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Report No: 67945-HT

PROJECT APPRAISAL DOCUMENT

ON A

PROPOSED GRANT
FROM THE INTERNATIONAL DEVELOPMENT ASSOCIATION

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

AND

A PROPOSED GRANT
IN THE AMOUNT OF US\$20 MILLION
FROM THE HEALTH RESULTS INNOVATION TRUST FUND

TO THE

REPUBLIC OF HAITI

FOR THE

IMPROVING MATERNAL AND CHILD HEALTH THROUGH INTEGRATED SOCIAL
SERVICES PROJECT

April 22, 2013

Human Development Management Unit
Caribbean Country Management Unit
Latin America and the Caribbean Region

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CURRENCY EQUIVALENTS
(Exchange Rate Effective March 31, 2013)

Currency Unit = Haitian Gourdes
US\$1 = 42.50 Haitian Gourdes
US\$1 = SDR 0.667

FISCAL YEAR
October 1 – September 30

ABBREVIATIONS AND ACRONYMS

BCG	<i>Bacille Calmette-Guerin</i> - Vaccine for Tuberculosis
DHS	Demographic and Health Survey
DPSPE	<i>Direction de la Promotion de la Santé et de la Protection de l'Environnement</i> - Directorate of Health Promotion and Protection of the Environment
DTC	<i>Diphtérie Tétanos Coqueluche</i> – Diphtheria, Tetanus, Pertussis
ESMF	Environmental and Social Management Framework
FAES	<i>Fonds d'Assistance Economique et Social</i> – Economic and Social Assistance Fund
FY	Fiscal Year
GDP	Gross Domestic Product
HIV/AIDS	Human Immunodeficiency Virus / Acquired Immuno Deficiency Syndrome
HRITF	Health Results Innovation Trust Fund
HSIS	Haitian Health Information System
IBRD	International Bank for Reconstruction and Development
IDA	International Development Association
IFR	Interim Financial Report
KF	<i>Kore Fanmi</i> – Family Support
MDG	Millennium Development Goals
MIS	Management Information System
MSPP	<i>Ministère de la Santé Publique et de la Population</i> - Ministry of Public Health and Population
NGO	Non Governmental Organization
OP/BP	Operational Policy/Business Policy
ORAF	Operational Risk Assessment Framework
SDR	Standard Drawing Rights
UGP	<i>Unité de Gestion de Projet</i> – Project Management Unit
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WFP	World Food Program
WHO/PAHO	World Health Organization/Pan-American Health Organization

Vice President:	Hasan A. Tuluy
Special Envoy for Haiti:	Alexandre V. Abrantes
Sector Director:	Keith Hansen
Sector Manager:	Joana Godinho/Mansoor Rashid
Task Team Leaders:	Maryanne Sharp/Francesca Lamanna

HAITI
Improving Maternal and Child Health through Integrated Social Services

TABLE OF CONTENTS

	Page
I. STRATEGIC CONTEXT	1
A. Country Context.....	1
B. Sectoral and Institutional Context.....	2
C. Higher Level Objectives to which the Project Contributes	6
II. PROJECT DEVELOPMENT OBJECTIVES	6
III. PROJECT DESCRIPTION	6
A. Project Components	6
B. Project Financing	8
C. Program Objective and Phases.....	9
D. Lessons Learned and Reflected in the Project Design.....	9
IV. IMPLEMENTATION	10
A. Institutional and Implementation Arrangements	10
B. Results Monitoring and Evaluation	11
C. Sustainability.....	11
V. KEY RISKS AND MITIGATION MEASURES	12
A. Risk Ratings Summary Table	12
B. Overall Risk Rating Explanation	12
VI. APPRAISAL SUMMARY	12
A. Economic and Financial Analysis.....	12
B. Technical.....	13
C. Financial Management.....	13
D. Procurement	14
E. Social (including Safeguards)	15
F. Environment (including Safeguards)	15

