



THE WORLD BANK
IBRD • IDA | WORLD BANK GROUP

FOR OFFICIAL USE ONLY

Report No: PAD2944

INTERNATIONAL DEVELOPMENT ASSOCIATION

PROJECT APPRAISAL DOCUMENT

ON A

PROPOSED IDA GRANT

IN THE AMOUNT OF SDR 39.7 MILLION

(US\$55 MILLION EQUIVALENT)

AND A

PROPOSED GLOBAL FINANCING FACILITY GRANT

IN THE AMOUNT OF US\$15 MILLION

TO THE

REPUBLIC OF HAITI

FOR THE

STRENGTHENING PRIMARY HEALTH CARE AND SURVEILLANCE IN HAITI PROJECT

APRIL 25, 2019

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

This document is being made publicly available prior to Board consideration. This does not imply a presumed outcome. This document may be updated following Board consideration and the updated document will be made publicly available in accordance with the Bank's policy on Access to Information.

CURRENCY EQUIVALENTS

(Exchange Rate Effective March 31, 2019)

Currency Unit = Haitian Gourdes

US\$1 = 84.10 HTG

US\$1 = SDR 0.7203

FISCAL YEAR

October 1 - September 30

Regional Vice President: Axel van Trotsenburg

Country Director: Anabela Abreu

Senior Global Practice Director: Timothy Grant Evans

Practice Manager: Daniel Dulitzky

Task Team Leader: Andrew Sunil Rajkumar

ABBREVIATIONS AND ACRONYMS

CDAI	Departmental Center for Supply of Inputs (<i>Centre Départemental d'Approvisionnement en Intrants</i>)
CDC	Centers for Disease Control and Prevention
CERC	Contingent Emergency Response Component
CHE	Current Health Expenditure
CHSIP	Community Health Strategy and Implementation Plan
CHWs	Community Health Workers
CNP	National Steering Committee for Results-Based Financing (<i>Comité National de Pilotage</i>)
CPF	Country Partnership Framework
DA	Designated Account
DDS	Departmental Health Directorate (<i>Direction Départementale Sanitaire</i>)
DELR	Directorate for Epidemiology, Laboratory and Research (<i>Direction d'épidémiologie, de Laboratoire et de Recherches, MSPP</i>)
DHS	Demographic and Health Survey
DPSPE	Directorate for Health Promotion and Protection of the Environment, at MSPP (<i>Direction de la Promotion de la Santé et de la Protection de l' Environnement</i>)
ESMF	Environmental and Social Management Framework
EVA	External Verification Agency (<i>Agence Externe de Vérification</i>)
FM	Financial Management
GAVI	Global Alliance for Vaccines and Immunization
GDP	Gross Domestic Product
GFF	Global Financing Facility
HF	Health Facility
HFA	Health Financing Assessment
IC	Investment Case
IDA	International Development Association
IFR	Interim Unaudited Financial Report
IRR	Internal Rate of Return
LICs	Low-Income Countries
LNSP	National Laboratory of Public Health (<i>Laboratoire National de Santé Publique</i>)
MESI	Monitoring Evaluation et Surveillance Intégrée
MSPP	Ministry of Public Health and Population (<i>Ministère de la Santé Publique et de la Population</i>)
NCHW	Non-Polyvalent Community Health Worker (<i>Agent de Santé Communautaire Non-Polyvalent</i>)
NGOs	Non-Governmental Organizations
NPV	Net Present Value
PAHO	Pan American Health Organization
PASMISSI	Improving Maternal and Child Health through Integrated Social Services (<i>Projet d'Amélioration de la Santé Maternelle et Infantile à travers des Services Sociaux Intégrés</i>)
PCHW	Polyvalent Community Health Worker (<i>Agent de Santé Communautaire Polyvalent</i>)
PDO	Project Development Objective

PES	Package of Essential Services
PHC	Primary Health Care
PHCPI	Primary Health Care Performance Initiative
PPSD	Project Procurement Strategy for Development
RAP	Resettlement Action Plan
RARP	Haiti Rural Accessibility and Resilience Project (<i>Projet d'Accessibilité et de Résilience Rurale en Haïti</i>)
RBF	Results-Based Financing
RFB	Request for Bids
RFP	Request for Proposals
RGAP	Regional Gender Action Plan
RMCHN	Reproductive, Maternal and Child Health and Nutrition
RMS	Results Measurement System
RPF	Resettlement Policy Framework
SISNU	National Health Information System (<i>Système d'Information Sanitaire National Unique</i>)
SPA	Service Provision Analysis
TA	Technical Assistance
TBAs	Traditional Birth Attendants
TVM	Time Value of Money
UC	Contracting Unit, at MSPP (<i>Unité de Contractualisation</i>)
UEP	Unit of Studies and Programming at MSPP (<i>Unité d'Etudes et de Programmation</i>)
UGP	Project Management Unit (<i>Unité de Gestion de Projet</i>)
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization
WB	World Bank



TABLE OF CONTENTS

DATASHEET i

I. STRATEGIC CONTEXT 1

 A. Country Context..... 1

 B. Sectoral and Institutional Context 1

 C. Relevance to Higher Level Objectives..... 5

II. PROJECT DESCRIPTION..... 6

 A. Project Development Objective 6

 B. Project Components 6

 C. Project Beneficiaries 11

 D. Results Chain 12

 E. Rationale for Bank Involvement and Role of Partners 12

 F. Lessons Learned and Reflected in the Project Design 13

III. IMPLEMENTATION ARRANGEMENTS 14

 A. Institutional and Implementation Arrangements 14

 B. Results Monitoring and Evaluation Arrangements..... 15

 C. Sustainability..... 15

IV. PROJECT APPRAISAL SUMMARY 16

 A. Technical, Economic and Financial Analysis 16

 B. Fiduciary..... 17

 C. Safeguards 18

V. KEY RISKS 21

VI. RESULTS FRAMEWORK AND MONITORING 23

ANNEX 1: Implementation Arrangements and Support Plan 32

ANNEX 2: Findings from Diagnostic Work and Results Under Ongoing Health Project 42

ANNEX 3: Detailed Description of Project Activities 45

ANNEX 4: Economic and Financial Analysis..... 52



DATASHEET

BASIC INFORMATION

Country(ies)	Project Name	
Haiti	Strengthening Primary Health Care and Surveillance in Haiti	
Project ID	Financing Instrument	Environmental Assessment Category
P167512	Investment Project Financing	B-Partial Assessment

Financing & Implementation Modalities

<input type="checkbox"/> Multiphase Programmatic Approach (MPA)	<input checked="" type="checkbox"/> Contingent Emergency Response Component (CERC)
<input type="checkbox"/> Series of Projects (SOP)	<input checked="" type="checkbox"/> Fragile State(s)
<input type="checkbox"/> Disbursement-linked Indicators (DLIs)	<input type="checkbox"/> Small State(s)
<input type="checkbox"/> Financial Intermediaries (FI)	<input type="checkbox"/> Fragile within a non-fragile Country
<input type="checkbox"/> Project-Based Guarantee	<input type="checkbox"/> Conflict
<input type="checkbox"/> Deferred Drawdown	<input type="checkbox"/> Responding to Natural or Man-made Disaster
<input type="checkbox"/> Alternate Procurement Arrangements (APA)	

Expected Approval Date	Expected Closing Date
16-May-2019	31-Dec-2024

Bank/IFC Collaboration

No

Proposed Development Objective(s)

The PDO of the proposed Project is to: (i) increase utilization of primary health care services in selected geographical areas; and (ii) strengthen surveillance capacity especially for cholera.



Components

Component Name	Cost (US\$, millions)
Strengthening Primary Health Care Service Delivery	44.00
Strengthening Surveillance and Control for Infectious Diseases	22.00
Supporting Project Management and Implementation Support	4.00
Contingent Emergency Response Component	0.00

Organizations

Borrower: Republic of Haiti
 Implementing Agency: Ministère de la Santé Publique et de la Population

PROJECT FINANCING DATA (US\$, Millions)

SUMMARY

Total Project Cost	70.00
Total Financing	70.00
of which IBRD/IDA	55.00
Financing Gap	0.00

DETAILS

World Bank Group Financing

International Development Association (IDA)	55.00
IDA Grant	55.00

Non-World Bank Group Financing

Trust Funds	15.00
Global Financing Facility	15.00



IDA Resources (in US\$, Millions)

	Credit Amount	Grant Amount	Guarantee Amount	Total Amount
National PBA	0.00	55.00	0.00	55.00
Total	0.00	55.00	0.00	55.00

Expected Disbursements (in US\$, Millions)

WB Fiscal Year	2019	2020	2021	2022	2023	2024	2025
Annual	0.15	5.55	6.70	12.90	19.80	19.40	5.50
Cumulative	0.15	5.70	12.40	25.30	45.10	64.50	70.00

INSTITUTIONAL DATA

Practice Area (Lead)

Health, Nutrition & Population

Contributing Practice Areas

Climate Change and Disaster Screening

This operation has been screened for short and long-term climate change and disaster risks

Gender Tag

Does the project plan to undertake any of the following?

a. Analysis to identify Project-relevant gaps between males and females, especially in light of country gaps identified through SCD and CPF	Yes
b. Specific action(s) to address the gender gaps identified in (a) and/or to improve women or men's empowerment	Yes
c. Include Indicators in results framework to monitor outcomes from actions identified in (b)	Yes

SYSTEMATIC OPERATIONS RISK-RATING TOOL (SORT)

Risk Category	Rating
1. Political and Governance	● High



2. Macroeconomic	● High
3. Sector Strategies and Policies	● Substantial
4. Technical Design of Project or Program	● Substantial
5. Institutional Capacity for Implementation and Sustainability	● Substantial
6. Fiduciary	● High
7. Environment and Social	● Moderate
8. Stakeholders	● Moderate
9. Other	● Substantial
10. Overall	● Substantial

COMPLIANCE

Policy

Does the project depart from the CPF in content or in other significant respects?

Yes No

Does the project require any waivers of Bank policies?

Yes No

Safeguard Policies Triggered by the Project	Yes	No
Environmental Assessment OP/BP 4.01	✓	
Performance Standards for Private Sector Activities OP/BP 4.03		✓
Natural Habitats OP/BP 4.04		✓
Forests OP/BP 4.36		✓
Pest Management OP 4.09	✓	
Physical Cultural Resources OP/BP 4.11	✓	
Indigenous Peoples OP/BP 4.10		✓
Involuntary Resettlement OP/BP 4.12	✓	
Safety of Dams OP/BP 4.37		✓



Projects on International Waterways OP/BP 7.50	✓
Projects in Disputed Areas OP/BP 7.60	✓

Legal Covenants

Sections and Description

IDA Financing Agreement Schedule 2 Section IV.1 and GFF Grant Agreement Schedule 2 Section IV.1: No later than one (1) month before the beginning of each fiscal year, the Recipient shall prepare and furnish an annual work plan (Annual Work Plan) for that fiscal year, satisfactory to the Association, including the activities to be carried out under the Project during said fiscal year. Said Annual Work Plan may be modified from time to time during the fiscal year, with prior approval of the Association.

Sections and Description

IDA Financing Agreement Schedule 2 Section IV.2 and GFF Grant Agreement Schedule 2 Section IV.2: No later than six (6) months after the Effective Date, the Recipient shall develop and furnish to the Association the Community Health Strategy and Implementation Plan referred to in Part 1(b) of the Project, all in a manner acceptable to the Association.

Conditions

Type	Description
Disbursement	IDA Financing Agreement Schedule 2 Section III.B.1 (b) and GFF Grant Agreement Schedule 2 Section III.B.1 (b): Notwithstanding the provisions of Part A, no withdrawal shall be made for payments made under Category (3) unless and until the Recipient has hired the Independent Verification Agency in a manner acceptable to the Association.
Disbursement	IDA Financing Agreement Schedule 2 Section III.B.1 (c): Notwithstanding the provisions of Part A, no withdrawal shall be made for payments made under Category (4) for Emergency Expenditures under Part 4 of the Project, unless and until the Association is satisfied, and has notified the Recipient of its satisfaction, that all of the following conditions have been met in respect of said Emergency Expenditures: (i) the Recipient has determined that an Eligible Emergency has occurred, has furnished to the Association a request to include said Eligible Emergency under Part 4 of the Project in order to respond to said Eligible Emergency, and the Association has agreed with such determination, accepted said request and notified the Recipient thereof; (ii) the Recipient has prepared and disclosed all safeguards instruments required for said Eligible Emergency, and the Recipient has implemented any actions which are required to be taken under said instruments, all in accordance with the provisions of Section I.D.1 of this Schedule; (iii) the Coordinating Authority has adequate staff and resources, in accordance with the provisions of Section I.D.1(b) of this Schedule, for the



	<p>purposes of said activities; and (iv) the Recipient has adopted the Emergency Response Operations Manual in form, substance and manner acceptable to the Association and the provisions of the Emergency Response Operations Manual are fully current in accordance with the provisions of Section I.D of this Schedule, so as to be appropriate for the inclusion and implementation Part 4 of the Project.</p>
Type Disbursement	<p>Description GFF Grant Agreement Schedule 2 Section III.B.1 (c): Notwithstanding the provisions of Part A of this Section, no withdrawal shall be made for payments made under Category (1) and (3) unless and until the Recipient has developed and furnished to the Association: (i) the Resource Tracking Mechanism referred to in Part 3(b)(ii) of Schedule 1 to this Agreement; and (ii) the Rationalization of Human Resources Plan referred to in Part 3(b)(iv) of Schedule 1 to this Agreement; all in a manner acceptable to the Association.</p>
Type Disbursement	<p>Description IDA Financing Agreement Schedule 2 Section III.B.1 (d): Notwithstanding the provisions of Part A, no withdrawal shall be made for payments made under Category (5) unless the pertinent RAP has been prepared, consulted, adopted and published by the Recipient in form and substance satisfactory to the Association, and in accordance with Section I.E of this Schedule.</p>
Type Effectiveness	<p>Description IDA Financing Agreement Article IV: The GFF Grant Agreement has been executed and delivered and all conditions precedent to its effectiveness (other than the effectiveness of this Agreement) have been fulfilled.</p>
Type Effectiveness	<p>Description GFF Grant Agreement Article IV: The execution and delivery of the GFF Agreement on behalf of the Recipient have been duly authorized or ratified by all necessary governmental action.</p>
Type Effectiveness	<p>Description GFF Grant Agreement Article IV: The IDA Financing Agreement has been executed and delivered and all conditions precedent to its effectiveness (other than the effectiveness of this Agreement) have been fulfilled.</p>



I. STRATEGIC CONTEXT

A. Country Context

1. **Despite advances in recent years, Haiti's economic growth has recently slowed substantially, and poverty remains high.** Due to the country's long history of political instability, repeated fiscal crises, and extreme vulnerability to a wide range of shocks, slow economic growth punctuated by frequent contractions has yielded an annual per capita income equivalent to just US\$760 (or US\$1,815 in purchasing-power-parity terms). After a spurt following the 2010 earthquake, gross domestic product (GDP) growth slowed in 2014, reached only 1.2 percent in 2017 and stalled at 1.5 percent in 2018. Between 2000 and 2012, the proportion of people living in extreme poverty declined from 31 percent to 24 percent (based on purchasing-power-parity). But poverty remains widespread, and the poverty headcount at the national poverty line is about 59 percent, reaching as much as 75 percent in rural areas and contributing to persistently poor health outcomes (see below).

2. **While macroeconomic stability was broadly preserved in the years immediately after the 2010 earthquake, a combination of domestic and external factors – including steadily falling levels of international aid – has substantially widened the fiscal deficit.** The fiscal deficit was reduced just after the earthquake, with the help of substantial donor assistance; at the same time, inflation was kept in check. But the return of international aid to pre-earthquake levels intensified fiscal pressure. Donor assistance fell from 15.8 percent of GDP in 2010 to 4.6 percent in 2017. Reduced donor support and the end of the *Petrocaribe*¹ arrangement (financed by Venezuela) are compounding Haiti's underlying fiscal vulnerabilities. Delays in the approval of the Government budget at the beginning of each fiscal year aggravate the already low predictability of public expenditure across ministries and their capacity to plan.

3. **Haiti continues to be vulnerable to recurrent natural disasters and climate change exacerbates these risks.** The projected impacts of climate change for Haiti include an increase in average temperatures of 0.5°C to 2.3°C by 2060, with the warming expected to be most marked from December to February. These impacts, coupled with predicted changes in precipitation patterns and likely rainfall decreases from June to August, are expected to increase the frequency, intensity and impacts of extreme weather events in the country, including hurricanes, storm surges, and flooding. The latest major disaster happened in October 2016 when Hurricane Matthew struck Haiti, affecting over two million people. The cholera outbreak that followed spread to the Southern departments and the Northwest and was only controlled after several months of intensified efforts. Post-hurricane reconstruction needs were assessed at 25 percent of GDP, or US\$2.2 billion. Public expenditure increased to meet post-Matthew reconstruction needs, but resource mobilization continues to be a challenge.

B. Sectoral and Institutional Context

4. **Haiti's health outcomes are poor, even when compared to other low-income countries (LICs), and progress has been limited during the last 10 years.** Haiti fares especially poorly with immunization coverage and deliveries at health facilities (HFs), with high inequalities across wealth quintiles (Table 1). Child mortality

¹ An Energy Cooperation Agreement initiated by the Government of Venezuela to provide a preferential payment arrangement for petroleum and petroleum products to some Caribbean and Latin American countries.



has fallen over the last decade, but infant mortality has not changed much, and neonatal mortality has risen from 25 to 32 per 1,000 live births. Maternal mortality per 100,000 live births increased from an estimated 523 in 2005 to 646 in 2016 (not statistically significant due to the sample size). Over the same period, the rate of fully vaccinated children has been stagnating at around 40 percent (and declined to 30 percent for children in the lowest wealth quintile), which has contributed to outbreaks of preventable diseases, particularly diphtheria. Poor health outcomes are linked to persistent poverty, poor access and quality of care, inadequate community engagement (e.g. to create demand for vaccinations or prenatal care) and – in particular – low levels of service utilization. Haitians make around 0.5 outpatient visits to HFs per year on average, and only 39 percent of pregnant women gave birth at HFs in 2016 – due largely to ingrained behavioral practices of going to Traditional Birth Attendants (TBAs, or “*matrons*”) for births², shortcomings in the quality of care, and significant user fees at many HFs. Only 13 percent of women from the lowest wealth quintile give birth at HFs, compared to 79 percent for those in the highest wealth quintile. In comparison with other LICs with a similar population size such as Burundi, Haiti has large geographical disparities in utilization rates, which are reflected by the fact that the 20 percent most productive HFs account for 65 percent of all new outpatient visits.³

Table 1. Health Statistics for Haiti and Select Countries

	Infant Mortality Rate (p. 1,000 live births)	Under-5 Mortality Rate (p. 1,000 live births)	HF deliveries (% of births)	All basic vaccinations received (% of children aged 12-23 months)	GDP per capita PPP (2017 USD)	Current Health Expenditure (CHE) per capita (all sources) (2015 USD)*	External Financing as a % of CHE (2015)*	Domestic Public Spending as a % of CHE (2015)*	Domestic Out-of-Pocket and Private Spending as a % of CHE (2015)*
Haiti	59	81	39	41	1815	54	49	11	40
Senegal	36	51	76	70	2712	36	12	32	57
Burundi	47	78	84	85	771	24	41	39	21
Malawi	42	63	91	76	1202	34	54	29	18
Rwanda	32	50	91	93	2036	57	44	21	34
Uganda	43	85	73	55	1864	46	40	13	47
LICs	51	78	N/A	N/A	1973	37	33	22	45

Sources: Demographic and Health Survey (DHS) of 2016 for Haiti, most recent DHSs for other countries, the Global Health Expenditure Database (GHED) and the WBG World Development Indicators. *Disaggregated data for capital health expenditure by funding source are not available, but capital health expenditure is small compared to current health expenditure for the countries considered.

