strengthen the SIMAST and to finalize the plan to implement the PNPPS.

31. The main activities planned in this intervention contributed to achieving 2 main deliverables: *Development of SIMAST* and *Support to the PNPPS.*

32. Some of the main achievements of the WFP include:

**Deliverable 1.1: Info pages (SIMAST public page)**

- A consultant was hired to create a SIMAST public website for better access to data of the MAST information system, by actors involved in SP in Haiti.
- The consultant has completed his work by designing the website architecture.
- SIMAST team is currently working on the design of the website, and is making final adjustments, in order to arrive at a final and publishable version by October 1.
- The website is to be considered as a living tool and will be regularly updated by SIMAST team.

**Deliverable 1.2: Fuzzy Look up (Reconciliation algorithm for beneficiary lists)**

- WFP had difficulty finding a consultant. When one was identified recently, he could not be contracted within the project timeframe.
- WFP is therefore at the disposal of FAES and the WB to discuss possible options.

**Deliverable 1.3: Interactive Vulnerability Mapping**

- In collaboration with the National Center for Geospatial Information, several mapping modules have been integrated into SIMAST.
- These modules fall under six main risk categories (landslides, floods, collapses, seismic faults, marine submersions).
- This integration is a first step in the use of SIMAST in risk and disaster management, as it allows for the overlay of structural vulnerability of households with their vulnerability to natural hazards.

**Deliverable 1.4: SIMAST Visibility**

- SIMAST visibility products were delivered to WFP by Teddy Concept and include:
    - Popularization of SIMAST through images and texts, notably for sensitization of populations, communities and local authorities
    - An institutional factsheet
    - An institutional brochure
- WFP commented on these first versions, and the final products are expected by October 15.

**Deliverable 2.1: Finalize the PNPPS**

**Coordination**

- The PNPPS Drafting Sub-Committee was reactivated with a provisional mandate to develop the National Action Plan and coordinate the development of Departmental Action Plans*;*
- WFP provided technical support to the Secretariat of the SPST for the organization of the 24th and 25th meetings (July 17 and September 11);
- A methodology for the formulation of the National Action Plan of the PNPPS was drafted and proposed to the members of the SPST, on September 11, 2020;
- The methodology for the National Action Plan was presented at the meeting of the PNPPS Drafting Sub-Committee, before the formal launch of the work.

**Documents**

1. 50 copies of a beta version of the PNPPS were distributed to the MAST along with 50 copies of the executive summary in French;
2. Through the Decree of June 5, with its full force, the PNPPS was published in the official gazette, Le Moniteur.
3. 400 copies of the final PNPPS document and its executive summary have been printed and the distribution plan is to be defined jointly with the MAST;
4. 400 additional copies of the PNPPS document, 400 copies of the executive summary (French version) and 100 copies of the executive summary (English version) have been printed, and will be delivered with the first set of printouts;
5. 100 copies of the Economic Commission for Latin America and the Caribbean (ECLAC) report on costs of the PNPPS cash transfers have been printed;
6. 100 copies (50 in French and 50 in English) of the Study on Payment Platforms and Systems in Haiti (produced by Development Pathways) have been printed;
7. 100 copies of the report to Expand of the Budgetary Framework for the PNPPS (prepared by Mr. D. Dorsainvil) have been printed;

8. 30 copies of the document on the Legal Framework for the PNPPS, prepared by Barr. A. Guillaume, have been printed,
9. The graphic design of the following documents was completed: the PNPPS, summaries in English and French of the PNPPS, the report to expand the Budgetary Framework (D. Dorsainvil), the report on the Legal Framework (by Me Guillaume).

**Deliverable 2.2: Cost analysis and costs of the PNPPS**

- The report on the costs of cash transfer mechanisms was delivered by ECLAC and presented at various fora (Drafting Sub-committee, Webinar on Shock-Responsive SP);
- The report on the costs of additional mechanisms (excluding cash transfers) has not yet been delivered by ECLAC, mainly because the work on the costs of essential health services packages has taken longer. It is expected that the report will be delivered by October 30.
- Due to limited international travels caused by the COVID-19 pandemic, the ECLAC team could not come to Haiti.