Annex 1: Results Framework and Monitoring..... 16

Annex 2: Detailed Project Description 21

Annex 3: Implementation Arrangements..... 41

Annex 4: Operational Risk Assessment Framework (ORAF)..... 59

Annex 5: Implementation Support Plan..... 65

Annex 6: Economic and Financial Analysis 68

PAD DATA SHEET*Haiti**Improving Maternal and Child Health through Integrated Social Services (P123706)***PROJECT APPRAISAL DOCUMENT***LATIN AMERICA AND THE CARIBBEAN REGION**HEALTH SECTOR UNIT (LCSHH)*

Report No.: 67945-HT

Basic Information			
Project ID	Lending Instrument	EA Category	Team Leader
P123706	Investment Project Financing	B - Partial Assessment	Maryanne Sharp/ Francesca Lamanna
Project Implementation Start Date		Project Implementation End Date	
01-Jul-2013		30-Jun-2018	
Expected Effectiveness Date		Expected Closing Date	
28-Jun-2013		31-Dec-2018	
Sector Manager	Sector Director	Special Envoy for Haiti	Regional Vice President
Joana Godinho/ Mansoor Rashid	Keith E. Hansen	Alexandre V. Abrantes	Hasan A. Tuluy
Recipient: Republic of Haiti			
Responsible Agency: Fonds d'Assistance Economique et Sociale			
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No.:			
Project Financing Data(US\$M)			
☐ Loan	☒ Grant	☐ Other	
☐ Credit	☐ Guarantee		
For Loans/Credits/Others Total Project Cost (US\$M): 90.00 Total Bank Financing 90.00 (US\$M):			

Financing Source					Amount(US\$M)		
RECIPIENT					0.00		
IDA Grant					70.00		
Multi-donor Trust Fund for Health Results Innovation					20.00		
Total					90.00		
Expected Disbursements (in USD Million)							
Fiscal Year	2013	2014	2015	2016	2017	2018	2019
Annual	0.00	6.00	15.00	20.00	20.00	22.00	7.00
Cumulative	0.00	6.00	21.00	41.00	61.00	83.00	90.00
Project Development Objective(s)							
The objective of the proposed Project is to increase the access and use of maternal and child health, nutrition and other social services in the Recipient’s territory. The Project will support services in at least three Departments with a total catchment population of around 1.8 million people, targeting pregnant women, children under five and vulnerable families. Progress on the objectives of the Project will be measured by the following: (i) percent of children under five immunized; (ii) percent of institutional deliveries; (iii) contraceptive prevalence rate; and (iv) decrease in percentage of families categorized as extremely vulnerable.							
Components							
Component Name						Cost (USD Millions)	
Component 1: Providing Maternal and Child Health, Nutrition and Social Services.						81.00	
Component 2: Strengthening the Stewardship and Management Capacity.						9.00	
Compliance							
Policy							
Does the project depart from the CAS in content or in other significant respects?						Yes []	No [X]
Does the project require any waivers of Bank policies?						Yes []	No [X]
Have these been approved by Bank management?						Yes []	No [X]
Is approval for any policy waiver sought from the Board?						Yes []	No [X]
Does the project meet the Regional criteria for readiness for implementation?						Yes [X]	No []
Safeguard Policies Triggered by the Project						Yes	No
Environmental Assessment OP/BP 4.01						X	
Natural Habitats OP/BP 4.04							X
Forests OP/BP 4.36							X
Pest Management OP 4.09							X