5. **These health challenges have been compounded by a cholera epidemic that started in October 2010. Cholera incidence is now at a historically low point, but underlying drivers persist – including poor water, limited sanitation and hygiene access, and fragile surveillance capacity.** In January 2019 there were less than 50 new suspected cholera cases per week compared to more than 1,300 in October 2016 when Hurricane Matthew hit Haiti, and over 2,000 per week in 2011. However, cholera should be considered endemic and the risk of resurgence of cholera – already experienced in 2015/16 – remains significant since water and sanitation

² Ongoing Advisory Services and Analytics (ASA) work: “Using Innovative Mechanisms in the Health Sector to Reduce Gender Inequalities and Enhance Economic Opportunities for Women” (P164065). See Annex 2 for more.

³ See “Lessons Learned and Findings from Diagnostic Work: Background Paper for Project Appraisal Document for Strengthening Primary Health Care and Surveillance in Haiti Project”.



access has not improved significantly, and surveillance and response efforts are still dependent on donor funding.

6. **The risk of a cholera resurgence and an outbreak of vector-borne diseases is affected by observed and anticipated climate change impacts.** In Haiti, natural hazards and climate change put additional strains on the health sector through the accelerated spread of infectious diseases and their impact on water and sanitation systems. Rising temperatures and precipitation create conditions for the biological proliferation of infectious, in particular vector-borne, diseases. For instance, storms that create debris and standing water establish breeding grounds for urban disease outbreaks. Increases in the incidence of vector-borne diseases such as dengue, malaria and water-borne diseases leading to diarrhea are a major public health threat for Haiti.

7. **The system is heavily dependent on rapidly falling external financing, while the already-low government allocation to health has continued to decrease since 2013.** In 2015, per-capita health expenditure from the Government and donors was around US\$32 in total – much less than the estimated cost of financing an essential package of services in LICs (US\$86⁴). The share of the Government’s domestic expenditure going to health has fallen steadily from an average of 14 percent (2000-2005) to only 4.3 percent (2017-2018), around half the average for LICs. The Government relies heavily on external financing (80 percent of non-private current health expenditure), but on-budget external financing has fallen by more than 80 percent since 2013.

8. **In this context of scarce resources, overall health outcomes can only be improved by using existing resources more efficiently.** This can best be achieved by a three-pronged approach that: (i) enhances Primary Health Care (PHC); (ii) addresses organizational weaknesses; and (iii) tackles systemic deficiencies – as highlighted in a recent World Bank (WB) Health Financing Assessment (HFA)⁵. Each of these is discussed below:

9. **Enhancing PHC.** International evidence shows that investing in PHC is one of the most efficient ways to spend resources on health – as highlighted by the PHC Performance Initiative (PHCPI).⁶ But in Haiti, relatively low priority is given to PHC.⁷ Haiti only spends 19 percent of its total health expenditure on preventive care, whereas 54 percent is spent on curative care. On a per-capita basis, the number of dispensaries (the lowest level of PHC facilities) is below the norms of the Ministry of Public Health and Population, MSPP (*Ministère de la Santé Publique et de la Population*), while the number of hospitals exceeds such norms. Resource allocation needs to be more oriented towards PHC for improved outcomes.

10. **Addressing organizational weaknesses.** Major organizational deficiencies in the coordination of and financing of the system – from the national to the community level – also need to be tackled. Weak coordination

⁴ See “Fiscal Space for Domestic Funding of Health and Other Social Services.” By Di McIntyre and Filip Meheus. Chatham House, London, UK.

⁵ “Better Spending, Better Care: A Look at Haiti’s Health Financing.” WB, 2017.

⁶ The PHCPI is a partnership of the WB, the World Health Organization (WHO), the Gates Foundation and Ariadne Labs and Research for Development. See also Kruk, Margaret Elizabeth et al. “The Contribution of PHC To Health and Health Systems In Low- And Middle-Income Countries”. *Social Science & Medicine* 70.6 (2010): 904-911.

⁷ See the PHCPI website for analysis of the different aspects of PHC system performance in Haiti (<https://improvingphc.org/>).



of external aid and the lack of a prioritized benefit package⁸ have led to significant overlaps between different streams of financing, while some priority areas – especially at the PHC level – remain underfinanced. A key deficiency is the co-existence of multiple uncoordinated programs for community health workers (CHWs) financed by different donors, that are weakly integrated with the rest of the health system – and with a large share of the population still without access to CHW-based care (Annex 3 Box 2). As one of the avenues to alleviate this situation, in November 2017, Haiti joined the Global Financing Facility for Every Woman Every Child (GFF), a multi-stakeholder partnership that supports countries to improve reproductive, maternal, newborn, child and adolescent health and nutrition through smart, scaled, coordinated and sustainable financing.

11. **Tackling systemic deficiencies.** Systemic deficiencies include, among others: (i) the low degree of service readiness of HFs; (ii) weaknesses in supply chains and in planning and management at the central, Departmental and HF levels; and (iii) a lack of accountability and incentives at different decision-making levels. A minority of Haitians have access to a PHC facility of good quality. While 91 percent of the population lives within 5 kilometers (km) of a dispensary or health center, only 23 percent of Haitians live within 5 km of a dispensary or health center that meets adequate service readiness standards.⁹ Weaknesses in supply chains and a lack of planning and management are also constraints to access and utilization of HF services, especially affecting vaccination coverage in the country.¹⁰ Low accountability of health workers and poor incentives for them to perform well lead to their low productivity; outpatient visits per health worker per day are less than four in three-quarters of Haiti’s health centers and dispensaries.

12. **In the specific case of interventions to control cholera, efficiency gains are especially needed because cholera surveillance and response capacities are heavily dependent on donor financing, which is falling rapidly.** The approach implemented under the National Plan for the Elimination of Cholera has been very effective at reducing cholera incidence, but the surveillance and response mechanisms should progressively evolve towards a broader, less cholera-specific approach to one focused on infectious diseases.¹¹ Years of activities focused on combatting cholera have led to verticalized structures that are now firmly established, such as: (i) cholera treatment centers (with dedicated staff, equipment, supply chains, etc.) disconnected from the rest of the health system; (ii) cholera-specific rapid response teams throughout the country; and (iii) cholera-specific surveillance systems. In the context of highly constrained resources and very low cholera incidence, there is a need to achieve efficiency gains by: (i) integrating the relatively well-functioning cholera-specific mechanisms into the general surveillance systems, and (ii) rationalizing cholera rapid response mechanisms while expanding their scope to cover infectious disease outbreaks in general.

⁸ The recently developed Package of Essential Services (PES) is broader than an essential package of services according to the WHO. The cost of providing the PES package on a large scale in Haiti would far exceed the available resources.

⁹ Service readiness refers to the availability of basic amenities (water, sanitation, power, phone etc.) basic equipment and the adherence to standard precautions for infection prevention. See Anna D Gage et al.: “Assessing the Quality of Primary Care in Haiti.” *Bulletin of the WHO* (2017) 95:182–190.

¹⁰ See “Lessons Learned and Findings from Diagnostic Work: Background Paper for Project Appraisal Document for Strengthening Primary Health Care and Surveillance in Haiti Project”.

¹¹ WB. 2017. “An Assessment of Community-Level Rapid Response Activities for Cholera in Haiti.” Washington, D.C.



13. **Given the many complex challenges with Haiti’s health system and the multiplicity of partners, WB support has had to be selective.** The past two WB-financed projects (2010-2013 and 2013-2019) have focused on two specific areas with relatively low support from other partners and significant financing gaps: (i) supporting a package of priority PHC services and enhancing accountability, mostly through MSPP Results-Based Financing (RBF) Program¹² financed jointly with United States Agency for International Aid (USAID) and Canada; and (ii) responding to the cholera epidemic. WB support is currently provided through the ongoing *Projet d’Amélioration de la Santé Maternelle et Infantile a travers des Services Sociaux Intégrés* (PASMISSI)¹³, which is on track to achieve its objectives. The results to date from the implementation of the RBF program show that vaccinations for under-5 children at targeted HFs rose by 44 percent; births at HFs rose by 27 percent; utilization of contraceptives at HFs rose by 17 percent; the number of young children receiving nutritional screening rose by 89 percent, and the average quality score at HFs rose from 61 percent to 74 percent. The low cholera incidence observed in 2019 is due in large part to PASMISSI increasing its geographical and financial support for cholera surveillance and response efforts after Hurricane Matthew. PASMISSI now accounts for more than 70 percent of all cholera-related financing.

C. Relevance to Higher Level Objectives

14. **The proposed Strengthening Primary Health Care and Surveillance in Haiti Project is aligned with the WB Group’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).** The proposed Project will support the CPF Area of Focus 2 (Human Capital), specifically Objectives 6 (Increase Access to Health Services for Mothers and Children) and 7 (Control Cholera in Priority Communes). In accordance with the PLR, the Project builds on the findings of the 2017 WB HFA and focuses 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.

15. **The proposed Project is fully aligned with MSPP’s *Plan Directeur de Santé 2012-2022 (Health Sector Development Plan)* and will contribute to achieving Sustainable Development Goals 3.1, 3.2, 3.3 and 5 (respectively on: maternal mortality, child mortality, communicable diseases, and gender equality).** The proposed Project will support the two components of MSPP’s Health Sector Development Plan 2012-2022: “Organizational and Operational Strengthening of the Health System” and “Provision of Health Services and Care”.

16. **The proposed Project is also aligned with the goals of the WB’s Health, Nutrition, and Population Global Practice of achieving universal health service coverage and protecting households from catastrophic health care costs – focusing particularly on women, children, and vulnerable families.** The proposed Project is also aligned with the WB’s Twin Goals of ending extreme poverty and boosting shared prosperity; its activities and the selection of the intervention areas are expected to especially benefit the poor and vulnerable. In addition, the expected improvements in basic health outcomes will strengthen human capital, which in turn will contribute to tackling poverty. The proposed Project is also fully aligned with the Human Capital Project of the

¹² The program supports results-based payments to HFs and public supervisory units (including the DDSs), based on performance regarding pre-defined quantity and quality indicators.

¹³ “Improving Maternal and Child Health Through Integrated Social Services” Project (PASMISSI, P123706).



WB. It will contribute to improving the three health ultimate outcomes indicators (probability of survival to age 5, stunting, and adult survival rate to age 60) included in the WB Human Capital Index.

II. PROJECT DESCRIPTION

A. Project Development Objective

PDO Statement

17. The PDO of the proposed Project is to: (i) increase utilization of primary health care services in selected geographical areas, and (ii) strengthen surveillance capacity especially for cholera.

PDO Level Indicators

- (i) Percentage of children aged between 12 and 23 months fully vaccinated in Project intervention areas;
- (ii) Percentage of institutional deliveries in Project intervention areas; and
- (iii) Percentage of notifications of suspected cases of cholera for which laboratory results are available to the Health Departmental Directorates (DDSs) within 10 days of collection.

B. Project Components

18. **The proposed Project will build on the successes of the ongoing PASMISSI project, continuing its areas of support while introducing further enhancements in PHC and surveillance systems.** Specifically, the proposed Project will support a stream of PHC activities in the same four Departments as under PASMISSI to deepen the impact in these Departments, building on the foundations already begun under PASMISSI while including a fifth (new) Department, Nippes, under this activity stream. This Department was chosen because: (i) it is among the poorer Departments in the country; (ii) it has relatively limited coverage by other donors; and (iii) the selection of Nippes enables synergies between HF-level interventions financed by the proposed Project and rural road investments under another WB-financed project.¹⁴ The activities to be financed in these five Departments will complement the coverage by other partners in the other Departments. This stream of activities will:

- (i) continue to finance RBF activities in support of a prioritized package of PHC services, but with modifications to increase their focus on the priority areas of immunizations and basic maternal care, and on community-level activities (see below for more details on these modifications);
- (ii) introduce new interventions to address organizational weaknesses, such as Technical Assistance (TA) to improve the design and nationwide implementation of a harmonized Community Health Strategy and Implementation Plan (CHSIP) oriented around CHWs; and

¹⁴ The Haiti Rural Accessibility and Resilience Project (RARP, P163490). One of the criteria explicitly used under the RARP Project to select rural road investments is the potential impact of these investments on physical access to HFs. The RARP Project covers the Nippes, South and South-East Departments. In the South Department, as in the case of Nippes, HF-level interventions under the proposed Project will be chosen, in part, based on potential synergies with rural road investments under the RARP Project.



- (iii) support new activities to address additional systemic deficiencies for which there is relatively little financing from other partners, and which particularly affect the poor – mainly the low service readiness at selected HFs¹⁵ that are key for the functioning of PHC referral networks; supply chain weaknesses especially for vaccines; and planning and management deficiencies, especially regarding vaccine service delivery.¹⁶

19. The proposed Project will also finance a second stream of activities supporting integrated surveillance and response efforts against infectious diseases (including diphtheria and measles due to the current epidemiological trends, in addition to cholera) so that cholera teams do not operate in an isolated fashion. It will hence adopt a more systemic, “de-verticalized” approach than under PASMISI, to achieve efficiency gains (Section I-B). This stream of activities will continue to have nationwide coverage, complementing other partners’ efforts.

20. **Component 1: Strengthening Primary Health Care Service Delivery (US\$32 million from IDA Grant, US\$12 million from GFF grant).** Component 1 will finance activities to strengthen PHC service delivery via PHC referral networks, with each network consisting of: (i) a community referral hospital, health centers and dispensaries operating at different levels within the network; and (ii) CHWs at the community level. This component will finance: (i) one set of activities – (a) to (c) listed below – supporting improvements in the structural and organizational capacity for PHC service delivery; and (ii) another set of activities – (d) and (e) below – to enhance results in service delivery through incentives and increased accountability. The activities to be financed will be:

- a) **Strengthening the service readiness of selected health service providers** (within selected PHC referral networks) and their associated supply chain infrastructure (especially for vaccines¹⁷) through rehabilitation activities; provision of goods, essential medicines and equipment; training and TA; and information systems for improved monitoring. The selection of the PHC facilities to be supported will be based on a data-driven exercise with the objective of maximizing access to PHC services of adequate quality, in particular for poor and vulnerable populations, given available resources (Box 1 of Annex 3). Improvements in service readiness will have positive climate change adaptation and mitigation co-benefits, including through improvements in water and sanitation systems, as well as the incorporation of energy efficiency standards and practices in rehabilitation activities of selected PHC facilities (e.g. the financing of solar-based cold chain equipment to improve the management of vaccines in an emission-neutral and sustainable way);
- b) **Strengthening the design and implementation of the existing national community health program.** Financing will be provided for TA to improve the design of a harmonized and sustainable CHSIP oriented around CHWs, as well as tools to support this Plan’s development and implementation – all to be done in a collaborative manner between MSPP and key donor agencies financing CHW programs in the

¹⁵ These will be chosen with the objective of maximizing access to PHC services of adequate quality, in particular for poor and vulnerable populations, given available resources (see Box 1 of Annex 3 for full details).

¹⁶ Vaccination rates are much lower among those in the lowest wealth quintile than for others (see Section I-B above).

¹⁷ This will include components of the cold chain for vaccines at HFs and at the Departmental warehouses where vaccines are stored.



country (Annex 3). In addition to the CHSIP, a Plan to define the role of TBAs and to enhance the safety of deliveries by pregnant women who go to TBAs for births will be developed, including testing of different approaches (the latter activities will be informed by ongoing analytical work¹⁸);

- c) **Strengthening the management and planning capacity of selected HFs, public health supervisory units and DDSs** to: (i) better achieve results in the intervention areas, through – *inter alia* – TA specific to issues of organization, planning and distribution for vaccines, and TA to help address deficiencies in health spending¹⁹; and (ii) increase their understanding of climate change adaptation and mitigation issues, such as the deployment of early-warning systems, and to improve the planning for relocation efforts in the event of natural disasters;
- d) **RBF payments for the delivery of a Package of Basic PHC Services as well as Packages of Health Service-Related Activities.** The former will have a special focus on Reproductive, Maternal and Child Health and Nutrition (RMCHN) services. The Packages of Health Service-Related Activities will include monitoring, supervision and planning activities, as well as activities in support of the storage of pharmaceutical products, by selected DDSs and public health supervisory units. The sustained financing of the RBF program will improve the treatment of climate-sensitive (i.e. water-borne) diseases leading to diarrhea;
- e) **Developing and implementing a program of activities to maintain and strengthen external controls** including carrying out of third-party verification of the Packages of Services, i.e. by an External Verification Agency (EVA). Community surveys will be included in the verification process to ensure feedback mechanisms between users and health providers under the RBF program. The satisfaction of users will impact incentive payments and based on the feedback, corrective action plans will be developed by the HFs.

21. **As in the case of the ongoing health project, RBF payment agreements will be signed with: (i) public and private non-profit dispensaries, health centers and community hospitals²⁰ for the delivery of the Packages of Basic PHC Services; and (ii) DDSs and public health supervisory units for the Packages of Health Service-Related Activities.** The size of the RBF Payments will be based on performance indicators reflecting the quantities of services produced, as well as on quality indicators. These will include indicators to incentivize referrals within PHC referral networks, especially for maternal care.

22. **The basic design of the accountability and results-focused activities under the existing health project (including its RBF program) will be retained under the proposed Project,** with adjustments being gradually incorporated to provide particular support to key goals as follows:

¹⁸ Specifically, “Using Innovative Mechanisms in the Health Sector to Reduce Gender Inequalities and Enhance Economic Opportunities for Women” (P164065).

¹⁹ Where needed, TA will also be provided for HFs to produce Business Plans (with budgets) to show how they will use resources coming from RBF payments, user fees and other sources.

²⁰ These are the HFs that make up the PHC referral networks in Haiti.