**Deliverable 2.3: Study on Social Safety Nets**

- The study report presents:
    - The priorities identified by the PNPPS relating to vision and SP net, based on cash transfers and past experiences in these areas in Haiti or the region;
    - Strategic and operational directions for a SP and promotion program that can be implemented rapidly in Haiti;
    - The ideal institutional anchor for such a program;
    - The conditions for building, maintaining and expanding a sustainable SP and promotion system (information system, payment platform, M&E, accountability).

**Deliverable 2.4: Organization of a workshop on Shock-Responsive SP**

- A webinar on Shock-Responsive SP was organized on September 18, 2020, with more than 50 participants, representing State institutions (MAST, DGPC, FAES, international organizations and humanitarian actors).

  **This webinar presented:**
    - The strategic orientations set out in axis 4 of the PNPPS - Shock-Responsive SP and Promotion;
    - Good practices and regional experiences in the field and their applicability in the Haitian context;
    - Estimates on the cost of Shock-Responsive SP in Haiti;
    - Viable and innovative financing mechanisms that exist for Shock-Responsive SP

**Deliverable 2.5: Study on Payment Systems**

- The final report on the study of payment platforms and systems was completed and submitted to Dr. Boisrond (FAES) and Mr. Odney (MAST)
- The main findings of the study were presented to the SPST on September 11, 2020.

### *6.3. Training SIMAST Steering Committee*

33. Training of the steering committee did not start as per the PASMISSI model, although the terms of reference were discussed and submitted to the MAST. This situation can be explained by the presence of SIMAST thematic group, coordinated by WFP, which had already held several meetings, including at least two during the past year with the main actors planned for the committee. WFP is open to restructuring this thematic group in order to make it work more efficiently, in accordance with the needs of the MAST.

### *6.4. Support to consultation workshops for the development of the PNPPS*

34. The process to come up with the PNPPS is a vast undertaking, which the MAST and its partners have embarked on over the past three years. This process started with the training conducted by ECLAC from March 5 to 18, 2018 for the benefit of a core group of 50 staff from different partner institutions on SP with the aim to assist in the drafting process of the PNPPS.

35. At the end of the process, the MAST organized a series of national consultations with leaders and actors from the ten departments of the country (Departmental Directors, Mayors, CASEC, ASEC, Representatives of Associations and NGOs, and others), all of whom work at some level in the field of SP and promotion. These workshops were an opportunity to present the work already done on the issue, and the views on this work, used in drafting a document that is truly representative.

36. The consultations began on June 27 and 28, 2020, at Hotel Kinam in Port-au-Prince for the representatives of the Southeast, West and Central departments. They continued at *Université Publique du Sud Aux Cayes* (UPSAC), on July 02 and 03, for the delegates of the Southern Peninsula (South East, South and Nippes). They ended on July 09 and 10, at Villa Cana Inn, in Cap Haitien, with the delegates from the North (Northeast, Northwest, North and Artibonite).

37. In total, the six consultation sessions brought together one hundred and ninety-two (192) participants, including fifty-six (56) women. Among these participants, ten (10) were representatives from town halls, nine (9) were delegates from CASEC/ASEC associations, eighty-five (85) were emissaries from decentralized departments, and eighty-eight (88) were representatives from grassroots associations and NGOs.

38. The consultation workshops conducted in the West and South regions were fully supported by USAID through CARE International and those in the North by PASMISSI.

Photographs on PNPPS consultation workshops

### *6.5. Support in drafting a monitoring-evaluation framework for the PNPPS*

39. A consultant was hired by PASMISSI to provide technical support for the development of a monitoring-evaluation framework for the PNPPS. This was in order to meet the needs of the PNPPS Drafting Sub-committee for drafting the monitoring-evaluation chapter of the national policy document. Thanks to the report produced at the end of the consultation, it was possible to articulate the existing mechanisms and procedures in this area and to propose appropriate indicators for integration into the PNPPS document.