Physical Cultural Resources OP/BP 4.11			X
Indigenous Peoples OP/BP 4.10			X
Involuntary Resettlement OP/BP 4.12			X
Safety of Dams OP/BP 4.37			X
Projects on International Waterways OP/BP 7.50			X
Projects in Disputed Areas OP/BP 7.60			X
Legal Covenants			
Name	Recurrent	Due Date	Frequency
Steering Committee within MSPP	X		Yearly
Description of Covenant			
For the purpose of ensuring the proper coordination and execution of the Project, the Recipient shall operate and maintain the Steering Committee within MSPP throughout the duration of the Project.			
Name	Recurrent	Due Date	Frequency
Appointment of Contracting Team at MSPP		30-Jul-2013	
Description of Covenant			
For the purpose of carrying out Subcomponents 1.1 and 2.1 of the Project, MSPP shall appoint by no later than one month as of the Effective Date and thereafter maintain throughout the duration of the Project a team of professionals in adequate numbers and with qualifications, experience and terms of reference satisfactory to the Association as set forth in the MSPP Operations Manual. The Contracting Team needs to be composed of staff members that are satisfactory to the Association.			
Name	Recurrent	Due Date	Frequency
Appointment of Project Team at FAES		30-Jul-2013	
Description of Covenant			
For the purpose of carrying out Subcomponents 1.2 and 2.2 of the Project, FAES shall appoint by no later than one month as of the Effective Date and thereafter maintain throughout the duration of the Project a team of professionals in adequate numbers and with qualifications, experience and terms of reference satisfactory to the Association as set forth in the FAES Operations Manual.			
Name	Recurrent	Due Date	Frequency
Social Protection Steering and Technical Committee for <i>Kore Fanmi</i>	X		Yearly
Description of Covenant			
For the purpose of ensuring the proper coordination and execution of the Project, the Recipient shall operate and maintain the multi-sectoral Social Protection Steering and Technical Committee for <i>Kore Fanmi</i> throughout the duration of the Project comprising representatives with qualifications and terms of reference satisfactory to the Association.			
Name	Recurrent	Due Date	Frequency
Appointment of External Auditor at MSPP and FAES		30-Dec-2013	

Description of Covenant	
MSPP shall appoint, and cause FAES to appoint respectively, independent auditors under terms of reference, qualifications and experience satisfactory to the Association.	
Conditions	
Name	Type
MSPP Operations Manual	Effectiveness condition of the IDA Grant
Description of Condition	
The Recipient has submitted to the Association the MSPP Operations Manual in form and substance acceptable to the Association, referred to in Article V, paragraph 5.01 (b) of the IDA Grant Agreement.	
Name	Type
Subsidiary Agreement	Effectiveness condition of the IDA Grant
Description of Condition	
The Subsidiary Agreement has been executed on behalf of the Recipient and FAES, referred to in Article V, paragraph 5.01 (a) of the IDA Grant Agreement.	
Name	Type
IDA Grant Financing Agreement	Effectiveness condition of the HRITF Grant
Description of Condition	
The Financing Agreement has been executed and delivered and all conditions precedent to its effectiveness or to the right of the Recipient to make withdrawals under it (other than the effectiveness of this Agreement) have been fulfilled, referred to in Article IV, paragraph 4.01 (a) of the HRITF Grant Agreement.	
Name	Type
MSPP Operations Manual	Effectiveness condition of the HRITF Grant
Description of Condition	
The Recipient has submitted to the Association the MSPP Operations Manual in form and substance acceptable to the Association, referred to in Article IV, paragraph 4.01 (c) of the HRITF Grant Agreement.	
Name	Type
Appointment of the Contracting Team by MSPP	Effectiveness condition of the HRITF Grant
Description of Condition	
The Recipient has appointed the Contracting Team with qualifications and terms of reference acceptable to the World Bank, referred to in Article IV, paragraph 4.01 (d) (i) of the HRITF Grant Agreement.	

Name	Type
Submission of the Impact Evaluation Plan	Effectiveness condition of the HRITF Grant
Description of Condition	
The Recipient has submitted to the World Bank an impact evaluation plan satisfactory in form and in substance to the World Bank, referred to in Article IV, paragraph 4.01 (d) (ii) of the HRITF Grant Agreement.	
Name	Type
Appointment of the Independent Verification Agency by MSPP	Effectiveness condition of the HRITF Grant
Description of Condition	
The Recipient has appointed an independent verification agency, referred to in Section I.F.4 (a) of Schedule 2 to the HRITF Grant Agreement.	
Name	Type
Appointment of the Contracting Team by MSPP	Disbursement condition of the IDA Grant
Description of Condition	
No withdrawal shall be made under Category (2) until and unless the Recipient shall have appointed the Contracting Team with qualifications and terms of reference acceptable to the Association, referred to in Section IV, B, 1(b) (i) of the IDA Grant Agreement.	
Name	Type
Submission of the Impact Evaluation Plan	Disbursement condition of the IDA Grant
Description of Condition	
No withdrawal shall be made under Category (2) until and unless the Recipient shall have submitted to the Association an impact evaluation plan satisfactory in form and in substance to the Association, referred to in Section IV, B, 1(b) (ii) of the IDA Grant Agreement.	
Name	Type
Appointment of the Independent Verification Agency by MSPP	Disbursement condition of the IDA Grant
Description of Condition	
No withdrawal shall be made under Category (2) until and unless the Recipient shall have appointed the independent verification agency, referred to in Section I.F (a) of this Schedule.	
Name	Type
Adoption of the Conditional Cash Transfer Manual	Disbursement condition of the IDA Grant
Description of Condition	
No withdrawal shall be made under Category (4) until and unless the Conditional Cash Transfer Manual has been adopted by the Recipient and FAES, referred to in Section IV, B, 1(c) (i) of the IDA Grant Agreement.	