- a) **Further boosting vaccination rates:** For both HFs and DDSs, the performance indicators under the ongoing RBF program will be adjusted – and new indicators added (Annex 3) – to place greater emphasis on boosting vaccination coverage, where performance has been especially poor in Haiti;
- b) **Reducing obstacles to increasing the demand of prioritized services:** To help address the problem of limited access to health services due to user fees – especially for the poor – HFs under the RBF program will be required to impose very low or zero user fees for certain types of maternal services, especially births.²¹ The RBF payments for these services will be raised significantly to compensate the HFs for the lost user fee revenues incurred. The scheme will be introduced gradually, starting initially with a limited number of HFs; and
- c) **Changes will be phased in gradually to support the implementation of the CHSIP** (see activity (b) of Component 1, above) – which is expected to be finalized within six months of effectiveness – as follows: in an initial phase, a portion of the RBF payments going to each HF will be shared with all CHWs attached to that HF; this is not typically done at present, despite the role played by CHWs in boosting the production of many HF indicators.²² In addition, the DDSs' existing performance indicators under the RBF program will be expanded to also include indicators of progress in the implementation of the CHSIP. In a second phase, additional community-level performance indicators to help measure CHW performance will be gradually introduced into the RBF program. See Annex 3 Box 3 for more details.

23. **All of these RBF activities will be conducted as part of a national RBF program with other co-financiers, as is now the case for the ongoing RBF program financed jointly by the WB, USAID and Canada.** All partners will follow a joint approach with the same indicators, tariffs, quality parameters and verification mechanisms.

24. **Component 2: Strengthening Surveillance and Control for Infectious Diseases (US\$20 million from IDA Grant, US\$2 million from GFF grant).** This component will help maintain the MSPP's effective nationwide surveillance and response capacity in the fight against cholera achieved under the ongoing PASMIS, while integrating cholera surveillance and response tools into the general surveillance and response systems. This component will continue to ensure the financing of critical surveillance and control activities for cholera and will expand to cover other infectious diseases, including two vaccine-preventable diseases – diphtheria and measles – and maternal deaths (all of which are part of the list of mandatory notifiable diseases), complementing the support of the Centers for Disease Control and Prevention (CDC) for MSPP's surveillance capacity. Such an integrated surveillance system will allow key climate-sensitive diseases to be monitored more easily, thereby reducing the vulnerability of the population to climate change. The strengthening of the surveillance system will be done in synergy with TA activities to support a robust CHSIP under Component 1. As part of the latter, the CHWs' role in the surveillance infrastructure and response efforts will be assessed to expand the surveillance system's geographical coverage and minimize the delay between the detection of potential outbreaks and the ensuing response efforts. Activities to be supported will include: (i) support for MSPP's monitoring, reporting and investigative capacity for the surveillance of national mandatory notifiable diseases, including maternal deaths; (ii) TA and training for transitioning to an integrated surveillance system (at both the central and Departmental levels); (iii) improvements of selected existing laboratories and infrastructure for surveillance, including regional laboratories; and (iv) support for the lab transport network of patients' samples for the three

²¹ Many of the services in the current RBF package are already provided for free (for example, child immunization).

²² The total RBF payment received by a HF, for any given level of performance, will be raised so that this new scheme does not imply lower payments received on the part of non-CHW.



notifiable diseases targeted (i.e. expanding the same support currently provided for cholera under the PASMISSI to also cover diphtheria and measles).

25. This component will support a shift from the emergency response tools used to fight the cholera epidemic towards a more developmental approach, including: (i) financing and progressively converting the current “cholera rapid response teams” into “rapid response teams for infectious disease” outbreaks particularly focusing on the three targeted diseases; and (ii) financing the “de-verticalization” of cholera treatment and community interventions to support the control of infectious diseases and other health conditions (including the integration of patient treatment, equipment and supplies into the general health system and support for MSPP’s treatment and response systems for the targeted diseases and other health conditions). This component would also finance TA activities to develop capacity building programs for the control of infectious diseases (through effective medical waste management to support the implementation of the national medical waste strategy and awareness raising about the links between climate change, natural disasters and infectious diseases). The component will be national in scope, but in geographic areas targeted for support by Component 1, the proposed Project will seek to further integrate surveillance and response into the PHC system.

26. **Component 3: Supporting Project Management and Implementation Support (US\$3 million from IDA Grant, US\$1 million from GFF).** This component will finance activities to strengthen the capacity of the central MSPP units and Departmental health authorities in the coordination, implementation management and supervision of the Project (including fiduciary aspects and monitoring and evaluation, safeguards and reporting of Project activities and results), and the carrying out of Project audits.

27. In addition to the above activities, the GFF grant will finance TA and tools for the Government to develop and implement the GFF Investment Case (IC), including: (i) activities to improve the coordination of donor funding and activities, including costing and prioritizing the country’s Health Sector Development Plan (IC); (ii) development of a mechanism to track donor resources and program costs; (iii) analyses of the efficiency of health spending and steps to address inefficiencies that are identified; (iv) TA to help develop a plan for enhancing the use of human resources in the health sector (Plan for Rationalization of Human Resources); and (v) TA to help improve the use of existing health data to inform health programming, including tracking progress on IC implementation and strategic decision making (Annex 3 Box 5).

28. **Component 4: Contingent Emergency Response Component (CERC) (US\$ 0 million from IDA).** This component will provide funding following an eligible emergency.²³ The component will include conditions for the use of funds, and will only be triggered when certain actions, as agreed by the Government and the WB, are met. These actions include the following: (i) an eligible emergency experienced by the country; and (ii) presentation of a sound and actionable country-level response plan.

²³ An eligible emergency means the imminent or actual occurrence of a natural or man-made crisis or disaster, which, in the opinion of the Government and the WB, has the capacity to cause major adverse economic, health and/or social impacts in the Recipient’s population.



29. **The proposed Project will have a strong focus on gender.** According to analysis undertaken for the FY16-FY19 WB Regional Gender Action Plan (RGAP) for Latin America and the Caribbean, the accumulation of health endowments is a key dimension of gender equality in the region. Relatively high maternal morbidity, and barriers to accessing reproductive health care, adversely affect women’s health endowments – particularly for poorer women – and this in turn further widens the gap between women’s and men’s economic opportunities.²⁴ Reduced access to reproductive health care also adversely affects agency – women’s ability to make decisions in order to achieve desired outcomes – which is another key dimension of gender equality according to the RGAP. The Project will have a strong focus on enhancing access to maternal and reproductive health care²⁵, thereby enhancing gender equality. In addition, key indicators including one of the PDO indicators – the percentage of children aged between 12 and 23 months fully vaccinated in Project intervention areas – will be monitored on a gender-disaggregated basis.²⁶ Furthermore, one PDO-level indicator and two intermediate indicators measure utilization of specific health services among women only.

C. Project Beneficiaries

30. **Geographical coverage and number of beneficiaries.** Component 1 will focus on the South, North West, North-East, Center and Nippes Departments. It will have an estimated three million beneficiaries. Activities under Component 2 will have national coverage and will benefit all residents of Haiti (around 11.1 million people). The potential number of beneficiaries of activities supported by Component 4 (CERC) will depend on whether an emergency occurs and the nature of the emergency.

²⁴ Maternal mortality and morbidity account for 7.73 percent of the global burden of disease (in Disability-Adjusted Life Years) for women aged 20-39 years, according to the Institute of Health Metrics and Evaluation’s Global Burden of Disease database. According to the 2016 DHS, a point estimate for maternal mortality in Haiti is 646 deaths per 100,000 live births.

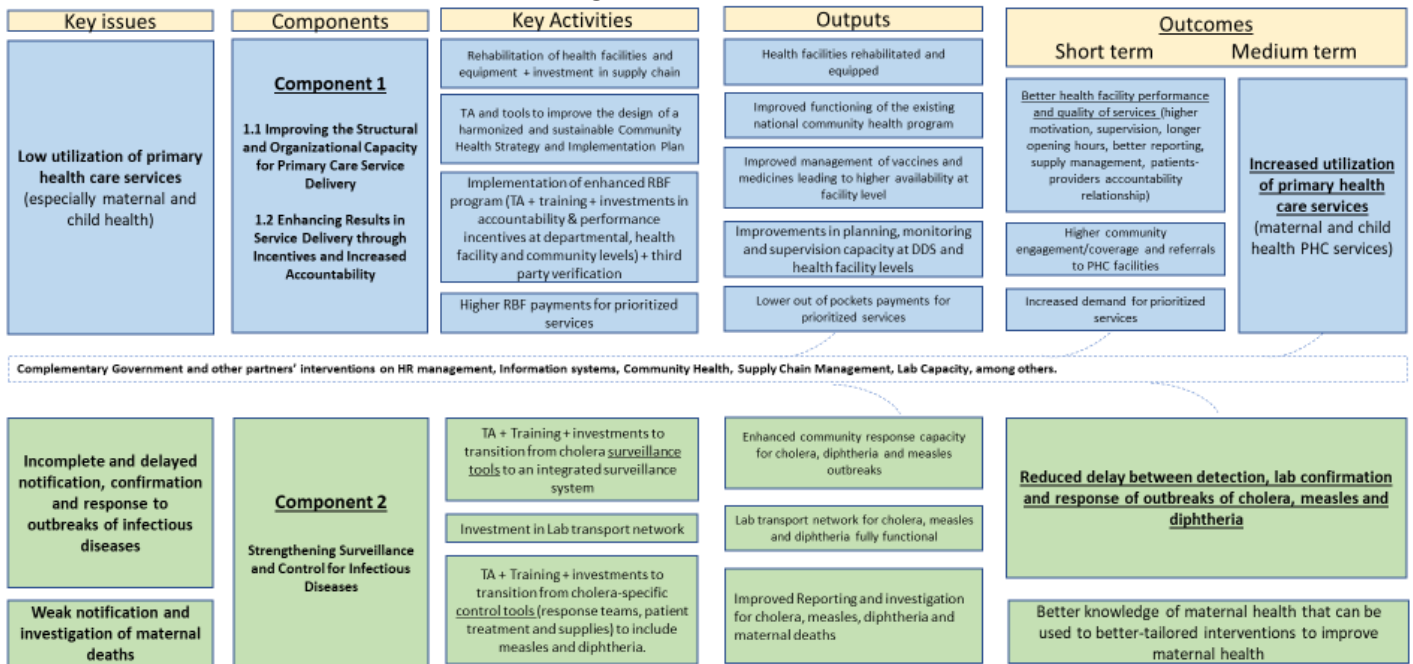
²⁵ Several services under the RBF program of Component 1 are reproductive and maternal health services.

²⁶ The baseline values for this indicator (from the 2016 DHS) are 38.4 percent for boys, and 44.4 percent for girls.



D. Results Chain

Figure 1. Results Chain



E. Rationale for Bank Involvement and Role of Partners

31. **The proposed Project is designed to address selected sectoral issues for which the WB has a comparative advantage while complementing other partner’s interventions.** Growing partners’ coordination since 2016 and the GFF process initiated in 2018 have enabled the Government and partners to increase their complementarity in the planning of activities, including for this Project. Several partners are already supporting the Government to address key sector issues such as human resources policies and management, health information systems and pharmaceutical policies/regulations, among others, and thus these areas were not included in this Project. Component 1 will build upon the success of the PASMISSI Project in implementing the RBF program and will complement USAID’s and Canada’s co-investment in the RBF program by focusing on additional HFs. Interventions designed to achieve higher vaccination coverage and strengthen the community health strategy will complement the financing and TA provided by CDC, the Global Alliance for Vaccines and Immunization (GAVI), the Pan-American Health Organization (PAHO), the United Nations Children’s Fund (UNICEF) and the USAID. Similarly, Component 2 will build upon the successes of PASMISSI to reduce the incidence of cholera and strengthen surveillance tools. The proposed activities will complement the support provided by CDC and PAHO for the surveillance system and the National Laboratory by strengthening the transportation network for patients’ samples and the epidemiological investigation capacity, as well as UNICEF’s and PAHO’s interventions to support the response to cholera, measles and diphtheria outbreaks.

32. **The development of an investment case (IC) under the GFF to define priority actions for enhanced coverage, quality, and access to essential PHC services will be financed by the GFF Grant linked to the Project.** Since Haiti joined the GFF, there has been emphasis on the need for the Government, with support and active engagement from technical and financial partners, to work towards the development of this IC, which involves



the following specific activities: (i) further prioritization and costing of the country's Health Sector Development Plan or benefit package (in the form of the IC) that technical and financial partners can align around; (ii) development of mechanisms to track different donor programs and their financing streams to identify gaps and duplications in service delivery and financing; (iii) increase in the efficiency and use of existing resources by assigning different priorities to different streams of donor (and Government) financing in a way that takes into account findings from the resource mapping and that is aligned with the priorities set out by the Government; and (iv) support for the use of data to track progress on key indicators and for decision-making.

F. Lessons Learned and Reflected in the Project Design

33. **The proposed Project draws on lessons learned from countries that have used a successful community health strategy to strengthen PHC.** CHWs play a critical role in PHC delivery in different settings worldwide. Within Haiti, some parts of the country benefit from localized CHW initiatives, although coverage is limited. To attain large-scale coverage, Haiti should look to other LICs that have successfully implemented CHW-based strategies nationwide with relatively limited resources, such as Ethiopia and Rwanda. Lessons from these experiences include: (i) need for a harmonized, nationwide approach based on common protocols (tasks, training, etc.) with strong linkages between CHWs and lower-level HFs, strong information systems and close attention paid to supervision of the CHWs; (ii) need for key parameters (such as the number of people covered per CHW) to be chosen in a sustainable manner based on available resources²⁷; (iii) recognition that with appropriate training, CHWs can engage in a fairly broad range of tasks including providing immunizations and testing/treatment for simple conditions like malaria and pneumonia²⁸; and (iv) need for a "risk stratification approach" where higher-risk households are identified and closely followed. In addition, Rwanda has shown that an appropriate system of incentives for CHWs can substantially boost performance. The Project will build on those experiences to help the Government to develop an effective CHSIP.

34. **The proposed Project also builds on the lessons from the ongoing PASMISSI Project and from analytical work (Annex 2²⁹), which highlight the necessity to: (i) make adaptations to the ongoing RBF program, particularly to enhance vaccination coverage and institutional deliveries, and (ii) finance complementary investments to enhance service delivery.** Performance in vaccine coverage can be substantially enhanced by providing targeted TA, and by adapting the performance indicators at the level of the DDSs, especially regarding management of the Departmental warehouses and regarding logistics, planning and distribution for vaccines. As for institutional deliveries, improvements will be limited unless two key constraints are addressed: significant user fees and the cultural importance of TBAs. Measures will be taken under the proposed Project to address both of these under Component 1.

²⁷ Ethiopia aims for a coverage of about 2,500 people per CHW (termed "Health Extension Workers" in Ethiopia), for example, with the CHWs being paid full-time salaries. This allows nationwide coverage on a sustainable basis. By contrast, the number of people covered per CHW is often much lower (e.g. 1,000) in richer middle-income countries like Brazil.

²⁸ This is especially important in low-income settings where people tend to visit HFs infrequently; services provided at the community/household level are especially important in these cases.

²⁹ Also see "Lessons Learned and Findings from Diagnostic Work: Background Paper for Project Appraisal Document for Strengthening Primary Health Care and Surveillance in Haiti Project".



35. **The effectiveness of the cholera response over the last two years is anchored in a significantly strengthened coordinated approach between the Government and partners combining community interventions (including in water, sanitation and hygiene), surveillance and prevention activities.** After Hurricane Matthew, the increased coordination between MSPP, the National Directorate for Safe Water and Sanitation (DINEPA), CDC, PAHO, UNICEF, the WB and Non-Governmental Organizations (NGOs) has allowed better targeting and more coordinated efforts on financial, political and technical aspects, at both the national and local levels. In the context of highly constrained resources and with the epidemic being at a low point, the Government and its partners are now aiming to achieve efficiency gains by building upon the relatively well functioning cholera-specific mechanisms to evolve towards a broader, less cholera-specific approach to infectious diseases surveillance and response. Integrated surveillance systems are more efficient and less costly than disease-specific ones, although they require strong coordination.³⁰ This Project will continue supporting such integrated and collaborative mechanisms at the central and local levels to ensure a strong and effective link between the surveillance and the response efforts to contain diphtheria, measles and cholera outbreaks.

III. IMPLEMENTATION ARRANGEMENTS

A. Institutional and Implementation Arrangements

36. **MSPP will have overall implementation responsibility for the proposed Project.** Implementation arrangements will be similar to structures already in place for implementing the ongoing health project.³¹ These arrangements have proven to be robust and have helped produce good performance with the RBF and the cholera activities, which account for the bulk of the ongoing project's funds. In the specific case of Component 4 under which funds will be used only in the case of an eligible emergency, implementation will be overseen by a Coordinating Authority to be assigned by the Government for the emergency (which may not be MSPP). Specifically, for the other components:

- a) **Technical responsibilities.** Under the general management of MSPP, Component 1 will be implemented by: (i) the RBF Contracting Unit at the central level (UC), as well as the Project Management Unit (*Unité de Gestion de Projet*, UGP) for activities to improve service readiness under this component; and (ii) the DDSs at the Departmental level. Component 2 will be implemented by: (i) the Directorate for Epidemiology, Laboratory and Research (DELR), in coordination with the National Laboratory for Public Health and the Unit Supporting Health Decentralization (UADS) at the central level; and (ii) the DDSs at the Departmental level. Overall coordination and supervision of activities under Component 2 will be the responsibility of the UGP.
- b) **Fiduciary and safeguards responsibilities.** All fiduciary and safeguards responsibilities for the proposed Project will be assigned to the UGP at the MSPP, which has been managing the ongoing WB-supported health project. The UGP would be headed by a designated Coordinator and would also include dedicated

³⁰ Garcia-Abreu, Anabela; Halperin, William; Daniel, Isabella. 2002. Public health surveillance: toolkit. Washington, DC: WBG. <https://hubs.worldbank.org/docs/imagebank/Pages/docProfile.aspx?nodeid=20339012>

³¹ This sentence refers specifically to the activities under the ongoing project that are implemented by MSPP. (The ongoing project also has activities implemented by the *Fonds D'Assistance Economique et Sociale* and the Haitian Institute of Statistics and Informatics).



environment and social specialists to ensure adequate monitoring of safeguards policies. The UGP will keep working closely with MSPP's Directorate for Health Promotion and Protection of the Environment (DPSPE) on both environmental and social safeguards since DPSPE is the main entity of the Ministry responsible for environmental aspects and community health interventions. Comprehensive procurement and financial management assessments have been conducted as part of project preparation (Annex 1).

37. **Conditions.** The development of an appropriate CHSIP is essential for improving PHC outcomes; the completion of an appropriate CHSIP within six months of effectiveness will be a legal covenant for both the IDA Grant and the GFF Grant. In addition, two other preconditions (among others) are necessary for the GFF approach to be implemented successfully: (i) formulation of an appropriate resource tracking mechanism for donor and Government resources; and (ii) formulation of an appropriate Plan for Rationalization of Human Resources (Annex 3 Box 5). These two actions will hence be disbursement conditions that will need to be fulfilled before the GFF grant can finance any activity other than TA and tools under Component 3 required to implement the GFF approach (see above).