### *6.6. Support in the promotion and dissemination of the PNPPS*

40. Stratcom was selected through a consultation process to produce 3 specific deliverables. 1) A communication and advocacy plan for the PNPPS. 2) Training of 50 facilitators in the 10 departments of the country. 3) Production of communication materials to ensure popularization of the PNPPS.

41. As per Stratcom's communication and advocacy strategy, mechanisms and strategies are proposed based on target audiences, communication axes and on messages to be disseminated for promotion of the PNPPS.

42. As far as training is concerned, Stratcom has conducted two training sessions for fifty (50) multiplier agents at the level of the ten (10) geographical departments of the country. These trainings took place respectively from August 31 to September 2, 2020, in the North (Cap-Haitien) for departments of the North, Northeast and North-West, Center and Artibonite. From September 7 to 9, 2020, in the West (Port-au-Prince) for departments of the West, South, South East, Grande Anse and Nippes.

43. Through these training sessions, participants were empowered to develop and execute communication and advocacy plans on the PNPPS in their respective departments.

44. At the end of the training, each participant received materials to design the advocacy plan on the PNPPS as well as communication materials (leaflets, posters) to promote the PNPPS in their department.

45. Among the communication materials developed by Stratcom on the PNPPS and which are mostly distributed in departments and at the level of several central offices of ministries and partner organizations of the MAST, we can make mention of two hundred and fifty (250) personalized USBs, ten thousand (10,000) posters, ten thousand (10,000) flyers (French and Creole), 300 folders, and 15 roll up banners.

Poster of persons with disabilities.

### *6.7. Support in drafting steering departmental operational plans*

46. The PNPPS must now contribute to departmental plans that will subsequently be translated into communal plans for the implementation of activities based on structures provided for in the PNPPS.

47. The North and North-West departments were chosen as steering departments to initiate the elaboration of departmental plans. The project supported the recruitment of a national consultant whose mission was to identify the socio-economic environment of each of these departments and to propose plans that are both realistic and adapted to the new policy. This service also included identification of all actors involved in the field of SP in the different departments, assessment of their actions and proposals for a better articulation.

48. In his final report, the consultant presented a description of the intervention methodology, data collection tools and steps taken with stakeholders, both in the field and remotely (online), to conduct individual and focus group interviews. He also presented the analysis methodologies that were used in developing the steering operational plans. This experience can serve as a guide for the development of future departmental plans to operationalize the PNPPS. It is important to note that this process was interrupted because of the Covid-19 pandemic. As a result, strategies that were initially envisaged by the consultant had to be readapted.

### *6.8.* Support in the functioning of the SPST

49. The SPST, was launched in April 2016, under the distinguished patronage of the Prime Minister in order to mobilize all actors operating in the field of SP in Haiti and assess and harmonize their actions. The role is, among others, to:

- Contribute in outlining a PNPPS;
- Contribute in developing and monitoring sectoral policies and strategies;
- Support the MAST PIU in its role of ensuring coherence between investment plans, programs and projects in the area of SP;
- Encourage programming and co-financing initiatives;
- Monitor donor-commitments;
- Avoid repetition in actions while promoting the efficient SP interventions

50. Management and coordination of activities of the Sectoral Table are carried out by a Secretariat composed of:

- A coordinator (The Director of Studies and Programming at the MAST)
- A technical advisor
- An administrative assistant
- A communication assistant

51. Financially supported since its creation by WFP and CARE International, through the *Kore Lavi* project, the functioning of this institution suffered with the end of this project in September 2019. PASMISSI will therefore be responsible for this body from October 1, 2019 to June 30, 2021, by providing the salaries of the SPST Technical Advisor, providing technical and financial assistance for the realization of 10 SPST monitoring meetings as well as meetings to elaborate the PNPPS document.