Name		Type	
Appointment of the Independent Verification Agency by FAES		Disbursement condition of the IDA Grant	
Description of Condition			
No withdrawal shall be made under Category (4) until and unless the independent verification agency with qualifications and terms of reference acceptable to the Association has been appointed, referred to in Section IV, B, 1(c) (ii) of the IDA Grant Agreement.			
Name		Type	
Institutional Assessment of FAES to carry out Conditional Cash Transfers Program		Disbursement condition of the IDA Grant	
Description of Condition			
No withdrawal shall be made under Category (4) until and unless the institutional capacity of FAES to implement Part A.2 (g) of the Project has been strengthened in a manner satisfactory to the Association, referred to in Section IV, B, 1(c) (iii) of the IDA Grant Agreement.			
Team Composition			
Bank Staff			
Name	Title	Specialization	Unit
Maryanne Sharp	Country Operations Adviser	Team Lead	LCC2C
Francesca Lamanna	Senior Economist	Co-TTL	LCSHS
Andrew Sunil Rajkumar	Sr Economist (Health)	Sr Economist (Health)	LCSHH
Benjamin P. Loevinsohn	Lead Public Health Specialist	Contracting Specialist	AFTHW
Mirja Channa Sjoblom	Young Professional	Economist (Health)	LCSHH
Claude Rugambwa Sekabaraga	Senior Health Specialist	Health RBF Specialist	AFTHE
Petronella Vergeer	Health Specialist	Health RBF Specialist	HDNHE
Marie Chantal Messier	Sr Nutrition Spec.	Nutrition, Health	SASHN
Eleonora Cavagnero	Economist (Health)	Economist (Health)	LCSHH
Ana Ocampo	Extended Term Consultant	Operations, Social Protection	LCSHS
Agostino Paganini	Consultant	Consultant	LCSHS
Jorge Alberto Serra	Consultant	Management Information Specialist	LCSHS
Kathleen E. Krackenberger	Consultant	Consultant	LCSHH
Jimena Jesus Mejia	Consultant	Operations, Health	LCSHH
Prosper Nindorera	Senior Procurement Specialist	Senior Procurement Specialist	LCSPT
Franck Bessette	Sr Financial Management Specialist	Financial Management	LCSFM
Josue Akre	Financial Management Specialist	Financial Management	LCSFM

Victor Manuel Ordonez	Senior Finance Officer	Finance Officer	CTRLN
Nyaneba E. Nkrumah	Sr Natural Resources Mgmt. Spec.	Environment Safeguards	LCSN
Ghada Youness	Senior Counsel	Senior Counsel	LEGLE
Viviana A. Gonzalez	Program Assistant	Program Assistant	LCSHH
Sonia M. Levere	Language Program Assistant	Language Program Assistant	LCSHH

Locations

Country	First Administrative Division	Location	Planned	Actual	Comments
Haiti		North East, North West and West			

Institutional Data

Sector Board

Health, Nutrition and Population

Sectors / Climate Change

Sector (Maximum 5 and total % must equal 100)

Major Sector	Sector	%	Adaptation Co-benefits %	Mitigation Co-benefits %
Health and other social services	Health	50		
Health and other social services	Other social services	50		
Total		100		

☒ I certify that there is no Adaptation and Mitigation Climate Change Co-benefits information applicable to this project.