B. Results Monitoring and Evaluation Arrangements

38. **Progress toward achieving the PDO will be monitored using the proposed Project's PDO-level Results Indicators** which will be tracked using the DHS surveys that are expected to be conducted in 2020 and 2024 (for indicators #1 and #2) and using the National surveillance system (including the National Laboratory Information system) to monitor indicator #3. If the second DHS survey is not conducted on time, the Project will finance a "mini-DHS" household survey, with fewer questions than in a regular DHS Survey and a smaller sample size – aiming to produce statistical estimates that are representative at the level of the Departments of focus.

39. **Intermediate results indicators will be used to track implementation progress for different activities.** The MSPP's UC will be responsible for monitoring results achieved under Component 1 through the RBF information system and will ensure the quality of the information provided by the EVA. This information will be published on a quarterly basis on the MSPP's RBF website. In addition to the RBF periodic third-party verification, the National Health Information System (SISNU) will be used to verify the consistency and quality of the data reported at the HF level. Investments in service readiness will be monitored through additional ad-hoc supervision visits conducted by UGP and UC to ensure the quality of rehabilitations, availability of equipment and supplies, and implementation of maintenance plans. Intermediate indicators for Component 2 will be monitored by the DELR and via the Laboratory information system.

C. Sustainability

40. **In the context of this Project, sustainability is assessed from a systemic viewpoint rather than a Project-specific one.** This means taking into account the costs and benefits stemming not just from the interventions of the Project, but also from the Project's impact on the system as a whole (including financing from MSPP and other donors). In that sense, the Project will – through the programmatic GFF approach that it is aligned with – reduce the fragmentation of donor support through the prioritization of activities and implementation of resource tracking mechanisms. By improving the coordination and harmonization among different sources of external as well as domestic financing, the Project will contribute to increased efficiency of



financing and hence to a more sustainable approach. Part of the objective of the GFF is to ensure that countries are on a trajectory toward sustainable health financing.

41. **In addition, a key element of the proposed Project that ensures its sustainability is its focus on the least resource-intensive and most cost-effective areas for healthcare delivery, namely PHC and CHWs** – thereby leading to better use of existing resources and allowing for a more sustainable approach. With respect to CHWs, the Project will support the CHSIP to improve the sustainability of the existing national community health program. Furthermore, investments in the service readiness of PHC facilities will contribute to shifting care delivery from hospital and inpatient settings to the PHC level which is more sustainable given Haiti’s epidemiological profile and financial constraints. These investments will also be tied to the implementation of maintenance plans. The Project also focuses its investments in surveillance on maintaining the effective nationwide surveillance and response capacity developed in the fight against cholera and gradually “de-verticalizing” it by focusing on additional diseases, which will make the surveillance approach more efficient. Lastly for the national vaccination program, the Project will ensure that staff are properly trained (e.g. temperature monitoring, maintenance of fridges and other equipment, stock management) in order to use available vaccines as efficiently as possible. Some savings (though difficult to quantify) in the provision of healthcare will also be generated from reductions in or early detection of high-risk pregnancies and deliveries.

IV. PROJECT APPRAISAL SUMMARY

A. Technical, Economic and Financial Analysis

42. **The proposed Project’s expected development impact will be, among others, to improve basic health outcomes, generating substantial benefits from reduced mortality and morbidity from direct Project interventions.** The following benefits are considered in the cost-benefit analysis of the Project: (i) the prevention of potential disease outbreaks (e.g. cholera) through an improved notification system; (ii) averted deaths of women of child-bearing age with improved access to institutional deliveries; and (iii) averted deaths of under-five children that are fully vaccinated.

43. **The cost-benefit analysis (Annex 4) finds a largely positive Net Present Value (NPV), for all scenarios considered.** The Project’s NPV – a measure of the difference between benefits and costs (with time discounting applied) – is largely positive (at least US\$9.50 million) and the estimated internal rate of return (IRR) ranges between 30.8 percent and 76.3 percent, depending on the scenario considered/discount factor used. This clearly shows the positive development impact of the Project interventions considered.

44. **Rationale for public sector provision/financing.** There are gains to public intervention when the pure market equilibrium is sub-optimal from the perspective of society and when the intervention can correct market failures. A recent review of micro-economic studies of health seeking behaviors in low-income settings³² shows that there are important market imperfections for preventive health care services that warrant public intervention. Households systematically underinvest in preventive health care due to: (i) lack of information (or ability to process information due to low education level) on illness prevention or on the cost-effectiveness of

³² Dupas, P., 2011. Health Behavior in Developing Countries. Annual Review of Economics; Vol. 3: 425-449.



preventative behaviors; (ii) credit constraints due to malfunctioning financial markets which affect people's ability to invest in health; and (iii) time-inconsistent preferences. Even if it is more beneficial for individuals to adopt healthy behaviors (e.g. seek preventive care) in the long run, they may not be willing to forgo short-term consumption of other goods and instead end up seeking sub-optimal and more expensive remedial care.

45. **Value added of World Bank's support.** The role of the WB is key in several respects, going beyond the financing provided. Among others, the WB's involvement enables the provision of high-quality TA, engagement in policy dialogue, the ability to benefit from international experience as well as the WB's implementation experience in various countries and its convening power.

46. **Climate change.** The proposed Project will reduce Haiti's vulnerability to climate change by improving the disease surveillance system for climate-sensitive diseases (e.g. vector- and water-borne diseases) and improving the design and implementation of the existing national CHW program. CHWs can play a pivotal role in improving disaster response and recovery because of their effectiveness in increasing disaster preparedness, supplementing the efforts of disaster responders, and building relationships of trust among all parties interested in disaster responses. Therefore, CHWs can significantly enhance community resiliency in anticipation of future disasters as well as emergency management planning and disaster recovery. Moreover, the Project will strengthen the provision of health care in rural areas that are highly vulnerable to climate impacts on health.

B. Fiduciary

(i) Financial Management

47. **The FM function for the Project will be undertaken by MSPP through the implementation unit in place for PASMISSE (UGP).** UGP's structure includes FM staff with adequate capacities, as has been assessed through the implementation of PASMISSE. The accounting and financial procedures to be followed are included in the Operations Manual. This Manual also has a section specific to the RBF stream of PASMISSE which includes general FM provisions that will also be applied to the proposed Project and are considered acceptable. FM arrangements for this Project will be fundamentally the same as for the ongoing PASMISSE, but RBF monitoring and supervision mechanisms will be strengthened.

48. **The main disbursement method to be used is the Advance of Funds.** Project funds will be advanced to a dedicated Designated Account (DA) to be managed by UGP; an additional account in local currency (HTG) will be opened for managing funds and making payments for Project activities. Advanced funds will be documented by UGP to account for grant proceeds and replenish the DA using Statement of Expenditures (SOE) agreed with the WB. The Reimbursement and Direct Payment disbursement methods will also be available for the Project. For the CERC component, an Emergency Response Operations Manual will be prepared; no disbursement will be made for this component unless this Manual has been agreed with the WB and adopted by MSPP.

(ii) Procurement

49. **Procurement for the proposed Project will be undertaken by MSPP through the Project Coordination Unit in place for the PASMISSE (UGP), and in compliance with the applicable WB policies and guidelines.** The UGP will be responsible for all procurement and contracting related queries and processing, including management and compliance with fiduciary requirements. All procurements under the Project will be carried



out in compliance with the applicable WB procurement guidelines and procurement policies for Investment Project Financing (Procurement Regulations for IPF Borrowers, issued on July 2016, revised on November 2017 and August 2018 - "Procurement Regulations"). Procurement arrangements shall be in line with all major aspects of the operation, and with the features and context described in the Project Procurement Strategy for Development (PPSD) prepared by the Recipient with full support from the WB.

50. **Procurement planning for the proposed Project shall follow provisions outlined in paragraph 5.9** of the above-mentioned "Procurement Regulations" and the WB's Systematic Tracking and Exchanges in Procurement (STEP) system will be used to prepare, clear and update Procurement Plans and to conduct all procurement transactions for the Project.

C. Safeguards

(i) Environmental Safeguards

51. **The proposed operation is rated as a Category B Project.** The Project's potential environmental impacts are anticipated to be minimal, site-specific and manageable to an acceptable level. Given the anticipated Project activities, three environmental Safeguard policies are triggered: Environmental Assessment (OP/BP 4.01), Pest Management (OP 4.09), and Physical Cultural Resources (OP/BP 4.11).

52. **At the time of appraisal, the range, scale, locations and number of sub-projects (rehabilitations) are unknown and as such the potential environmental and social impacts to be mitigated cannot be foreseen with a degree of certainty.** In line with applicable national legislation and WB Operational Policies, and to reflect the range of potential impacts (depending on the above-mentioned factors), the Government has prepared an Environmental and Social Management Framework (ESMF); public consultations took place on November 14, 2018 and this ESMF was disclosed on the MSPP's website on March 15, 2019 and on the WB's website on March 20, 2019. The ESMF sets out standards, methods and procedures specifying how sub-projects will systematically incorporate and address environmental issues in their screening, selection, categorization, siting, design, implementation and maintenance throughout implementation.

53. **The overall environmental impacts from this Project are expected to be resoundingly positive,** both for local communities in terms of access to adequate health care and promotion of human development in Haiti, and for the environment, in terms of investment in more efficient supply chain infrastructure and application of internationally accepted good practices in promoting sustainable biomedical waste management.

54. **Nonetheless, Project interventions may result in impacts that could adversely affect the biophysical environment if proper mitigation measures are not in place.** These potential impacts are varied but could include ground water contamination, air and noise pollution, as well as an elevated public health risk associated with the management of waste from health structures during project implementation and operation. The ESMF includes specific provisions to mitigate against potential risks from medical waste in Project areas. Consistent with the approach agreed at Project inception, the preparation of the instruments followed a broad consultation process that involved relevant stakeholder groups from both the public and private sectors, as well as local communities. This participatory approach will be continued throughout implementation, supervision, maintenance and evaluation of the Project activities.



55. **The UGP will be responsible for environmental safeguards implementation and will keep working closely with MSPP's DPSPE.** A dedicated environmental specialist has been recruited in 2018 under PASMISSE to strengthen UGP's and DPSPE's safeguards implementation and monitoring capacity. Given the capacity improvements observed during the last 12 months of PASMISSE implementation, the proposed Project will maintain this approach.

(ii) Social Safeguards

56. The policy on Involuntary Resettlement (OP/BP 4.12) has been triggered. Potential small-scale impacts could lead to: (i) damage to existing structures surrounding the targeted buildings to be rehabilitated; and (ii) business interruption and loss of economic income during the rehabilitation activities. Persons who could be affected include squatters, owners or renters of property, as well as street vendors, owners of kiosks or individuals involved in other economic livelihood activities. Given that the exact list of sites is not known at the time of project appraisal, the MSPP has prepared a Resettlement Policy Framework (RPF) for which public consultations took place on November 14, 2018. The RPF has been disclosed on the MSPP's website on March 15, 2019 and on the WB's website on March 20, 2019. As the rehabilitation efforts will target existing structures, physical resettlement of households or land acquisition is not expected at this time. Considering the long delays that other projects in Haiti have experienced in completing land acquisition and land-related compensation, the Project team will exert all efforts to avoid land acquisition, as well as permanent physical resettlement. Systematic preliminary screening of sub-projects will be conducted to identify and manage potential social impacts, including involuntary resettlement, land acquisition and other livelihood impacts. Most labor for rehabilitation works is expected to be local, with only a few high skilled/technical workers required from outside the community. The Project will require that Environmental and Social Management Plans include labor influx management, worker safety, and community health and safety measures. It will also ensure that labor-related commitments are reflected in the contract bidding documents.

57. **The DPSPE, as well as the UGP safeguards specialists contracted under PASMISSE, will continue their support for strengthening capacity under the Project.** Under PASMISSE, UGP's safeguards team has demonstrated their capacity to adequately perform safeguards screening of sites identified for rehabilitation activities. A dedicated social specialist will be maintained in UGP and will keep working closely with DPSPE on social safeguards and citizen engagement mechanisms. The UGP's safeguards specialists will be involved from an early stage in site selection and be part of technical discussions on the rehabilitation works to avoid or minimize safeguards impacts from the start. They will interact with communities and contractors during the implementation of works to manage any adverse impacts that may not have been foreseen at the outset and enhance positive impacts.

58. **The proposed Project will leverage the lessons learned from the PASMISSE Project with respect to citizen engagement.** Citizen engagement mechanisms will include patient surveys that are systematically conducted during the verification process of HFs under the RBF program. To ensure that the feedback loop is closed, facilities will develop concise action plans to address issues under their control (this mechanism will be incorporated in the RBF manual). In addition, there will be: (i) direct consultations and engagement of project beneficiaries, community leaders, community associations active in the municipality, as well as representatives of municipal authorities in the preparation, implementation and monitoring of civil works and community-level activities; and (ii) a project-specific Grievance Redress Mechanism (GRM) operated by UGP allowing beneficiaries and potentially affected individuals to submit complaints and ensure timely feedback and



resolution. The GRM will rely on local GRM focal points (Community Section Administrative Councils or CASECs) to uptake complaints, complemented by consultations, documentation and monitoring led by the Project social specialist. The GRM will: (i) place emphasis on communications and on closing the feedback loop among the Project team, contractors and project beneficiaries; (ii) require that all contractors assign community focal points for addressing grievances; and (iii) ensure frequent reporting and monitoring by UGP on grievances received and steps for their resolution. The Project Indicators include a citizen engagement indicator.

(iii) Other Safeguards

59. **Pest Management (OP 4.09) and Physical Cultural Resources (OP/BP 4.11):** OP 4.09 was triggered as a precautionary measure since project activities may include the reconstruction or rehabilitation of HFs. Provisions on Pest Management with a view to preventing termite infestation are included in the ESMF. Pest Management would also be needed in the event of rodent or other insect infestations at medical facilities, and mitigation measures are presented in the ESMF. OP 4.11 was also triggered as a precautionary measure. Given the nature of project activities, the likelihood of finding physical cultural resources is low. Nonetheless, physical cultural resources may be found during small-scale rehabilitation activities.



Grievance Redress Mechanisms

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

V. KEY RISKS

61. **The overall Project risk is Substantial.** This is based on several types of risks, identified below, that are rated as Substantial or High.

62. **Political and Governance Risk is rated High.** The country's fragility, characterized by socio-political instability, weak governance and low levels of accountability, continues to constrain the Government's capacity to lead and implement its programs; this could adversely affect implementation of the proposed Project and of the GFF approach for which coordination among different donor programs is key. This will be mitigated by close dialogue with key personnel at MSPP and other Government agencies, to be undertaken by the WB together with other key GFF donors like USAID and Canada that are part of the GFF multi-stakeholders' platform. The success of the GFF approach is key for several large donors, and this will help ensure its success – as well as the success of the proposed Project as a whole.

63. **Macroeconomic risk is rated High.** Macroeconomic stability risks and limited fiscal space could further reduce the Government's domestic budget allocation to health and affect the population's capacity to overcome financial barriers to access health services. This risk will be mitigated by deepening close engagement and coordination with counterparts and key stakeholders, and broader policy dialogue by the WB and key donors on the importance of protecting public social allocations.

64. **Sector Strategies and Policies risk is rated Substantial.** Potential delays in costing and prioritizing the Health Sector Development Plan, combined with a multiplicity of partners involved in the sector might hinder the MSPP's capacity to ensure complementarity and synergies between different interventions and strategies. This will be mitigated by the use of the GFF multi-stakeholders' platform – which includes the WB as well as other key GFF donors, among others – and tools provided by the GFF to facilitate efforts to move towards harmonization and joint approaches.

65. **Technical Design of Project or Program risk is rated Substantial.** The addition of new features and expansion of the RBF program to new health facilities establishes new technical challenges for different units of MSPP. To mitigate this risk, the new features will be introduced in a gradual manner and the technical units will be strengthened through capacity building and TA. The WB will work closely with the technical units to ensure timely and adequate support as needed.



66. **Institutional Capacity for Implementation and Sustainability risk is rated Substantial.** Weak institutional and coordination capacity across different technical and administrative units combined with frequent turnover of MSPP civil servants pose substantial implementation risks. The proposed project includes in its design coordination structures involving all relevant MSPP units (at the central and Departmental levels) and TA to mitigate this risk.

67. **Fiduciary risk is rated High.** The Procurement risk is rated high and the FM risk is rated substantial. While the FM capacity has been assessed as adequate, the FM assessment undertaken for the proposed Project noted: (i) some weaknesses in internal controls, and in accounting and documenting transactions and expenditures; and (ii) absence of effective implementation and budget planning and execution monitoring tools. Mitigation measures include the recruitment of an internal controller, transition to a new system for accounting and financial records (ACCPAC) as well as close supervision and support from the WB. Procurement risks are mostly linked to capacity limitations and poor experience in applying the WB's new Procurement Framework. The WB will provide close support to the UGP's procurement team to ensure proper understanding of how to apply the WB's procurement procedures and hence avoid delays. Additional measures are included in the PPSD and in Annex 1, and UGP will need to submit an action plan with details on the proposed mitigation measures.

68. **The persisting high vulnerability of the country to natural disasters is also a Substantial risk to achieving the PDO.** As observed after Hurricane Matthew struck in 2016, natural disasters could trigger a disruption of health services and deterioration of water, sanitation and hygiene conditions contributing to a surge in cholera and infectious diseases cases. To mitigate this risk, the project will seek to foster synergies with a separate WB-supported line of TA that aims at strengthening the Government's pandemic and emergency response capabilities.³³

³³ Financed by the Policy and Human Resources Development (PHRD) Trust Fund.



VI. RESULTS FRAMEWORK AND MONITORING

Results Framework

COUNTRY: Haiti

Strengthening Primary Health Care and Surveillance in Haiti

Project Development Objectives(s)

The PDO of the proposed Project is to: (i) increase utilization of primary health care services in selected geographical areas; and (ii) strengthen surveillance capacity especially for cholera.