### *6.9.* Support in drafting the FAES Strategic Plan

52. As stated in the objectives of PASMISSI, strengthening FAES is one of the priorities that should help empower the GoH in ensuring better management, coordination, and monitoring of the SSR. The needs of FAES in the light of

this support are clearly described in the TOR for hiring the consultant who will develop the institution's five-year strategic plan for 2020-2025. Through this plan, FAES should be able to put in place mechanisms that will lead to the following results:

- Strengthening the capacity of FAES and its modernization
- Strengthening FAES to better carry out its support mission through appropriate communication with citizens and by helping them to better interact with FAES
- Helping FAES to mobilize and organize all internal and external resources in an optimal manner, in order to better strengthen its capacity

53. Despite delays caused by the Covid-19 pandemic, the consultant submitted the final version of the strategic plan after two discussion and validation working sessions with FAES staff. After analyzing the external context in relation to some of the major challenges of the day (increase in the incidence of poverty, decrease in official development assistance, impact of Covid-19, natural and socio-political shocks, etc.) and the internal context of the institution, this report presented the 2020-2025 strategies for FAES. These strategies were articulated around a vision in which FAES shall become a prime enforcement agency for the GoH that is agile, and efficient. They are also based on five pillars: poverty reduction, economic recovery, strengthening local governance, knowledge management and learning, and institutional strengthening.

54. It should be noted that this plan helps the institution to better guide its results when drafting its new Operations Manual.

55. **Note on comments received by FAES regarding the ICR:** FAES has reviewed the ICR document and proposed a few clarifications that were included in its revised final version, with the exception of the suggested mention of an improvement in the FM of the project in the last years of implementation, which was deemed inaccurate by the project team.

## 7. MAIN CONSTRAINTS

56. Prior to the 2017 restructuring, PASMISSI faced a major shortage of social services, in the communes concerned, to work with health services provided by the project. This was compounded by weaknesses in project governance between the then FAES administration and implementing NGOs. This explained some delays recorded in clarifying several financial reports that were deemed non-compliant by the WB in 2019.

57. From 2018-2019 the political situation in the country deteriorated with violent protests and burning barricades. This situation, commonly referred to as “Pays Lock”, disrupted the normal functioning of institutions, limited travel and prevented the conduct of any training activities or workshops for at least 6 weeks. However, if it is true that the political climate of the country began returning to normal between the end of 2019 and the beginning of 2020, the Covid-19 epidemic that broke out in March 2020 paralyzed activities in the field for at least 3 months through the health emergency declared by the GoH to prevent the spread of the disease. Thus, several field activities such as CNSA surveys, training sessions, development of departmental plans, etc. were temporarily halted. When resumed later, some strategies underwent changes aimed at complying with Covid-19 protection and prevention measures.

## 8. LESSONS LEARNED

*Although the conditions for implementing PASMISSI were difficult, the following lessons were learned:*

- For project implementation, there is always a need for proper planning and negotiation with stakeholders, particularly the MAST, which developed SIMAST with WFP while FAES was setting up the SSR. This did not facilitate the development of the SSR.
- Although SIMAST does not currently comply with all criteria for a SSR, it is a precursor to it, which must be strengthened in order to achieve this objective.
- The flexibility of the WB has helped PASMISSI to adapt in order to play its role in strengthening the MAST through support in developing SIMAST
- The commitment and leadership of the new FAES administration has contributed greatly to facilitating the achievement of PASMISSI results
- Projects are likely to be affected by climatic and socio-political hazards that must be considered during the planning phase.

## 9. CONCLUSION

58. The Project titled: “Improving Maternal and Child Health through Integrated Social Services” (PASMISSI) has had the merit of laying the groundwork for a solution to one of the major problems, which the GoH faces in implementing social projects in Haiti, which is accurate household identification. Although the SSR has not been efficient, as is the case with other countries in the region, the PASMISSI project has contributed to laying the foundation for developing SIMAST. This has been through the transfer of household data to SIMAST database following surveys conducted at the beginning of the project in the intervention communes, as well as by supporting the expansion of SIMAST through household surveys conducted in two new communes in the country during the past year, thereby contributing to the growth of this database. Other important PASMISSI support, such as for operationalizing the SPST, developing the PNPPS and steering departmental plans, etc., have helped build bridges for more effective SP programs in the future. Through the implementation of the steering activities, PASMISSI will be credited with having contributed in achieving experiences that can serve as a guide for future social interventions.