Themes

Theme (Maximum 5 and total % must equal 100)

Major theme	Theme	%
Human development	Population and reproductive health	30
Human development	Child health	30
Human development	Nutrition and food security	20
Social protection and risk management	Other social protection and risk management	20
Total		100

I. STRATEGIC CONTEXT

A. Country Context

1. Two-and-a-half years after the earthquake that struck near Port-au-Prince, emergency response and early reconstruction activities are phasing out. Increasingly, Haiti and its partners are focusing on the structural issues that hamper the country's development. The earthquake killed 230,000 people, injured 300,000, and displaced 1.5 million. It resulted in damages and losses of US\$7.9 billion (120 percent of GDP) and US\$11.3 billion in estimated reconstruction needs. Massive efforts have been made, but much remains to be done to improve living conditions and support sustainable change. Increasing the capacity of institutions and improving overall governance are critical to achieving sustainable results in Haiti.

2. **The earthquake struck a country that is facing major development challenges.** With a GDP per capita of US\$726 in 2011, one of the lowest in the world, Haiti is also one of the most unequal countries with a Gini coefficient of 0.59. Over half of its 10 million population was estimated to live on less than US\$1 per day, 78 percent on less than US\$2 per day in 2001¹, and 40 percent are categorized as food insecure. Any poverty gains from the country's average real growth of 2.2 percent p.a. from 2004 to 2009 are likely to have been eradicated by the earthquake. The country performs poorly on the non-income dimensions of poverty and ranks 158th out of 187 in the 2011 Human Development Index. While this historical context presents substantial challenges for reconstruction and medium-term goals, Gallup's most recent yearly perception poll shows Haitians' trust in the new Government, which was sworn in in 2011, is at its highest level since polling began in 2006 and 30 percent higher than in 2010.

3. **Following the earthquake, a severe cholera outbreak in October 2010 put pressure on the already fragile health system, further compromising the welfare and health status of the population.** As of January 2013, nearly 650,000 cases of cholera have been reported since the beginning of the epidemic, with almost 8,000 attributable deaths. This represents the largest epidemic ever recorded in a single country². The already fragile public health system was confronted with the challenge of treating patients with health workers who lacked experience in managing cholera cases. Moreover, due to separate funds for cholera prevention and treatment, parallel emergency responses systems were put into place in an unstructured manner. The Ministry of Public Health and Population (MSPP) has now launched its Cholera Elimination Plan which seeks to integrate cholera response activities back into the public health system to improve the efficiency and sustainability of the response with the ultimate goal of stopping the secondary transmission of cholera in Haiti.

4. **Although progress has been made on some human development indicators, Haiti is unlikely to achieve Millennium Development Goal - MDG 4 (reduce child mortality) and MDG 5 (improve maternal health).** While under-five mortality has decreased from 152 per 1,000 live births in the 90s, it remains high at 87 per 1,000 live births³ (three times the regional average) and is not improving at a pace to allow Haiti to achieve the MDG 4 target of 50 per 1,000 live births by 2015. Moreover, children from the poorest households face a mortality rate

¹ Latest available poverty data.

² Plan d'Élimination du Cholera 2013-2015. December 2012 and presented on March 2013

³ Ministère de la Santé Publique et de la Population (MSPP) [Haiti]. Haiti Demographic and Health Survey (DHS) 2012. Preliminary Report.

that is more than double that of children from the richest households. Malnutrition rates have stagnated since 2000: one quarter of children is born with a low birth weight, nearly one-third of children under-five suffer from stunted growth and three-quarters of children 6-24 months are anemic. Cholera is becoming endemic and the incidence of diarrheal diseases⁴ is high among children, especially those between six months and two years old (39 percent), and those living in rural areas (25 percent)⁵.