Project Development Objective Indicators

Indicator Name	DLI	Baseline	End Target
Increase utilization of primary health care services in selected geographical areas			
Percentage of children aged between 12 and 23 months fully vaccinated in Project intervention areas (Percentage)		45.30	51.00
Percentage of institutional deliveries in Project intervention areas (Percentage)		38.20	44.00
Strengthen surveillance capacity especially for cholera			
Percentage of notifications of suspected cases of cholera for which laboratory results are available to the Health Departmental Directorates (DDSs) within 10 days of collection (Percentage)		45.00	70.00



Intermediate Results Indicators by Components

Indicator Name	DLI	Baseline	End Target
Component 1: Strengthening Primary Health Care Service Delivery			
People who have received essential health, nutrition, and population (HNP) services (CRI, Number)		0.00	828,000.00
People who have received essential health, nutrition, and population (HNP) services - Female (RMS requirement) (CRI, Number)		0.00	79,000.00
Number of children immunized (CRI, Number)		0.00	260,000.00
Number of women and children who have received basic nutrition services (CRI, Number)		0.00	500,000.00
Number of deliveries attended by skilled health personnel (CRI, Number)		0.00	68,000.00
Contracted service providers achieving the minimum quality score (Percentage)		71.00	78.00
Number of health facilities undergoing rehabilitation (Number)		0.00	55.00
Contracted health providers supervised at least quarterly - maintained at 100 percent (Percentage)		100.00	100.00
Citizen Engagement: percentage of facilities under RBF that developed an action plan(s) based on the results of community satisfaction surveys (Percentage)		0.00	50.00
Component 2: Strengthening Surveillance and Control for Infectious Diseases			
Percentage of suspected cases of diphtheria investigated and responded to within 48h after notification (Percentage)		72.00	90.00
Percentage of suspected cases of measles investigated within 48h after notification (Percentage)		77.00	85.00
Percentage of notified maternal deaths investigated per year (Percentage)		0.00	10.00



Monitoring & Evaluation Plan: PDO Indicators

Indicator Name	Definition/Description	Frequency	Datasource	Methodology for Data Collection	Responsibility for Data Collection
Percentage of children aged between 12 and 23 months fully vaccinated in Project intervention areas	Number of children aged 12-23 months who received immunization for BCG, Polio, Rotavirus, DTC3 and/or Pentavalent and Measles appropriate for their age in Project interventions areas.	Twice during Project period	DHS surveys (expected in 2020, 2024) (or endline survey to be conducted towards end of Project).	DHS Surveys 2020 and 2024. If the second DHS survey is not conducted on time, the Project will finance a “mini-DHS” household survey (representative at Departments level). In the meantime, progress will be monitored using administrative data (from SISNU).	UEP/MSPP
Percentage of institutional deliveries in Project intervention areas	Number of institutional deliveries in Project intervention areas.	Twice during Project period	DHS surveys 2020, 2024 (or endline survey to be conducted towards end of Project).	DHS Surveys 2020 and 2024. If the second DHS survey is not conducted on time, the Project will finance a “mini-DHS” household survey (representative at Departments level). In the meantime, progress will be monitored using administrative data	UEP/MSPP



				(from SISNU).	
Percentage of notifications of suspected cases of cholera for which laboratory results are available to the Health Departmental Directorates (DDSs) within 10 days of collection	Numerator: number of laboratory results for suspected cases of cholera that are available to the DDSs within 10 days after collection from patient. Denominator: Number of notifications of suspected cases of Cholera in all departments.	Twice a year	(DELR + LNSP)/MSPP	- Compilation of departmental-level surveillance data (for the number of suspected cases). - Lab database compiling: 1) Lab results for lab-tested samples (LNSP and others); 2) dates of sample collection; 3) dates on which lab results were sent and made available to DDS.	DELR/LNSP (MSPP)

Monitoring & Evaluation Plan: Intermediate Results Indicators

Indicator Name	Definition/Description	Frequency	Datasource	Methodology for Data Collection	Responsibility for Data Collection
People who have received essential health, nutrition, and population (HNP) services		Annual	RBF Information System (through third-party verification agency) + SISNU	Sum of sub-indicators : "Number of children immunized", "Number of deliveries attended by skilled health personnel", "Number of women and children who have received basic nutrition	UC/MSPP



				services".	
People who have received essential health, nutrition, and population (HNP) services - Female (RMS requirement)		Annual	RBF Information System (through third-party verification agency)	The sum of the following indicators in the RBF program: "Number of institutional births, including cesareans", "number of pregnant women receiving first prenatal consultation during their first trimester", and "number of women receiving postnatal consultation".	UC/MSPP
Number of children immunized		Annual	SISNU	Children that have received at least one vaccination (such as BCG) will be counted to reduce the risk of double counting.	UEP/MSPP
Number of women and children who have received basic nutrition services		Annual	RBF Information System (through third-party verification agency)	The sum of the following indicators in the RBF program: "Children who received vitamin A supplementation", "number of pregnant women receiving first	UC/MSPP



				prenatal consultation during their first trimester", and "number women receiving postnatal consultation".	
Number of deliveries attended by skilled health personnel		Annual	RBF Information System (through third-party verification agency)	RBF Information System (through third-party verification agency). The value will be the cumulative value of RBF indicator "Number of institutional births, including cesareans".	UC/MSPP
Contracted service providers achieving the minimum quality score	Numerator: Number of contracted service providers in Project intervention areas having achieved at least 60 percent during the quality scorecard assessment undertaken by the external verification entity. The quality scorecard includes a number of indicators, for example: properly organized patient files, public posting of fees for services and source and uses of facility financing, cleanliness of	Annual	RBF Information System	RBF Information System (external verification led by third-party verification agency).	UC/MSPP



	facilities and management of medical waste and others. Denominator: Number of contracted service providers in Project intervention areas.				
Number of health facilities undergoing rehabilitation	Number of HFs rehabilitated by the Project.	Annual	Annual Project implementation reports (UGP/MSPP)	Tracking of facilities rehabilitated for which civil works are 100% executed and having received the final reception by UGP/MSPP.	UGP/MSPP
Contracted health providers supervised at least quarterly - maintained at 100 percent	Numerator: Number of contracted health providers that have received a supervisory visit by the departmental health authorities at least quarterly. Denominator: Number of contracted health providers.	Twice a year	RBF Information System	RBF Information System (Through third party verification agency).	UC/MSPP
Citizen Engagement: percentage of facilities under RBF that developed an action plan(s) based on the results of community satisfaction surveys	Numerator: Number of HFs under the RBF Program that developed an action plan based on the results of community satisfaction surveys. Denominator: Number of HFs under RBF Program.	Annual	RBF Information System	Surveys are conducted by the third-party verification agency during RBF verification. A sample of patients is used to collect patient's feedback and the	UC/MSPP



				agency verifies that the provider has developed and implemented the corrective action plan (for issues within their control) during the next verification.	
Percentage of suspected cases of diphtheria investigated and responded to within 48h after notification	Numerator : Number of suspected cases of diphtheria investigated and responded to within 48h after first notification (first point of notification: HF, CHW or any MSPP personnel/entity). Denominator : Number of suspected cases of diphtheria notified.	Quarterly	Data base investigation Monitoring Evaluation et Surveillance Intégrée (MESI)	Compilation of HFs mandatory notifiable diseases data + investigation forms and reports at DDS level. Number of notified cases of diphtheria (from MESI). Number of cases investigated and responded (from DDS). DELR will prepare a response tracking tool for diphtheria for DDS. DELR will ensure the compilation and analysis of investigation and response forms and will produce the report.	DELR
Percentage of suspected cases of measles investigated within 48h after notification	Numerator : Number of suspected cases of measles investigated within 48h after notification (first point	Quarterly	Data base investigation MESI	Compilation of HFs mandatory notifiable diseases data + forms and investigation	DELR



	of notification: HF, CHW or any MSPP personnel/entity). Denominator : Number of suspected cases of measles notified.			reports from DDS. Number of notified cases of measles (from MESI); Number of cases investigated and responded (from DDS). DELR will prepare a response tracking tool for measles for DDS and ensure the compilation and analysis of investigation and response forms and will produce the report.	
Percentage of notified maternal deaths investigated per year	Numerator: Number of reports of maternal deaths investigated per year based (based on Investigation Form of DELR). Denominator: Number of notified maternal deaths.	Annual	Report from DDS Denominator : Weekly epidemiological bulleting of mandatory notifiable diseases	DELR compiles : 1) data/reports for Mandatory Notifiable diseases sent by HFs; 2) and Investigation Forms and Reports at DDS level	DELR



ANNEX 1: Implementation Arrangements and Support Plan

COUNTRY: Haiti

Strengthening Primary Health Care and Surveillance in Haiti

A) Overall Institutional and Implementation Arrangements

1. **MSPP will have overall implementation responsibility of the Project.** Implementation arrangements will be similar to structures already in place for the implementation of the ongoing health project (PASMISSI). These arrangements have proven to be robust and have helped produce good performance with the RBF and the cholera activities, which account for the bulk of the ongoing project's funds. In the specific case of Component 4 under which funds will be used only in the case of an eligible emergency, implementation will be overseen by a Coordinating Authority to be assigned by the Government for the emergency (which may not be MSPP). This Annex covers the institutional and implementation arrangements for the other Components of the Project.

Institutional and Implementation Arrangements for Component 1

2. **Under the general management of MSPP, Component 1 will be implemented by: (i) the RBF Contracting Unit at the central level (UC), as well as the Project UGP for activities to improve service readiness under this component; and (ii) the DDSs at the Departmental level.** Activities in support of the CHSIP will be overseen by a steering committee comprised of the Minister's Cabinet Deputy Director and representatives of the *Unité d'Etudes et de Programmation* (UEP), the DPSPE, the Directorate for Human Resources (DRH) and the Directorate for the Organization of Health Services (DOSS). The RBF program will be implemented following the RBF manual that has been revised in 2019 to reflect the lessons learned from the PASMISSI. Figure 1 below depicts the implementation arrangements of the RBF program. The individuals at UC will be chosen by MSPP, subject to approval by the WB.

3. **All fiduciary and safeguards responsibilities for the proposed Project will be assigned to an existing Project UGP at the MSPP,** which has been managing the ongoing WB-supported health project. Verification will be undertaken by independent agencies, and – for certain activities by community health agents – by their respective supervisors when community RBF is introduced. The implementation of the RBF scheme involves the following functions: (i) central oversight; (ii) departmental oversight; (iii) payment; (iv) verification; and (v) providers.

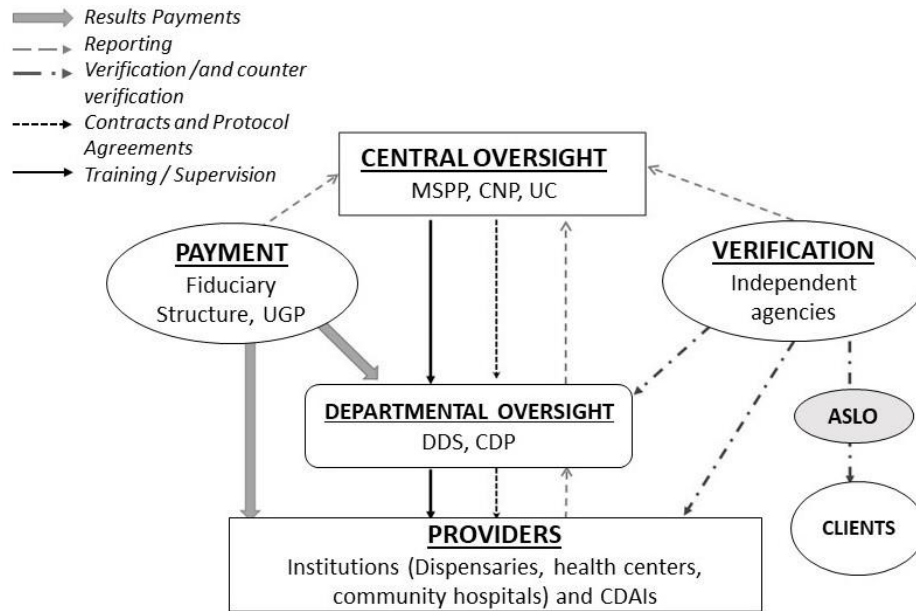
Central Oversight

4. The General Directorate of the MSPP ensures overall supervision and monitoring of RBF. UC is hierarchically dependent on them and reports directly to them on their activities. The National Steering Committee for RBF (*Comité National de Pilotage, CNP*) is focused on funding, governance and strategic coordination of the implementation of RBF at the national level. Chaired by the Minister of Health, the CNP's tasks are to: monitor the implementation of RBF at the national level; provide national guidance and validate



strategic directions; and coordinate the mobilization of necessary resources with the Government and current and potential Technical and Financial Partners.

Figure 1. Implementation Arrangement for Results Based Financing Program



5. The UC is the executive body responsible for the technical and operational implementation of RBF. Its main functions are to coordinate and monitor RBF implementation activities; build capacity of RBF actors at all levels; and monitor the financial execution of RBF. UC also coordinates and manages the Technical Group (GT/RBF). The GT is composed of all members of the UC, the managers of the other central directorates whose activities are directly related to the implementation of the RBF, and technical staff involved in RBF. The GT supports UC by helping to identify potential bottlenecks across the program and proposing solutions.

Departmental Oversight

6. The DDS is the regulatory body at the intermediate level responsible for implementing the Government’s health policy in its respective Department. As part of the implementation of RBF, the DDS is responsible for identifying HFs to be contracted according to the eligibility criteria and managing the performance contracts. DDSs also work with the institutions to validate their business plans and analyze the performance audit reports. They also supervise the administrative and FM of the Department’s HFs and secure all administrative and financial documents, activity reports and quality assessment reports.

7. The Departmental Steering Committee (*Comité Départemental de Pilotage* or CDP) is part of a framework specifically set up at the DDS to co-ordinate the implementation of RBF in the Department. The main functions of the CDP are to monitor the implementation of RBF in the Department, including analyzing action plans, conducting supervisory activities and following up on implementation activities.



Payment

8. In the RBF model, fiduciary responsibilities are assigned to UGP. In all cases, the funds are transferred directly from the accounts of UGP to contracted institutions without any intermediary³⁴; UC and DDSs monitor the effectiveness, promptness and completeness of payments. UGP also: analyzes payment requests submitted by UC; follows the entire payment channel until funds arrive at the beneficiary level; archives transfer orders from RBF funds; and prepares quarterly inventory of payments of contractual structures.

Verification

9. The EVA oversees verification of the quantitative and qualitative indicators of the HFs, as well as evaluating the performance of the Departmental Center for Supply of Inputs (*Centre Départemental d'Approvisionnement en Intrants or CDAIs*) and DDSs. UC is responsible for reviewing and assessing the performance of the EVA and ensuring that corrective measures are undertaken, if necessary.

10. For quantitative data, the EVA is responsible for: (i) verifying the authenticity of the monthly quantitative benefits declared by the HFs within the given deadlines; (ii) preparing a narrative report; (iii) drawing the samples necessary for the completion of the community audit; (iv) participating in the training of verifiers on the indicators to be verified and on the verification methodology in the community; and (v) entering the reported and verified data (quantitative and qualitative data) into the billing database / RBF Portal.

11. For the evaluation of the quality of the HF's services, the EVA has the same tasks but must also identify potential quality issues, discuss them with stakeholders and propose possible solutions to the CDP and HFs. For the evaluation of the DDSs, and CDAIs, the EVA is responsible for performing the quarterly evaluation of the services of the DDSs, CDAIs and returning them to the structures concerned. They also identify performance issues, discuss them with stakeholders, and propose possible solutions to UC and the structure.

12. The community verification is carried out at the same time as the institutional verification by the *Associations Locales* (Local Organizations, ASLOs) under the supervision of the EVAs. Fifty patients per health center and 100 per hospital are interviewed on the quality of care each trimester. Based on this feedback, HFs develop corrective action plans to address issues that are under their responsibility. Indicators introduced through the community RBF will be verified by the supervisor of each CHW ex-ante (i.e. before payment). The supervisor will be a nurse working at the HF to which a CHW is linked. In addition, the EVA will conduct ex-post verifications for a sample of CHWs and indicators, chosen on a random basis.

Providers

13. Results-based agreements are signed with public and private non-profit dispensaries, health centers and community hospitals for the delivery of the Packages of Basic PHC Services.

³⁴ However, payments are notified to UC, for monitoring purposes.



14. The CDAI is a pharmaceutical establishment placed at the level of a health department and whose function is to ensure the efficient management of the stocks as well as the supply to the HFs of medicines and other health inputs from the department. As part of the implementation of RBF, the CDAI must track inventory and monitor storage conditions of inputs daily. Every quarter, they produce and submit activity reports to the DDS.

Institutional and Implementation Arrangements for Component 2

15. **Overall coordination and supervision of activities under Component 2 will be the responsibility of the UGP.** The UGP will have the responsibility to work with DELR and National Laboratory of Public Health (*Laboratoire National de Santé Publique, LNSP*) at the central level and DDSs at the Departmental levels to implement the Project in a timely manner, conforming to agreed-upon quality standards. Memorandums of Understanding (MoU) will be developed and signed every year between the DELR, LNSP and the UGP and will include at least: (i) annual operational plans with comprehensive list of activities; (ii) clear definition of responsibilities; and (iii) annual budgets reflecting the activities. DELR will have the responsibility to coordinate the formulation of annual plans and budgets with the DDSs and work with the UGP for validation. The UGP will have the responsibility to review and ensure the final technical and financial appropriateness of the operational plans and budgets.

16. **The UGP will have the primary responsibility for tracking progress related Project' activities, outcomes and results, except for activities under the RBF program which will be the responsibility of UC.** The UGP, in coordination with UC for RBF activities, will prepare biannual Project reports including the following information: (i) the compliance with the planned Project activities under component 2; (ii) the updated Procurement Plan; (iii) progress on the achievement of indicators, as defined in the Results Framework; (iv) progress on environmental and social management, including detailed reporting on potential grievances related from beneficiaries and non-beneficiaries; and (v) any bottlenecks in project implementation and actions planned to address them. The UGP will submit to the WB Project reports twice a year prior to the respective disbursement requests, but not later than 45 days after the end of the period covered by each report.

17. The UGP will be headed by a Coordinator (appointed by the Minister of Health, subject to WB approval) and would also include a Monitoring and Evaluation Specialist, a FM Specialist, a Procurement Specialist, a Social Specialist and an Environmental Specialist to ensure adequate monitoring of safeguards policies. All of them will be recruited according to specific Terms of Reference subject to WB approval. The UGP is expected to be completed, fully staffed and operational at Project effectiveness. The UGP and UC staff financed by the Project will be subject to yearly performance reviews based on previously agreed objectives with the WB.

18. The UGP will keep working closely with MSPP's DPSPE on both environmental and social safeguards since DPSPE is the main MSPP entity responsible for environmental aspects and community health interventions. In addition to all safeguards requirements set out in the ESMF and RPF, the UGP will be responsible for working with DPSPE and the DDSs to: (i) systematically monitor and provide support to stakeholders involved in collecting, recording, addressing grievances in project sites; (ii) periodically assess and review the adequacy of citizen engagement mechanisms to ensure that the feedback loop between patients and service providers is closed (i.e. actions are undertaken based on patients and community feedback, including through the community survey under the RBF program); (iii) propose improvements and support the



implementation of communication interventions to support the achievement of the Project's objective; and (iv) monitor and support DPSPE in improving medical waste management.