**MAIN ACHIEVEMENTS BY PASMISSI as of September 30, 2020**

| Activities | Descriptions | Achievement | Mode of verification |
|---|---|---|---|
| **1. Creation of the Single Social Registry** | | | |
| Conduct SIMAST surveys in two (2) new communes Bahon and Limonade. | To extend SIMAST | Surveys conducted on 14,042 households in the 2 communes and data integrated into SIMAST. A total of 276,042 households added to SIMAST database out of a planned 300,000. | Data on the 2 new communes available on SIMAST |
| Train institutional staff (IBESR, BSEIPH, CAS, FAES etc.) on the use of SIMAST. | Training for a more appropriate use of SIMAST | 20 staff members at the central level trained on the use of SIMAST.<br>33 departmental executives trained on SIMAST. | Training report available |
| Purchase equipment and materials to strengthen SIMAST computer system. | More appropriate use of SIMAST | Distribution of computer equipment (11 laptops, 26 desktops, 17 tablets, 26 UPS). | Report on the distribution of materials available |
| WFP TA for the extension of SIMAST and finalization of the PNPPS. | | Tools and materials to strengthen SIMAST and finalize the PNPPS have been produced | WFP report available |
| **2. MAST support in coordinating the social sector** | | | |
| Technical and financial support for the functioning of SIMAST steering committee (MAST, FAES, WFP, BSEIPH, IDB, EU, etc.). | The committee will follow up on the development of SIMAST | A SIMAST thematic group coordinated by WFP is operational (2 meetings held) | Meeting reports |
| Salary of the technical advisor of the SPST | For a resumption of the SPST | The SPST technical advisor has been hired by the project for 10 months | Recruitment contract of the SPST Advisor available |
| Financial support for the coordination meetings of the SPST. | To ensure the SPST is operational (1 meeting/month) | The SPST meeting has been held online / a physical meeting is being planned | The SPST meeting report available |
| **3. MAST support in drafting the PNPPS** | | | |
| Financial support for conducting the MAST multi-sectoral consultation workshops to finalize the PNPPS. | Conduct at least 2 other workshops. | Financial support provided for conducting a consultation workshop on the PNPPS in the North involving 61 persons, 42 of whom were men and 19 women. | Workshop report available |
| Technical and financial support for the process to elaborate departmental PNPPS plans. | 3 months pay | A consultant hired and departmental steering plans in the Northwest and North drafted | Departmental steering operational plans available |
| Training in SP and Promotion for social sector personnel in 4 departments. | Accommodation, transportation, per diem, fuel, hall rental for 40 persons in 4 departments for 3 days. | Training conducted in two departments, the North-West and the North, involving 50 staff. | Training report available |

| | | | |
|---|---|---|---|
| Hiring a firm to support the implementation of a communication and advocacy plan on the PNPPS. | Fees and other indirect costs (materials, travel expenses and others). | Production by STRATCOM of an advocacy plan for the PNPPS, training of 50 PNPPS extension agents, production of awareness materials (leaflets, posters, USB keys, etc.) for the promotion of the PNPPS / Distribution of 50% of the materials to various ministries and partner institutions | Delivery note for the MAST sensitization material.<br>The PNPPS communication and advocacy strategy available<br>Training report available<br>Communication material available |
| Financial support for sensitization and advocacy sessions at the national level. | Accommodation, transportation, per diem, fuel, hall rental, vehicle rental, snacks for 8 meetings in the 4 departments | Not planned due to COVID-19/ sessions will be scheduled for all 10 departments during training by Stratcom. | Training report available |
| Training workshops on SIMAST SP, and dissemination of the PNPPS in FAES regional offices | Accommodation, transportation, per diem, fuel, hall rental, vehicle rental, snacks in 6 departments | Participation of FAES staff in the sessions conducted in the Northwest and North.<br><br>Joint planning with the MAST for the Center and Southern departments. But not done due to COVID-19. | Training report available |
| 4. **Institutional strengthening of FAES** | | | |
| Hiring a consultant to conduct a strategic analysis for FAES | fees and other costs for the restitution workshop | Consultant hired, strategic analysis conducted/ report submitted | FAST Strategic Plan Report available |
| Purchase supplies and materials for the FAST computer system | Purchase of computer equipment | Distribution to FAES of 15 laptops, 50 desktops, 34 UPS and 2 scanners | Distribution report available |
| Support for the operation of FAES | | Support to the operation of FAES | Financial report submitted to WB |