5. **Despite the efforts of the Haitian authorities, maternal mortality is the highest in the region at 630 per 100,000 live births⁶ and far from the MDG target of 155 deaths per 100,000 live births.** Maternal mortality increased between 2000 and 2005 from 523 deaths per 100,000 live births to 630 deaths per 100,000 live births (six times the regional average). During childbearing years, a Haitian woman has a 1 in 37 risk of dying from maternal causes. The nutritional status of women of childbearing age is of concern since underweight and anemic women can perpetuate the cycle of inter-generational under-nutrition and increase the risk of maternal death during childbirth⁷. Although on the decline, Haiti has the highest fertility rate in the Americas and access to family planning services is low.

6. **Public spending on health and other social services is low, thus increasing the population's vulnerability and affecting health outcomes.** The share of total expenditure on health as a percentage of GDP is 6.9 percent (around US\$8.5 per capita) and the major sources of financing of the sector⁸ are (i) out of pocket expenditures (47 percent); (ii) external donors and not-for profit organizations (31 percent), and (iii) the Government (22 percent). Government public spending on social services is low; spending on social safety nets is less than 1 percent of GDP and insufficient to respond to the pressing needs. Social sector investments continue to be highly dependent on donors, including the United Nations agencies, the World Bank, the Inter-American Development Bank, the Brazilian, Canadian, Cuban and U.S. Governments. The poor health and social outcomes in Haiti are a result of financial barriers and poor quality health care.

B. Sectoral and Institutional Context

7. **Low coverage rates of key maternal and child health interventions play a key role in Haiti's poor maternal and child health outcomes.** Children under five continue to have a high morbidity risk from preventable illnesses, including diarrheal diseases and pneumonia. Routine immunization rates are low, with 55 percent of Haitian children 12-23 months old not fully vaccinated, and 7 percent receiving no vaccine at all⁹. Maternal mortality is largely attributable to poor nutrition, the high incidence of home deliveries and limited post-natal care, and poor access to family planning services. Only 26 percent of women gave birth with qualified assistance, and among the poorest, less than one in ten women benefitted from a medically trained assistant at birth¹⁰, impacting post-natal follow up. Overall, 64 percent of women did not have any follow-up, and more than 80 percent of those who did not give birth in a health center

⁴ The three most deadly diarrheal diseases are cholera, bacillary dysentery and typhoid.

⁵ DHS 2005/06.

⁶ The DHS 2005/06 is the most recent national representative survey on maternal and child mortality in Haiti.

⁷ Black, R. E., Allen L.H, et al. (2008). Maternal and child undernutrition: global and regional exposures and health consequences. *Lancet* 371(9608): 243-260.

⁸ MSPP. August 2008. Health Accounts Report on HIV/AIDS, tuberculosis & malaria, FY 2005-2006.

⁹ DHS 2012. Preliminary Report.

¹⁰ DHS 2005/06.

did not receive post-natal care. Half of women of childbearing age are anemic, with urban and pregnant women affected disproportionately. Despite such a high prevalence of anemia, only 30 percent of pregnant women receive adequate iron supplementation (90 days or more), and 27 percent receive none¹¹. With respect to family planning, only 40 percent of women who do not want any more children, or who would like to wait to have children, have access to modern methods of contraception.

8. There are significant disparities in the access and quality of health care across wealth quintiles. Medical assistance provided by a trained professional at birth varies along the socio-economic strata. Among the richest quintile, more than half of deliveries are assisted by a doctor, and a further 16 percent by a nurse or auxiliary personnel. In contrast, only 6 percent of women from the poorest quintile have trained medical assistance during delivery. Antenatal care provides an opportunity to prepare women for childbirth and identify problems by providing information about pregnancy complications, skilled attendance at birth, and the importance of post-natal check-ups. Quality of antenatal care is poor in Haiti and there are wide variations across economic strata: among the poorest, less than half had a blood and/or a urine sample collected, while among the richest almost 9 out of 10 women benefitted from these standard tests.