B) Financial Management, Disbursement Arrangements and Risk Assessment

Summary

19. The FM risk for this Project is deemed **Substantial**. FM arrangements for this Project will be fundamentally the same as for the PASMISSI, in terms of budgeting, internal control, accounting and financial reporting, disbursement and external audit. Under the PASMISSI, the RBF component performance has not been uniformed among the Departments covered by that project. In addition, delays in the contracting process for the EVA and delays in the payment to HFs have been observed. To improve RBF performance, it will be necessary to strengthen RBF monitoring and supervision mechanisms; Subcomponent 1.1 envisages, among other, training and TA for HFs, DDSs and public health supervisory units to enhance their planning and management capacity, which should contribute to improved performance of the RBF program.

Implementing Entity

20. The Project will be implemented by the MSPP, which will be responsible for overall implementation and coordination. Overall implementation arrangements will be similar for those in place for the ongoing Project (PASMISSI, P123706), which have proven adequate. The RBF component (Subcomponent 1.2) will be initially implemented under the same mechanism in place for the PASMISSI but will be gradually adjusted.³⁵ The DDSs will continue to control, produce and provide information to MSPP at the central level for RBF interventions, that will be consolidated and incorporated in Project financial reports. Oversight function over the DDSs will have to be closely implemented and monitored, including requirements for record-keeping, and preparation of progress reports.

21. The FM function for the Project will be undertaken by MSPP through the UGP in place for the PASMISSI (UGP). The UGP structure includes FM staff with adequate capacities,³⁶ as has been assessed through the implementation of the PASMISSI, although it will be necessary to consider hiring complementary staff to ensure that the increased volume of transactions will be absorbed.³⁷ The WB has approved the hiring of an internal controller to provide support to the PASMISSI, which will also support this Project.

22. The UGP accounting and financial procedures manual and organizational structure of UGP-MSPP are being updated and still pending approval from its Executive Direction; once this manual is approved, it will be implemented and applied to the Project, on terms acceptable to the WB.

³⁵ Adjustments will be gradually made to incorporate: (i) a plan to implement incentives and monitoring to support the implementation of the harmonized CHSIP; (ii) the use incentives to further strengthen the immunization program and improve vaccination rates; and (iii) the reduction of obstacles to increase the demand of prioritized services.

³⁶ In addition to the FM staff in place at central level within UGP-MSPP, an accountant is in place at each of the four DDSs.

³⁷ UGP-MSPP also participates in other projects financed by other development partners, mainly the Inter-American Development Bank.



Budgeting Arrangements

23. UGP will be overall responsible for the planning of Project activities and preparing the annual operational plan and budget, jointly with UC for component 1, to be approved by the WB and monitored periodically throughout implementation.

Accounting

24. UGP has recently transitioned to the Accounting Package (ACCPAC) accounting system for keeping accounting and financial records for the PASMISSI; this system will be used for the Project and will allow UGP to keep separate records and produce financial and budgetary reports for the projects implemented by MSPP; and to identify the different financing sources for the Project (IDA grant and GFF funds).

Financial Reporting

25. Interim unaudited financial reports (IFRs) will be prepared and submitted not later than forty-five days after the end of each fiscal quarter, in form and substance acceptable to the WB. IFRs will allow the monitoring of disbursements, as well as financial and budgetary information for the Project.

Internal Control and Internal Auditing

26. UGP has in place a Project Operational Manual specific to the PASMISSI, in addition to an internal administrative, finance and accounting manual which is being revised. The UGP organizational structure (included in the internal manual) is also being revised and updated. The PASMISSI Operational Manual includes general FM provisions that will also be applied to the Project and are considered acceptable. An RBF manual is in place for the PASMISSI RBF component; it has been updated to incorporate the indicators for RBF payments to be made under this Project and reflects the gradual adjustments to be made for the RBF component under this Project.

Flow of Funds

27. The main disbursement method to be used is the Advance of Funds. Project funds will be advanced to a DA to be managed by UGP-MSPP – one for each co-financier. An additional account in local currency (HTG) will be opened for managing funds and making payments for Project activities. Advanced funds will be documented by UGP-MSPP to account for grant proceeds and to replenish the DA using Statements of Expenditures (SOEs) agreed with the WB. The Annual Work Plan will pre-determine respective expenditures eligible under each co-financier.

28. The reimbursement and direct payment disbursement methods will be available for the Project. For the Contingent Emergency Response Capacity component, an Emergency Response Operations Manual will be prepared, no disbursement will be made for this component unless this manual has been agreed with the WB and adopted by MSPP.



External Audit and Controls

29. Annual audits on Project financial statements and eligibility of expenditures will be performed in accordance with WB policy, under terms of reference and by an independent auditor acceptable to the WB. An independent EVA will conduct verification on the achievement and implementation of the interventions envisaged under the RBF component, which will also be implemented through specific RBF Payments Agreements that will include, among others, the obligation of the RBF beneficiaries to maintain adequate records to reflect the transactions, operations and expenditures incurred under the supported interventions, that will be subject to independent audits upon request from MSPP or the WB, if deemed necessary. MSPP and the WB will also be allowed to conduct inspections of the RBF beneficiaries' procured goods, records and documents corresponding to the interventions supported under this component.

FM Supervision Strategy

30. The WB will conduct at least two full FM supervisions per year. FM performance and compliance will also be monitored via the review of quarterly IFRs and audit reports and may also include the inspection of the RBF beneficiaries' records and documents.

C) Procurement

31. The Project will be executed in accordance with the WB's Procurement Regulations for Borrowers under Investment Policy Financing (July 2016, revised on November 2017 and August 2018).

32. Procurement for the proposed Project will be carried out by MSPP's UGP. The Project will be executed in accordance with the WB's Procurement Regulations for Borrowers under Investment Policy Financing (July 2016, revised on November 2017 and August 2018) ("Procurement Regulations"), and the provisions stipulated in the Procurement Plan and the Project Operational Manual. During the last supervision mission UGP was found to have the necessary capacity to handle procurement functions for this Project. The UGP will be responsible for all procurement and contracting related queries and processing, including management and compliance with fiduciary requirements.

33. A PPSD was carried out and identified the appropriate selection methods, market approach and type of WB's review. Major activities under the proposed Project will be carried out through: (i) Request for Proposal (RFP); (ii) Request for Bids (RFB); (iii) Request for Quotations (RFQ); and (iv) Direct Selection. An acceptable Procurement Plan was also prepared and will be included in the new Systematic Tracking of Exchanges in Procurement system. Procurement arrangements for the Emergency Response Component (Component 4) are described in the Emergency Response Mechanism Operational Manual. For post-review procurements, in addition to the WB Standard and Sample Bidding Documents, MSPP/UGP will be using standard bidding documents agreed with the *Commission Nationale des Marchés Publics*.

34. Following the market analysis, risks identified, and contract amounts it was determined that the most important activities under the proposed Project will be carried out as follow: (i) works amounting in total US\$3.36 million for small-scale rehabilitation in the targeted Departments; (ii) goods amounting to a total of US\$2.9 million comprising mostly US\$2.0 million for health center equipment that will be acquired through RFBs

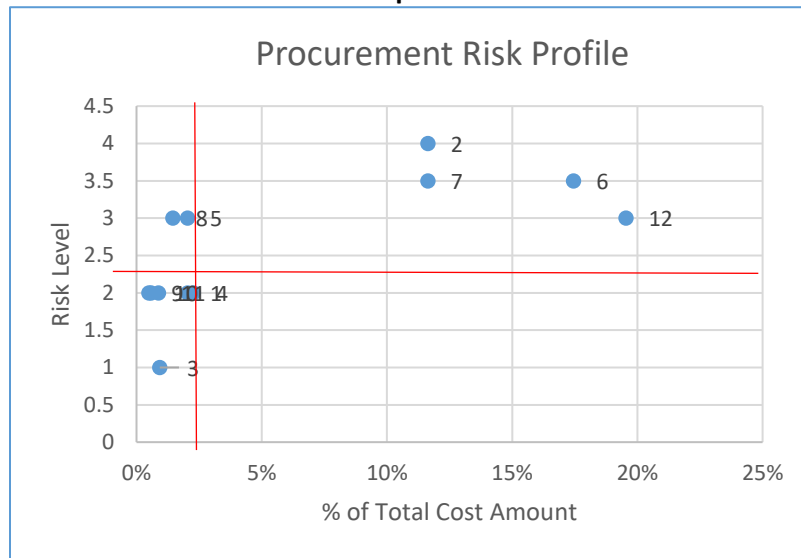


at the international level; and (iii) consultancies amounting to US\$5.93 million including: (a) US\$3.0 million for RBF that will be acquired via RFP, and (b) US\$2.0 million for RBF verification that will be acquired via RFP. (See Table 1 and Graph 1 below).

Table 1. Contracts Under Proposed Project

No.	Activities	Amount (US)	% cost amount	Risk
1	Management tools (registers SISNU)	350,000	3%	2
2	Small equipment for 30 renovated HF's	2,000,000	16%	4
3	Office furniture and IT Equipment	160,000	1%	1
4	Acquisition of vehicles and motorcycles	390,000	3%	2
5	Maternal mortality survey (RAMOS)	350,000	3%	3
6	TA to implement RBF (2 years)	3,000,000	25%	3.5
7	Consulting firm for RBF implementation (external verification)	2,000,000	16%	3.5
8	Qualitative Evaluation of the Project to strengthen primary and maternal health care	250,000	2%	3
19	Recruitment of two consultants for the management of the ESMF (annual contract)	84,000	1%	2
10	Accounting and financial Audit of the funds of the Project	100,000	1%	2
11	Consultant (TA) for rehabilitation of 30 institutions	150,000	1%	2
12	Rehabilitation of 30 health institutions	3,360,000	28%	3
	TOTAL	12,194,000	100%	

Graph 1



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



D) Strategy and Approach for Implementation Support

36. The strategy for implementation support is based on the nature of the Project and its risk profile as well as lessons learned from other WB-financed health projects in Haiti including the ongoing Health project (PASMISSI). The implementation support plan focuses primarily on providing support to the MSPP for the implementation of the risk mitigation measures mentioned in Section V above in the main document.

Implementation Support Plan and Resource Requirements

37. **Operational Support.** The WB's implementation support to the Government of Haiti will include the following activities: (i) improve service readiness of PHC facilities and their supply chain; (ii) continue to ensure the timely production of the annual implementation plans and RBF payment agreements; (iii) continue to track the progress of Project indicators, to monitor the implementation of Project components, and to ensure that the Project is in conformity with the Operational Manual; (iv) revisit the sustainability measures implemented throughout the implementation period; (v) ensure the results-based mechanism is being implemented appropriately; and (vi) ensure that the Project is in compliance with submitting financial reports.

38. **Technical Support.** The WB will bring value-added to the Project implementation in the form of technical support in the following areas among others: (i) provide technical guidance and assistance to improve vaccination rates; (ii) improve the structural and organizational capacity for PHC service delivery; (iii) maximize performance in RBF; (iv) improve information systems and results monitoring; (v) improve the design of a harmonized and sustainable CHSIP; and (vi) enhance planning and managerial capacity to better achieve results.

39. **Monitoring and Evaluation.** The WB will provide close hands-on support to ensure that the EVA conducts its verification activities appropriately for the packages of services provided under the RBF program. Support will also include: (i) monitoring of the CHSIP; (ii) providing technical support to analyze the information needed to maximize access to HFs by the population; (iii) monitoring of performance indicators under the RBF program and assisting with adjustments needed to improve performance; and (iv) monitoring of progress under the Results Framework and Project indicators.

40. **Fiduciary Aspects.** In the area of FM, the WB will review the Project's FM system, including, but not limited to, accounting, reporting, internal controls, and compliance with financial covenants. A FM specialist based in the WB's country office will help the UGP to review interim unaudited financial reports, annual Project audits, and external audits (as relevant). The specialist will carry out on-site FM supervision once a year. In the area of procurement, a WB procurement specialist will provide the following implementation support: (i) training the UGP staff and providing them with detailed guidance on the WB's Procurement Guidelines as needed; (ii) reviewing procurement documents and providing timely feedback to the Project procurement team; (iii) providing guidance to the UGP on the implementation of the Procurement Framework; and (iv) undertaking post-procurement reviews.

41. **Environmental and Social Aspects.** The WB will help the UGP to effectively implement the ESMF and the RPF, with particular emphasis on the adequate management of medical and non-medical waste. Also, the Project will support the Government of Haiti with the preparation of site-specific Resettlement Action Plans



(RAPs) if needed. WB social and environmental specialists will be available to provide timely assistance to the MSPP, the UGP, and local staff; and will carry out field visits on a regular basis.

Table 2. Details of Implementation Support Required

Focus	Skills Needed	Estimated # of Staff Weeks (per year)
Project management	Task Team Leadership, Senior Health Economist, Health Specialist and Economist	22 each
Operational support	Senior Operations Officer/ Economist	18
Support on CHSIP and related activities	Economist	12
Support for monitoring and evaluation, data analysis	M&E Specialist/ Data Analyst/ Economist	18
Strengthening procurement capacity	Procurement Specialist	6
Strengthening FM capacity	FM Specialist	4
Knowledge management and communication	Knowledge and Communication Specialist	2
Social and environmental specialists	Social Specialist	2
	Environmental Specialist	3



ANNEX 2: Findings from Diagnostic Work and Results Under Ongoing Health Project

COUNTRY: Haiti

Strengthening Primary Health Care and Surveillance in Haiti

A. Findings from Analytical Work and from Implementation of Ongoing Project

1. Box 1 presents some key findings so far from ongoing analytical work being undertaken by the WB, and from implementation of the ongoing Project. Further details are provided in a separate background paper, available on request.³⁸

Box 1: Selected Findings from Analytical Work and from Implementation of Ongoing WB-financed project

- The productivity of health workers at PHC facilities is very low – due, in part, to low accountability and poor incentives to perform well. Outpatient visits per non-CHW per day are less than four in three-quarters of Haiti’s health centers and dispensaries.
- Overall utilization at PHC facilities is significantly affected by the following aspects of service readiness: (i) availability of basic amenities (water, sanitation, power, phone, connectivity, state of consultation rooms etc.); (ii) extent of adherence to standard precautions for infection prevention (storage and safe disposal of medical sharps and waste; use of gloves, disinfectant, disposable syringes; guidelines for standard precautions, etc.); and (iii) availability of basic equipment. This association is particularly strong for the first two of these dimensions of service readiness, and especially in rural areas.
- Due to poor coverage nationwide of CHW programs, many HFs lack adequate CHWs. Yet overall HF utilization at PHC facilities is significantly higher for HFs with more CHWs per institutional (i.e. non-community) health worker, especially in rural areas. Utilization is also increased when there is clear identification of the CHWs’ tasks, proper supervision of the CHWs and strong linkages with the HF.
- The performance of PHC facilities is adversely affected by poor skills in management, planning and budgeting on the part of many HF managers. Because of the latter, the limited resources available to many HFs – many have access only to user fee revenues, in limited amounts – are often used inefficiently.
- The challenges that contribute to the persisting low levels of immunization coverage can be summarized as: (i) low motivation and lack of skilled human resources at all levels; (ii) limited adequate storage capacities; (iii) weak logistics/distribution capacity and low cold chain coverage; (iv) low availability of routine vaccination services leading to costly campaigns; (v) weak supervision, management and coordination at the central, Departmental and facility levels; (vi) difficulties in creating demand for vaccination; and (vii) decreasing health financing. It is important to work on several fronts to confront these challenges. (See Section C for more details).
- Institutional deliveries are constrained by significant user fees at many HFs, and by behavioral practices leading many women to go to TBAs, regardless of access and cost issues. Significant gains could be made by policies to encourage TBAs – who are valued community members – to encourage pregnant women to go to HFs for prenatal and postnatal care and for births, and ideally even to accompany them to the HFs for births. These policies could include monetary incentives, or more appropriately, “social incentives” (e.g. a “TBA of the month” type of prize).

³⁸ See “Lessons Learned and Findings from Diagnostic Work: Background Paper for Project Appraisal Document for Strengthening Primary Health Care and Surveillance in Haiti Project”.



B. Results Under RBF Program Supported by Existing Health Project

2. The existing Health project has been financing an RBF program since the last quarter of 2014 – accompanied by TA at the HF level as well as independent external verification of all performance indicators (undertaken by NGOs). The program started with a pilot phase incorporating seven sites (HFs) in the North-East department. The program was scaled up in the last quarter of 2016 to include 95 additional sites with WB financing in three other Departments: The South, Center, and North-West. A further 22 sites with WB financing were included in the fourth quarter of 2018. At the same time, sites financed by USAID and Canada were gradually included in the program, and the program currently has 84 USAID-financed sites (of which 30 started in the fourth quarter of 2018) and 7 Canada-financed sites. In total, there are sites in 8 Departments that are now covered by the national RBF program: the four mentioned above, as well as the North, Grand-Anse, Nippes and Artibonite Departments.

3. During the scale-up phase, 50 WB-financed sites have been receiving RBF payments and TA, while an additional 45 have been receiving only TA, as part of the Impact Evaluation (IE) exercise. At the same time, as part of the same exercise, 33 USAID-financed sites were receiving RBF payments and TA, while an additional 21 have been receiving only TA. A baseline survey was conducted just before the scale-up phase, and an end line survey will be conducted in mid-2019 – after which, all sites under the IE will receive RBF payments and TA.

4. Under the RBF program, HFs receive performance payments based on a set of quantity indicators and based on a quality score derived from a set of quality indicators. The DDSs also receive performance payments, based on a set of indicators including indicators of management of the Departmental warehouses for pharmaceutical products.

5. This Review focuses on the RBF performance of the HFs financed by the WB.

6. **On average, there is a positive trend for indicators contracted under the RBF, but progress is less for institutional births and family planning.** Overall, quantitative indicators are progressing in the four Departments covered by the WB (see Tables 1a and 1b). But the improvements in institutional deliveries and for family planning are lower than for the other indicators. There are substantial differences in performance across Departments. For institutional deliveries and vaccinations – especially the former – the Northwest Department shows worse performance than other Departments. The South Department shows some weaknesses with consultations and, in particular, with postnatal visits.