## ANNEX 6. SIGNIFICANT CHANGES DURING IMPLEMENTATION

1. There were significant changes introduced during the operation's lifetime in response to the changing external implementation environment, including Hurricane Matthew, the continuous threat posed by cholera and significant fluctuations in donors' contributions. The main changes can be summarized as follows:

2. *Level 2 restructuring - March 2017* - Although the PDO remained unchanged, this restructuring introduced considerable modifications to the operation's design and implementation framework to reflect the country's evolving needs and priorities. Specific changes under this restructuring included:

- SP activities provided by the *KF* (KF) network were eliminated as a result of severe cuts in SP programs due to lack of funding. Thus, the original Subcomponent 2.1 was eliminated with funds being reallocated except for US$2.5 of past disbursements; KF-related PDIs and IRIs were dropped. SP activities under Subcomponent 2.2 were limited to support for the development of a national social registry in Haiti.
- Activities to combat cholera were given higher priority and strengthened given the heightened risk of outbreaks as a result of the flooding and destruction caused by Hurricane Matthew. Cholera activities previously under Subcomponent 1.1 were moved to a new Subcomponent 2.1; additional funds were allocated; additional cholera-related PDI and IRIs indicators were added.
- A new Subcomponent 1.3 was added for Contingent Emergency Response (CER) to improve the country's response capacity in the event of an emergency by ensuring the immediate availability of funds.
- A new Component 3 (Piloting Vulnerability Indicators for More Targeted Social Service Delivery) was added aimed at piloting the calculation of vulnerability indicators, a key step in targeting the vulnerable in the delivery of social services. To achieve this objective, it also provided support to the IHSI in preparing the Fifth Demographic and Housing Census, particularly piloting the census in four departments. The IHSI, under the supervision of the MEF, was responsible for the implementation of component activities, with TA and management services provided by the UNFPA.
- Other modifications included: i) revision of the PRF, including changes in the PDO indicators (see Table 6.1); ii) changes in Project components (see Table 6.2); iii) reallocation of proceeds from the IDA Grant and TF No. 14474; iv) revision of legal covenants; v) extension to the closing dates of the IDA Grant and TF 14474 by 12 months to December 31, 2019; and (vi) expansion of implementation and institutional arrangements to include the UNFPA to provide fiduciary services for activities under Component 3.

**Table 6.1. Changes in PDO Indicators (PDIs)**

| Original PDIs | | Revised PDIs March 2017 | | Revised PDIs June 2017 | |
|---|---|---|---|---|---|
| **PDI 1.** | Children under five immunized | **PDI 1.** Children under five immunized | *No change* | **PDI 1.** Children under five immunized | *No change* |
| **PDI 2.** | Institutional deliveries | **PDI 2.** Institutional deliveries | *No change* | **PDI 2.** Institutional deliveries | *No change* |
| **PDI 3.** | Contraceptive prevalence rate | **PDI 3.** Contraceptive prevalence rate | *No change* | **PDI 3.** Contraceptive prevalence rate | *No change* |
| **PDI 4.** | Families categorized as extremely vulnerable | -- | *Dropped* | | |
| | | **PDI 4.** Cholera fatality rate | *Added* | **PDI 4.** Cholera fatality rate | *No change* |
| | | | | **PDI 5.** Pilot census carried out | *Added* |

3. *AF and Level 1 restructuring - June 2017* - An AF for US$25 million was approved on June 14, 2017 as part of a package of a US$100 million of support from the WB to help the GoH recover and rebuild after Hurricane Matthew. The AF provided financial support for Hurricane response activities in the affected areas, mainly: i) to restore the quality and supply of health services 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 also filled the financing gap created under the Original Grant to finance emergency response activities immediately after Hurricane Matthew. Table 6.2 shows the allocation of AF funds. Concomitantly, a Level 1 restructuring was carried out to reflect the changes made under the AF, including: i) revise the PDO and PRF to reflect the expanded geographical coverage and emergency response objectives; ii) activate new safeguards policies;[46] and iii) add a new disbursement category for potential compensation of affected individuals under OP/BP 4.12.