Table 1a. Percentage Change from Q4 2016 to Q3 2018 by Department

	1st prenatal consultation	4th prenatal consultation	Vaccination	Methods of family planning	Institutional births and caesarians (Q4 2016 to Q3 2018)
Center	14.3%	150.0%	9.9%	27.9%	30.9%
South	362.1%	408.3%	162.3%	51.4%	50.4%
Northwest	41.8%	18.2%	10.6%	43.0%	-13.4%
Northeast²	130.3%	393.3%	311.5%	-38.5%	140.5%
National	64.0%	146.0%	44.0%	17.0%	27.0%

(See notes below)



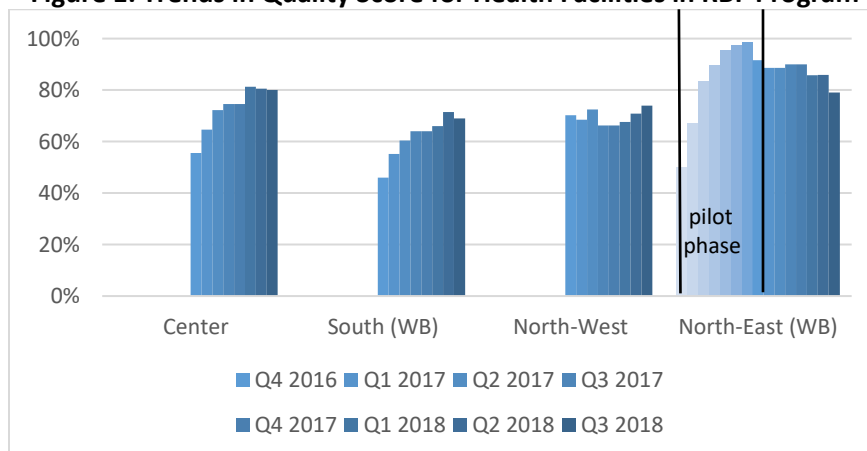
Table 1b. Percentage Change from Q4 2016 to Q3 2018 by Department

	Vit A supplementation	New institutional consultations	Deworming of children 12-59	Institutional screening for malnutrition	Postnatal home visits 0-3 days	VAT2+
Center	144.5%	39.6%	94.7%	50.6%	498.0%	7.9%
South	136.7%	-6.0%	1135.7%	549.2%	-79.2%	350.8%
Northwest	287.2%	95.7%	211.0%	1039.4%	124.6%	41.6%
Northeast ²	430.8%	33.0%	281.8%	182.9%	198.8%	246.2%
National	142.0%	29.0%	142.0%	89.0%	141.0%	51.0%

1. The figures reflect performance only for the HFs where the RBF program is financed by the WB.
2. For the Northeast Department, the figures show the percentage change starting from the first full quarter under the pilot phase, Q4 2014.
3. Since these figures depict the change in the Northeast starting from Q4 2014 and not Q4 2016, these figures are not comparable with the percentage changes in the last row under “National” where the calculations are based on percentage changes starting from Q4 2016 for all facilities including in the Northeast.

7. There has been a substantial improvement in the overall quality score for HFs, with the average quality score increasing from 61 percent in Q4 2016 to 74 percent in Q3 2018, but there are large inter-Departmental differences and performance in the Northwest Department has stagnated. These trends are shown in Figure 1 (for HFs where RBF is financed by the WB). The South Department began with a much lower score than the other Departments – due largely to the effects of Hurricane Matthew – but its performance since then has been steadily increasing. The average quality score in the Northwest Department has fluctuated over time but has largely remained the same. The quality score in the Northeast Department rose rapidly to almost 100 percent during the pilot phase and then fell somewhat although it still remains high. This may reflect the fact that for any program, performance during the pilot phase – when all attention and TA can remain focused on just a few areas – tends to be better than during the scale-up phase. There were also some delays in payments during the scaleup phase, unlike in the pilot phase (see below). Furthermore, during the scale-up phase, the value of the Gourde deteriorated sharply, and inflation rose; tariffs should have been rapidly adjusted upwards to compensate, but in practice this did not happen fast enough.

Figure 1. Trends in Quality Score for Health Facilities in RBF Program





ANNEX 3: Detailed Description of Project Activities

COUNTRY: Haiti

Strengthening Primary Health Care and Surveillance in Haiti

1. **Component 1: Strengthening Primary Health Care Service Delivery (US\$32 million from IDA Grant, US\$12 million from GFF grant).** Component 1 will finance the following activities:
 - a) **Strengthening the service readiness of selected health service providers** and their associated supply chain infrastructure (especially for vaccines³⁹) through rehabilitation activities; provision of goods, essential medicines and equipment; training and TA; and information systems for improved monitoring. The selection of the PHC facilities to be supported will be based on a data-driven exercise described in detail in Box 1 below. Improvements in service readiness will have positive climate change adaptation and mitigation co-benefits, including through improvements in water and sanitation systems, as well as the incorporation of energy efficiency standards and practices in rehabilitation activities of selected PHC facilities (e.g. the financing of solar-based cold chain equipment to improve the management of vaccines in an emission-neutral and sustainable way);
 - b) **Strengthening the design and implementation of the existing national community health program.** Financing will be provided for TA to improve the design of a harmonized and sustainable CHSIP oriented around CHWs, as well as tools to support this Plan's development and implementation – as described in detail in Box 2 below. In addition, a Plan to define the role of TBAs and to enhance the safety of deliveries by pregnant women who go to TBAs for births will be developed, including testing of different approaches (the latter activities will be informed by ongoing analytical work);
 - c) **Strengthening the management and planning capacity of selected HFs, public health supervisory units and DDSs** to: (i) better achieve results in the intervention areas, through – *inter alia* – TA specific to issues of organization, planning and distribution for vaccines, and TA to help address deficiencies in health spending⁴⁰; and (ii) increase their understanding of climate change adaptation and mitigation issues, such as the deployment of early-warning systems; and to improve the planning for relocation efforts in the event of natural disasters;
 - d) **RBF payments for the delivery of a Package of Basic PHC Services as well as Packages of Health Service-Related Activities.** The former will have a special focus on RMCHN services. The Packages of Health Service-Related Activities will include monitoring, supervision and planning activities, as well as activities in support of the storage of pharmaceutical products, by selected DDSs and public health supervisory units. The sustained financing of the RBF program will improve the treatment of climate-sensitive (i.e. water-borne) diseases leading to diarrhea;
 - e) **Developing and implementing a program of activities to maintain and strengthen external controls** including carrying out of third-party verification of the Packages of Services, by an EVA. Community surveys will be included in the verification process to ensure feedback mechanisms between users and health providers under the RBF program. The satisfaction of users will impact incentive payments and based on the feedback, corrective action plans will be developed by the HFs.

³⁹ Including components of the vaccine cold chain at HFs and at the Departmental warehouses where vaccines are stored.

⁴⁰ Where needed, TA will also be provided for HFs to produce Business Plans (with budgets) to show how they will use resources coming from RBF payments, user fees and other sources.



Box 1. Selection of PHC Facilities for Investments in Service Readiness

The choice of facilities to be supported by the Project through investments to improve service readiness is made with the objective of maximizing access to PHC services of adequate quality, in particular for poor and vulnerable populations, given available resources. Investments will support the structural capacity of already-existing PHC facilities in the Departments covered by Component 1 – the Northwest, Northeast, Center, South and Nippes Departments. Within these departments, *arrondissements* where Project investments will be made will be chosen based on: (i) the increased presence of a poor and vulnerable population; (ii) the absence of other donor programs already providing (major) service readiness support to HFs, to avoid duplication of efforts by different donors; and (iii) the potential for synergies with rural road investments under the WB Rural Accessibility and Resilience Project.

These facilities will benefit from investments in basic infrastructure and basic amenities, as well as the provision of goods and equipment. The focus will be on ensuring that the facilities are ready to deliver basic PHC services, especially for RMCHN care. Detailed information on the current state of readiness along different dimensions of basic infrastructure, amenities, equipment etc. are available for *all* HFs in the country, from the recent 2016/17 Service Provision Analysis (SPA), a census survey of HFs. (The 2016/17 SPA survey data are not yet available).

Once the *arrondissements* have been chosen, the selection of individual Project sites (i.e. PHC facilities) will be based on a geospatial analysis of facilities and their nearby populations. This analysis incorporates data on geographical access on the part of different individuals to PHC services of adequate quality. The data shows that lack of proximity to a HF with adequate service readiness is much more of a constraint than lack of proximity to a HF per se. This supports the Project's approach of extending the geographical coverage of PHC services of adequate quality through already-existing facilities in Haiti, instead of constructing additional facilities.

Using existing geospatial data on the locations of HFs and about the distribution of the population, one can quantify access to PHC as the proportion of the population living within a certain distance of any HF. Most of the needed data for this will come from: (i) the 2016/17 SPA census survey of HFs; and (ii) spatial demographic data from the WorldPop database. (This analysis can only be done once the 2016/17 SPA data are released in mid-2019). This basic analysis will be further refined using information about the road network and the quality of different roads, to measure access not only in terms of distance, but to compute actual travelling times. Such information exists and has been used by WB staff for different purposes.

Using the data sources described above (and visualization through maps), HFs will be selected based on the following criteria: (i) a low score for service readiness (basic infrastructure and basic equipment); (ii) a big enough catchment area (population living nearby); and (iii) sufficiently high production of healthcare services. The reason for incorporating the latter is that at least in the short run, increases in production (and utilization) are likely to take place steadily; short-run percentage increases are not likely to be huge. A fixed percentage increase (even a doubling) starting from a larger base is likely to be larger in absolute terms than a percentage increase starting from a smaller base. Hence, in the short run, the absolute increase in production/utilization would likely be larger if production is large to begin with. From a cost-benefit standpoint, this is important to take into account.

Improvements in service readiness of HFs will have positive climate change adaptation and mitigation co-benefits. The improvements will focus on water and sanitation systems, as well the incorporation of energy efficiency standards and practices in rehabilitation activities of the selected PHC facilities (e.g. the financing of solar-based cold chain equipment to improve the management of vaccines in an emission-neutral and sustainable way).



Box 2. Developing a Community Health Strategy and Implementation Plan for Haiti

Community health interventions are extremely cost-effective; establishing an effective community health strategy with national coverage is an essential part of a PHC-oriented approach. But there is much to be done before this can be achieved. The number of CHWs in Haiti relative to the national population is comparable to or higher than the equivalent ratio in other LICs with successful CHW programs, such as Ethiopia and Nepal. Yet overall coverage by CHWs is poor, and the country fares poorly for many basic health indicators where effective community care should have a strong positive impact (see Table 1 of the main part of this document). The challenges here for Haiti include the following:

- i. **Many agencies financing CHWs, and lack of agreement on a common model.** According to a census exercise of all CHWs in the country, which has just been completed, there are around 50 different agencies in the country – mostly different donor/NGO programs – financing a total of around 5,210 CHWs nationally; of these, just 1,000 are financed by MSPP. Out of all these CHWs, three-quarters (3,867) are CHWs with a range of different health tasks, mostly preventative and promotive; these are called Polyvalent Community Health Workers (*Agents de Santé Communautaires Polyvalents*, PCHWs). The remaining CHWs (1,343) specialize in particular diseases / conditions like malaria, tuberculosis and HIV; they are called Non-Polyvalent Community Health Workers (*Agents de Santé Communautaires Non-Polyvalents*, NCHWs). All PCHW programs are supposed to follow a particular model with characteristics defined by MSPP; but in practice there are disagreements between some implementing agencies and MSPP on certain tasks/protocols, leading to differences in operational modalities of different PCHW programs. Regarding the NCHW programs, MSPP wants them all to be converted to PCHW programs, but this is often not possible due to their financing being tied to certain diseases / conditions. Major donors are willing to “meet MSPP halfway” on this, so that a percentage of the NCHWs’ time is devoted to broader PCHW tasks; but there is no clarity on what this percentage should be.
- ii. **Lack of tools to allocate CHWs efficiently across localities; lack of systematic tracking of CHWs.** Tools to allocate CHWs efficiently across localities, in a manner that prioritizes the localities with the greatest needs, are missing. Furthermore, there is sometimes overlap of different CHW programs, so that some localities are over-financed while others are under- or not financed (for CHWs). In part, efficient allocation is not possible since systematic tracking of CHWs has not been taking place, to begin with. A census exercise of all CHWs in the country has just been carried out. But before this, key details regarding the different CHW programs – where each CHW operates, how long the program will be financed, etc. – were not systematically recorded and updated.
- iii. **Need for “risk stratification” approach.** Many of the versions of CHW models being implemented in Haiti – including the PCHW model being promoted by MSPP – do not systematically incorporate a “risk stratification” approach where the agents would: (i) first use a predetermined methodology to classify all households into risk categories – identifying, in particular, the most vulnerable (highest risk) households – and then (ii) focus most of their efforts on the highest-risk households. Such an approach has been shown in several countries (Brazil, Ethiopia etc.) to be successful in enabling CHWs to have maximum impact with their limited time.
- iv. **Lack of emphasis on a sustainable approach.** For several years, MSPP has been insisting to donors/NGOs that each PCHW should cover no more than 1,000 people – implying a need for around 10,000 PCHWs for nationwide coverage. MSPP also insists on salaries for the PCHWs that are not far from those of auxiliary nurses. But until recently almost all PCHWs in the country were financed entirely by donors/NGOs. Even just after the earthquake when the sector was flush with donor financing, there have never been more than around 4,000 PCHWs in the country. Today, MSPP finances 1,000 PCHWs and plans to finance more; but possibilities to do so are constrained by a limited domestic health budget. Unless the country puts substantially more of its own resources into community health, it has become clear that the norm of 1000 people to one PCHW – a standard followed by some other countries in the region like Brazil – is not achievable for Haiti as part of a nationwide approach. The country should



follow more closely the example of other LICs like Ethiopia and Nepal with successful community health approaches where each CHW covers many more than 1,000 people on average – although there may be variations in this ratio across localities. (The number of people per paid CHW is around 2,400 and 6,900, respectively, in Ethiopia and Nepal).

Efforts have now begun to address these issues, as part of a harmonized CHSIP. MSPP is leading these efforts, in collaboration with the WB and other key donors. The CHSIP would incorporate the following:

- i. **Finalization of a CHWs Operational Manual for both PCHWs and NCHWs, clearly specifying details of tasks, protocols, task allocation and other operational modalities for both these types of agents. This would be done in a collaborative manner between MSPP and key donors**, to ensure that implementation is then carried out in a harmonized way. For NCHWs, if they cannot be converted to full PCHWs, the goal is for them to dedicate a predetermined percentage of their time to PCHWs tasks (clearly defined and with clear task time allocations).
- ii. **Introduction of a “risk stratification” approach.** This would be as described above.
- iii. **Tools and TA to determine CHW needs in different localities, consistent with a sustainable approach.** In practice, CHW needs and ideal ratios for people per CHW are different in different localities, due to differences across localities in population density, household vulnerability and other factors. A modelling exercise will be undertaken to determine optimal allocations for CHWs across localities. The model would be calibrated so that the ratio of people per CHW would, on average, be more in line with the norms of countries like Ethiopia and Nepal – i.e. well more than 2,000, as part of a sustainable approach for a LIC like Haiti – but this ratio would vary across localities.
- iv. **Systematic tracking of all CHWs.** A system would be established for tracking key details of all PCHWs and NCHWs on a regular basis. The census that has just been conducted of all agents in the country – see above – is the start of efforts towards tracking all agents. Moving forward, a mechanism will be put in place for regular tracking/updating of information on the location of all agents and the details of the duration of each externally financed CHW program.
- v. **Plans for allocation and reallocation of all CHWs.** Once CHW needs are established from the modelling exercise mentioned above under (iii), these will be compared with the actual number of CHWs as determined from the census of CHWs that has just been conducted. When new programs financing CHWs are started, they should be directed towards the localities with a deficit in CHWs (rather than those with a “surplus” of CHWs), particularly if these are vulnerable localities. The DDSs will play a key role in this exercise, for which TA will be essential.

2. **Modifications to the stream of accountability and results-focused activities:** As noted in the main part of this document, the basic design of this stream of activities under the existing Health project (including its RBF program) will be retained under the proposed Project, with adjustments being made to provide particular support to key goals, including to support the implementation of the CHSIP. More details on this are given in Box 3 below. In addition, modifications will be made to this stream of activities to further improve vaccine performance, as described in Box 4.

3. **GFF Approach and Components 2, 3 and 4:** Box 5 below provides information on the GFF approach to be supported by the proposed Project, which includes a US\$15 million grant from the GFF. See the “Project Components” of the main part of this document for a description of the activities to be financed under Components 2, 3 and 4. (The focus of this Annex is on Component 1 and on the GFF approach, providing additional details here that are not provided in the main body of this document).



Box 3: Adapting the RBF Program to be More Oriented Towards Community Activities

In the RBF program under the existing Project, with the help of close TA, HFs produce a Business Plan every quarter which shows how cash from the RBF program as well as from user fees and other sources will be spent. HFs are allowed to allocate a portion of these revenues to HF workers – based on a method that rewards individual performance – and the workers that will receive payments are listed in the Business Plan.

Currently at many HFs, CHWs are often not counted as staff at the HF and their names are not listed in the Business Plans; hence they do not receive any RBF-related individual incentive payments. This is despite the fact that HFs receive RBF payments based on performance regarding certain services where total utilization at the HF level is substantially influenced by activities of the CHWs. (Each CHW is attached to a HF, and reports to a supervisor – usually a nurse – at the HF level.) These services include vaccinations, prenatal and postnatal consultations, nutritional screening for children and others. Hence CHWs often have little incentive to put in additional effort to enhance HF-level utilization of these services.

This is a particularly significant problem with vaccinations. With this particular service, most CHWs (depending on the modalities adopted by the financier of the CHW program) are allowed to administer this service directly to children in communities, and the CHWs are supposed to enter the appropriate data on the vaccinated children and their families into specific HF registers. CHW-administered vaccinations where the data are recorded appropriately at the HF level are counted as vaccinations administered by the HF to which a CHW is attached, and the HF gets paid for these vaccinations under the RBF program. But if the CHW does not receive any individual incentive – or an insufficient incentive – from the RBF payments, he/she often may not even properly record the data from the vaccinations into the HF registers.

Under the proposed Project, adaptations to the current RBF program will be gradually phased in, once the CHSIP has been finalized and agreed to by the Government and key donors. HFs will be required to list all CHWs in their Business Plans, if these CHWs perform tasks as required under the CHSIP. With close, hands-on TA, an appropriate method will be implemented at the level of each HF to allocate a portion of the RBF payments (and other cash revenues) to the CHWs – especially for payments received by the HF for indicators whose utilization levels the CHWs can significantly influence, like vaccinations, prenatal consultations, nutritional screening for children, etc. TA will also be provided to support the activities of the CHWs supervisor (usually a HF-level nurse).

The DDSs will play an important role in the implementation of the CHSIP. The performance indicators for the DDSs under the RBF program will include indicators of progress in this implementation, including: (i) submission initially of meaningful Action Plans for allocation/re-allocation of CHWs across HFs and localities according to the requirements of the CHSIP; and (ii) measures of progress regarding these implementation plans.

Additional community-level indicators will eventually be introduced, such as: (i) the number of children or pregnant women referred by CHWs to HFs for certain services such as prenatal and postnatal care; (ii) the number of vaccination outreach sessions organized by the CHWs (i.e. public areas in the community where mothers can bring children to be vaccinated); (iii) the number of community sessions undertaken by the CHWs to promote vaccinations; (iv) the number of community sessions undertaken to promote prenatal and postnatal consultations, deliveries at HFs, etc.; (v) the number of community outreach sessions for nutritional screening undertaken (where mothers can bring children for screening); (vi) participation by the CHWs in coordination meetings organized by the CHWs supervisor (usually a HF nurse); (vii) fulfilment of reporting requirements to the HF; and (viii) measures of CHW identification of children in the target population.



Box 4: Summary of Vaccination Challenges and Selected Project Interventions To Address Them

Although vaccination utilization under the RBF program rose since the national scaleup started in October 2016, overall vaccination coverage in the country remains poor and has stagnated over time (see Annex 2) – reflecting persistent weaknesses of the vaccination system and more generally of the health system. Recent reports have highlighted the main challenges⁴¹, summarized below. While the Project does not have the resources needed to address all the issues impacting vaccination, it will provide selected support – going beyond the activities and emphasis of the current Project – to complement other partners’ investments and TA. This will be done mainly through adaptations to the RBF program to further enhance performance in vaccine coverage, and activities to enhance the impact of the national CHW program.

Main Challenges	Interventions
The low motivation and lack of skilled human resources at all levels	<ul style="list-style-type: none"> • Adaptation of existing RBF incentives to improve motivation and performance for HF and DDS staff regarding actions to boost vaccine coverage under Component 1 activities (d) and (e), through additional indicators at the facility and DDS levels (see below). • Adaptation of existing RBF program to be more oriented towards community activities – hence enhancing performance of CHWs, HF workers and DDSs regarding community health actions to improve vaccine coverage (see Box 2). • TA to CHW supervisors at the health facility-level, including for supervision of vaccine-related activities undertaken by the CHWs.
Limited adequate storage capacity and weak logistics/distribution	<ul style="list-style-type: none"> • Selected investments in storage infrastructure and equipment at the HF and DDS levels under Component 1 activity (a). • New vaccine-specific RBF indicators at the DDS level to incentivize and monitor actions to improve planning, stock management, storage conditions, and distribution under Component 1 activities (d) and (e). • TA to improve vaccine management at the HF and especially the DDS levels (including on planning, logistics and distribution issues) under Component 1 – complementing TA provided by UNICEF, PAHO and GAVI at central and Departmental levels.
Low cold chain coverage	<ul style="list-style-type: none"> • Selected investments in solar-based cold chain equipment at the facility and DDS levels under Component activity (a) – complementing investments and TA provided by UNICEF, PAHO and GAVI at the central and Departmental levels.
Low availability of routine vaccination services leading to costly campaigns	<ul style="list-style-type: none"> • The combination of activities supported by the Project and those supported by other partners (including at the community level) is expected to improve routine vaccination services and thus reduce the need for ad-hoc campaigns to address outbreaks of preventable diseases on a recurring emergency basis.
Weak supervision, management and coordination at the central, departmental and facility levels	<ul style="list-style-type: none"> • New vaccine-specific RBF indicators to enhance the quality of supervision by the DDSs and coordination between HFs, DDSs and central level staff under Component 1 activities (d) and (e). • Supervision, coordination and management to be improved under the TA to be provided to HF and DDS staff under Component 1.
Difficulties in creating demand	<ul style="list-style-type: none"> • Demand for vaccination will increase with the adaptation of the existing RBF program to be more oriented towards community activities (see Box 3).

⁴¹ The table lists six of the seven main challenges described in the key reports. The seventh challenge is diminished health financing, which cannot be addressed under this Project. The key reports are: “*Rapport de l’évaluation conjointe*” (Joint Appraisal), GAVI, 2018; and “*Rapport d’évaluation de la Gestion Efficace des Vaccins (GEV)*” (Effective Vaccine Management (EVM) Assessment), MSPP, DPEV, Oct. 2018.



Box 5. The Proposed Project and the Global Financing Facility (GFF) Approach

The GFF is a multi-stakeholder partnership that supports countries to improve reproductive, maternal, newborn, child and adolescent health and nutrition through smart, scaled, and sustainable financing. A principal activity under the GFF is the development of an IC that defines priority actions needed to enhance the coverage, quality, and access to essential PHC services. Haiti joined the GFF in November 2017, and under the leadership of the Government and with support and active engagement from technical and financial partners, aims to get on a trajectory to achieve the maternal and child health SDGs by: (a) strengthening dialogue and coordination among key stakeholders around a clear set of priority activities and results that all partners commit their resources to achieving (as part of the “IC”); (b) by increasing both the efficiency (use) and allocation (amount) of domestic Government resources for health; and (c) strengthening systems to track progress, learn and course-correct.

There is now a need to follow key principles underlying the GFF approach. These include the following:

- a) There is emphasis on the need for the Government, with partner support, to: (i) develop mechanisms to track different donor programs and their financing streams – i.e. a resource tracking mechanism; (ii) to cost and prioritize the country’s Health Sector Development Plan or benefit package to create an IC that donors can align around; and (iii) to align and coordinate the IC priorities to donor and Government financing and activities.
- b) The GFF places a strong emphasis on community health.
- c) Domestic resource mobilization (DRM) for health is key for the GFF; this includes the notion of making domestic resources *more effective*, and not just increasing the total domestic resources per se. In the case of Haiti, around 90 percent of MSPP’s domestic recurrent budget goes towards salaries.⁴² This leaves little fiscal space (just around US\$6 million) for all non-salary recurrent items such as essential medicines and supplies, and other operating costs. Yet there are various inefficiencies that constraint the effectiveness of the domestic spending on Human Resources, contributing to low HR productivity. These include the following among others.⁴³
 - Around 47 percent of all HRH in the health sector are administrative personnel, which is very high.
 - Those at MSPP who want to retire need to wait several years before they can do so, because there is a long backlog in processing the requests – leading to a large share of the workforce consisting of older people who may not even come in to work, or who are less productive if they do come in.
 - HR productivity is low; outpatient visits per non-CHW health worker per day are less than four in three-quarters of health centers and dispensaries. There is a need to assess the “real HR needs” for each HF based on workloads⁴⁴, to compare these with the current staffing and then to reallocate as needed.

Given the importance of the above 3 issues for the GFF, they are all linked to legal conditions to be fulfilled under the GFF Grant. Specifically, an appropriate CHSIP will have to be finalized within 6 months of effectiveness of the Grant. In addition, formulation of an appropriate resource tracking mechanism and of an appropriate Plan for Rationalization of Human Resources will be disbursement conditions for the GFF grant. These two conditions will need to be fulfilled before the GFF grant can finance any activity other than TA and tools under Component 3 for the Government to implement the GFF approach. The latter can help with the attainment of the above-mentioned preconditions; hence they can be financed from the beginning under the GFF grant.

⁴² On top of that, donors provide additional financing for HR, with 21% of the health workforce financed by external donors.

⁴³ The information below comes from the “Strategic Plan for the Development of Human Resources for Health 2030, Phase I 2018-2022.” MSPP, 2018.

⁴⁴ This can be done using WHO’s Workload Indicators of Staffing Need (WISN) tool, for example.



ANNEX 4: Economic and Financial Analysis

COUNTRY: Haiti

Strengthening Primary Health Care and Surveillance in Haiti

The Development Impact of the Project

1. Global evidence shows high social returns to investments in maternal and child health. Poor health erodes human capital, by harming physical and cognitive development, and results in reduced educational outcomes and economic productivity. The returns to investing in health services are likely to be high in Haiti. Essential health indicators, especially those for maternal and child health, are still lagging behind other countries in the region and, more strikingly, even behind other LICs (see Table 1 of the main document).
2. This economic and financial analysis estimates the benefits of the Project based on the PDO and Indicators (i.e. an increase in vaccination rates of under-five children, an improved notification system for suspected cholera cases, and an increase in the use of institutional deliveries) and compares them to the Project costs. The analysis considers both benefits and costs from the Project itself (IDA financing) as well as the costs of the GFF grant. The benefits from improved donor coordination and health financing planning (i.e. costing and prioritization of the country's Health Sector Development Plan and benefit package) as part of the support from the GFF are not being considered – hence leading to an underestimate of the benefits relative to the costs.
3. The economic benefits of immunizations and particularly vaccinations have been studied relatively extensively. Childhood vaccinations are a key public health measure to avert high medical treatment costs of children getting sick and the lost income of family members taking care of their sick children. In addition, there is growing evidence that the economic benefits of vaccination extend far beyond the direct treatment costs that are usually accounted for in economic evaluations. Most importantly, vaccinations together with other measures to support early childhood development are an important factor for a greater adult productivity and the human capital formation of a country: Children whose lives are saved through immunizations and who grow up healthily will be able to contribute to the economy. In addition, childhood vaccines have proven to have additional benefits by protecting persons who are still susceptible to infection but who are too old to be vaccinated, through “herd protection”. Finally, preventing epidemic outbreaks through immunization saves societies the opportunity cost of reacting to these outbreaks after they have occurred.
4. The benefits from disease surveillance go well beyond the health benefits of limiting cases, deaths and disabilities from disease. Epidemics affect economic activity at all levels (individuals, households, villages, cities or even entire countries). During epidemics, large numbers of people become ill at the same time, often clustering in particular areas and segments of society. If the affected people cannot easily be replaced, the mechanisms that are normally used to cope with illness can be overwhelmed and can cause a breakdown in normal activity, resulting in far greater economic loss than if the same number of days lost to illness were spread over a longer period of time. In particular, developing countries like Haiti with weak water and sanitation systems are vulnerable to epidemics which can cause dramatic disruptions to economic activity (such as trade and tourism).



5. For increases in the use of institutional deliveries (the second dimension of the PDO), the economic benefits are well-established and accrue through two channels. Deliveries being carried out in an institutional setup have a lower risk of experiencing complications and hence a considerably lower mortality rate (in comparison to deliveries in non-institutional settings). First, there are reductions in avoidable healthcare costs, given that the number of high-risk pregnancies and health complications during delivery will decrease. In addition, by averting maternal deaths, deliveries in institutional settings also contribute to the human capital formation of a country: Women in a fertile age who do not die during delivery can contribute to their country's economy.

6. For the purpose of the cost-benefit analysis, the following benefits are being considered: (i) the prevention of potential disease outbreaks (e.g. cholera) through an improved notification system; (ii) averted deaths of women of child-bearing age with improved access to institutional deliveries; and (iii) averted deaths of under-five children that are fully vaccinated. For (ii) and (iii), only the economic value of the lives saved as a result of the Project interventions is being considered in the analysis. Savings from averted avoidable health care costs – although potentially of considerable magnitude – are not being accounted for. A major yet long-term benefit to materialize from the Project is that investments in PHC also prepare the country for the – already happening – transition in the disease burden towards more non-communicable diseases (NCDs). This long-term benefit is however not being reflected in the analysis.

Specification and Assumptions of the Cost-Benefit Analysis

- a) **The cost-benefit analysis** summarized below considers both a baseline as well as a low-effectiveness/low-impact scenario. Under the baseline scenario, it is assumed that the Project interventions lead to a 30 percent decrease in the maternal and under-five mortality rates in the five departments chosen for the Project interventions. Under the low-effectiveness scenario, this percentage is assumed to be only 20 percent. For the impact of epidemic prevention, it is assumed that under the baseline scenario the economy would suffer a one-time (i.e. for one year) 4 percent reduction of GDP. In the case of a less impactful epidemic (considered under the alternative scenario together with the less effective aversion of deaths), the reduction would be 3 percent. For both scenarios, the monetary value of maternal and under-five deaths being averted is being measured by considering the economic value of life (this does not account for the intrinsic or social value of any year of life). This economic value is determined as the GDP per capita of Haiti times the number of years during which the persons whose lives are saved can participate in the labor force. To estimate the benefits of epidemic prevention through the Project, it is assumed that the Project interventions lower the probability of a major epidemic by 2 percent, each year during the analysis period. The economic loss due to such an epidemic is valued for both scenarios according to the above description.
- b) **Period of time considered.** The costs of the Project occur from 2019 to 2024. Due to the delay with which benefits start materializing, benefits accruing until 2028 (so over a period of 10 years) are considered in the analysis. At the same time, these benefits are expected to persist for even longer. However, benefits accruing after the reference period of 10 years for the analysis are not considered in the analysis due to the increasing uncertainty about the counterfactual scenario in the absence of the Project. Benefits from reduced mortality will start accruing after the second year of the Project (during year one and two they are assumed to be zero) and achieve their full effectiveness (30 percent or 20



percent, respectively) in year ten. For the benefits from improved disease surveillance, it is assumed that they only apply (i.e. actually lower the probability of a major epidemic by 2 percent) after year two.

Table 1. Assumptions to Estimate the Benefits from Reduced Under-five and Maternal Mortality Rates in the Project Intervention Areas and the Prevention of Epidemics

Benefit	Modelled Change	Scenarios Considered
Aversion of Under-5/Maternal Deaths	10-Year Decrease in Mortality Rates	30% (Baseline) / 20% (Low-Effectiveness)
Prevention of Epidemics (Cholera etc.)	Annual 2% Decrease in the Chance of a One-time Reduction of GDP	4% (Baseline) / 3% (Lower-Impact Epidemic)

- c) **Basic discount rate.** In order to make the costs and benefits occurring at very different points in time during (and after) the Project comparable, they need to be discounted taking into account both inflation and the time value of money (TVM). The TVM reflects the fact that money that is available today can be invested to yield a positive return and is therefore more valuable than the same amount of money received in the future. Nevertheless, the choice of the TVM discount rate (especially in longer-term and public investment contexts) is to some extent subjective. A higher rate implies a higher relative valuation of the Project costs, given that benefits that do not start accruing immediately are discounted more heavily, whereas a lower rate implies a lower relative valuation of the costs. Therefore, costs and benefits are discounted at 7 percent to account for inflation (2 percent) and the TVM (5 percent). A higher discount rate of 12 percent (reflecting a 10 percent discount rate accounting for the TVM) is also applied to verify the sensitivity⁴⁵ of the results to this assumption. A sensitivity analysis with respect to inflation is not conducted, given that the expected benefits are measured in real terms, being unaffected by inflation anyway.
- d) **Beneficiary population.** The most immediate beneficiaries are women of fertile age and children aged under five in the Project’s target Departments. However, Project interventions to improve vaccination rates and disease surveillance clearly offer benefits to a much larger part of the population (in principle, the entire population of Haiti will benefit from the prevention of epidemic disease outbreaks).
- e) **Expected disbursements of investments.** When discounting the financial costs of the Project, it is assumed that the funds provided by the WB are disbursed according to the planned disbursement schedule (see Project Financing Data).

7. Table 2 shows for the baseline scenario and the high TVM (the logics is the same for the other scenario/TVM combinations considered), the net benefits of the Project start out being negative at the beginning of the Project, but steadily increase and turn positive after year 2. The economic benefits from averted maternal and under-five deaths and prevented outbreaks from epidemics are very similar in their magnitude (69.7 vs. 71.5 million USD in the presented scenario and TVM choice).

⁴⁵ The estimated benefits are sensitive to a higher TVM, since it decreases the present value of the more distant benefits from gains in human capital. The related reforms are long-term oriented, and it takes some time until benefits materialize.



Table 2. Annual Project Costs and Benefits (in million USD) throughout the Reference Period of the Analysis - Baseline Scenario and a High TVM

Benefits / Costs	Year										Total
	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	
Aversion of Under-5/Maternal Deaths	0.0	0.0	1.8	4.7	9.7	15.9	17.7	19.9	21.0	22.2	69.7
Prevention of Epidemics (Cholera etc.)	0.0	0.0	11.0	11.4	11.8	12.2	12.4	12.8	13.2	13.7	71.5
(A) Economic Benefits	0.0	0.0	12.8	16.1	21.4	28.1	30.1	32.8	34.2	35.7	141.3
PV of Economic Benefits	0.0	0.0	9.6	11.0	13.3	15.8	15.4	15.3	14.6	13.8	80.5
(B) Project Costs	0.3	5.6	9.4	15.6	19.7	19.4	0.0	0.0	0.0	0.0	70.0
PV of Project Costs	0.3	4.4	6.7	10.6	12.3	10.9	0.0	0.0	0.0	0.0	45.3
Net Present Value	-0.4	-4.4	2.9	0.4	1.0	4.9	15.4	15.3	14.6	13.8	35.2

Source: Based on authors' calculations.

Financial Summary Measures

8. Table 3 presents the NPV and the estimated IRR of the considered interventions. The NPV of the interventions (taking into account the streams of both benefits and costs) is largely positive and the estimated IRR ranges between 30.8 and 76.3 percent, depending on the effectiveness scenario employed, which clearly shows the positive development impact of the considered Project interventions.

9. Note that the benefits are substantially underestimated; the following are items where actual benefits are likely quite high, but where estimated benefits are zero due to insufficient information to be able to accurately calculate the benefits: (a) The benefits from improved donor coordination and strategic health financing planning (i.e. costing and prioritization of the country's Health Sector Development Plan and benefit package) as part of the support from the GFF; (b) the savings from averted avoidable health care costs, due to the Project's interventions; and (c) the benefits from reduced morbidity and increased productivity of persons due to reduced illness or improved health conditions (such as improved nutritional status).

Table 3. Net Present Value (in million USD) and Internal Rate of Return of the Project for Different Effectiveness Scenarios

TVM Discount Factor	Baseline Effectiveness		Low Effectiveness	
	NPV	IRR*	NPV	IRR*
5%	70.0	76.3%	35.7	30.8%
10%	27.9		9.5	

Source: Based on authors' calculations. *Net of inflation



References for the Economic Analysis

- *The Economic impact of a cholera epidemic on Mozambique and Bangladesh*, A report for the International Vaccine Institute June 2010, Oxford Economics.
- www.oxfordeconomics.com/publication/open/222590
- *The Economic Value of Vaccination: Why Prevention is Wealth*. J Mark Access Health Policy. 2015; 3:10.3402/jmahp.v3.29414. Published 2015 Aug 12. doi:10.3402/jmahp.v3.29414
- *Evaluating the costs and benefits of national surveillance and response systems*, WHO 2005.
- http://apps.who.int/iris/bitstream/handle/10665/69335/WHO_CDS_EPR_LYO_2005_25_eng.pdf;jsessionid=C9B54C31A1013A925885E8943E621AC1?sequence=1
- Carrera, C., Azrack, A., Begkoyian, G., et al. *The comparative cost-effectiveness of an equity-focused approach to child survival, health, and nutrition: a modeling approach*. Lancet 2012; published online Sept 20. [http://dx.doi.org/10.1016/S0140-6736\(12\)61378-6](http://dx.doi.org/10.1016/S0140-6736(12)61378-6).
- Dupas, P., 2011. *Health Behavior in Developing Countries*. Annual Review of Economics; Vol. 3: 425-449.
- <https://www.annualreviews.org/doi/abs/10.1146/annurev-economics-111809-125029>
- Victora, C.G., Adair, L., Fall, C. Hallal, P.C. Martorell, R., Richter, L., Singh Schdev, H. 2008. *Maternal and child undernutrition: consequences for adult health and human capital*. Lancet: 371: 417-40
- [https://www.thelancet.com/article/S0140-6736\(07\)61692-4/abstract](https://www.thelancet.com/article/S0140-6736(07)61692-4/abstract)