**Table 6.2. Changes in Project Components**

| | |
|---|---|
| ▪ Subcomponent 1.2 (Results-oriented support for poor and vulnerable families) eliminated due to termination of SP activities under the *KF* network.<br>▪ New Subcomponent 1.2 (Prevention and treatment of cholera) added to include cholera-related activities previously under Subcomponent 1.1.<br>▪ New Subcomponent 1.3 (Contingent emergency response) added to ensure the availability of contingency financing in case of emergency.<br>▪ Subcomponent 2.2 (Strengthening SP coordination and management) modified to focus solely on the development of Social Registry.<br>▪ New Component 3 (Piloting vulnerability Indicators) added to support the piloting of the Housing census and vulnerability indicators. | ▪ Subcomponent 1.1 (Performance-based Maternal and Child Health and Nutrition Service Delivery) with an additional US$9.5 million from the AF to expand coverage to areas affected by Matthew.<br>▪ Subcomponent 1.2 (Prevention and treatment of cholera and other diarrheal diseases) with an additional US$13.5 million from AF to expand activities in areas affected by Matthew and fill financing gap from emergency response after Hurricane Matthew.<br>▪ Subcomponent 2.1 (Strengthening MSPP's Stewardship and Management Capacity) with an additional US$2 million from the AF for M&E of Project activities in areas affected by Matthew. |

4. *Level 2 Restructuring - December 2019* - This restructuring addressed the implementation delays caused by ongoing social and political unrest and aimed to ensure the full utilization of the grant proceeds. The specific modifications included: i) extension of the closing date by three months--from December 31, 2019 to March 31, 2020; ii) the transfer of the key health activities with continuous support under the follow-on operation (P167512 - PROSYS) and iii) the reallocation of funds between disbursement categories under the Project's original IDA grant (IDA- H8640) to ensure the completion of pending Project activities managed by FAES (i.e., the finalization of the National SP Strategy and SIMAST) and the financing of civil works and activities supported by this operation and implemented by UN agencies.

5. *Level 2 Restructuring - March 2020* - This restructuring aimed to support the MSPP's efforts to address the COVID-19 pandemic. The specific modification included: i) a six-month extension --from March 31, 2020 to September 30, 2020; and ii) the reallocation of funds between disbursement categories under the Project's original IDA grant (IDA- H8640) from unused FAES funds to the MSPP-implemented activities to support the MSPP's capacity to address the pandemic.

[46] 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).

**Table 6.3 Significant Changes Introduced during Implementation**

| Type | L2 Restructuring | L1 Restructuring + AF | L2 Restructuring | L2 Restructuring |
|---|---|---|---|---|
| **Date** | March 2017 | June 2017 | December 2019 | March 2020 |
| **Cumulative Disbursements** | | | | |
| • US$ Million | 30.95 | 30.95 | 97.05 | 107.55 |
| • % Total Actual Disbursements | 0.28 | 0.28 | 0.89 | 0.98 |
| **Changes to:** | | | | |
| • PDO | -- | Yes | -- | -- |
| • PDO Indicators | Yes | Yes | -- | -- |
| **Other changes:** | | | | |
| • Closing Date | Yes | -- | Yes | Yes |
| • Safeguards | -- | Yes | -- | -- |
| • Project Components and Costs | Yes | Yes | -- | -- |
| • Institutional arrangements | Yes | -- | -- | -- |
| • Disbursement Categories | Yes | -- | Yes | Yes |