9. Global evidence has highlighted a number of low-cost interventions with significant impacts in reducing morbidity and mortality rates of women and children under five. Some examples include access to family planning services, maternal screenings and treatment for pre-eclampsia, asymptomatic bacteriuria, and syphilis, tetanus toxoid vaccine, skilled maternal care to address labor complications, emergency neonatal care, community-based management of neonatal pneumonia and support for breastfeeding mothers¹². Health and nutrition services for young children, such as vaccination, prevention and management of cholera and other diarrheal diseases, pneumonia, sepsis and HIV/AIDS and malaria control, could reduce the number of deaths of infants and children by over half in countries with high child mortality rates.

10. On the supply side, access and quality of health services as well as the Government's difficulties in coordinating services providers constitute key challenges. There are three core service delivery issues in Haiti: (i) lack of access to essential services (particularly in rural areas), information and life-saving commodities; (ii) poor quality of services; and (iii) inability of the Government to set clear policy and standards and effectively coordinate and monitor integrated service delivery. The last issue is particularly important given the large number and variety of organizations currently involved in health service delivery in the country, which has contributed to a fragmented health and social system with different standards and implementation mechanisms. Annex 2 provides an overview of the organization of health service delivery. Following the earthquake, the emergency health response brought in a significant number of external agencies, bilateral aid and nongovernmental organizations (NGOs) to Haiti, mainly concentrated in Port-au-Prince. So while NGOs may have ensured continuation of service delivery, they did not necessarily increase access or address existing barriers. To address these issues, the quality and coverage of services at the institutional level needs to be improved, the gap between families and service providers must be bridged, and the Government's stewardship

¹¹ DHS 2012. Preliminary Report.

¹² Adam T., Lim S., Mehta S., Bhutta Z., Fogstad H., Mathai M., Zupan J., Darmstadt G. 2005. Achieving the Millennium Development Goals for health. Cost effectiveness analysis of strategies for maternal and neonatal health in developing countries. *BJM*; 331:1107.

function needs to be strengthened to ensure a focus on results and on the efficient use of resources to improve health outcomes.

11. On the demand side, financial constraints are the most important barrier to service utilization across socio-economic quintiles and particularly among women. Of those who were seriously sick and did not seek treatment (24 percent of all those who reported being sick) in the 30 days preceding the 2005/06 Demographic Health Survey (DHS), almost half cited financial reasons and 20 percent physical accessibility. The problem with financial barriers is most acute in rural areas (46 percent) and among women: almost eight out of ten women cited financial difficulties when seeking health care, with the problem being most severe among the poorest (92 percent). These demand-side barriers and social determinants of health need to be addressed at community and household level to help improve maternal and child health outcomes, particularly for the poor. The most vulnerable populations, and especially poorly educated mothers, tend to be the most ill-informed about common illnesses, symptoms, prevention and available treatments, and tend to utilize traditional and informal providers more readily than public health services.

12. Reducing maternal and child mortality thus requires a multi-pronged approach with support to improving the supply and coverage of, and stimulating the demand for, maternal and child health and other essential social services. As confirmed by international evidence¹³, an integrated approach of addressing both supply and demand side constraints is the most effective strategy to reduce the likelihood of occurrence of the three main delays in accessing effective interventions to prevent maternal and child mortality, namely delay in decision to seek care, delay in reaching care and delay in receiving appropriate care. If MDG-4 and 5 are to be achieved, Haiti should focus its efforts on ensuring universal coverage of proven cost-effective interventions that have high-impact on maternal and child health through the combination of (i) maternal health care services, (ii) family planning interventions, (iii) prevention and integrated management of childhood illnesses, with particular focus on diarrheal disease; (iv) community nutrition programs targeting children under-five and pregnant and lactating women, and (v) family support to improve the access of poor and vulnerable households to essential social services. Health outcomes are largely affected by other social determinants of health and the behavior of the family. Behavior change communication is a proven evidence-based strategy to improve infant and child under nutrition in the most food insecure regions¹⁴.

13. The proposed Project supports the Government's objective of increasing access and removing barriers to the use of maternal and child health, nutrition and other social services at various levels. To do this, the proposed Project will support the delivery of a well-defined package of evidence-based, high-impact, cost-effective maternal and child health and nutrition and other social services¹⁵, provided in part at facility level, in part at community level and directly to vulnerable households. At the institutional level, public and non public providers

¹³ A review is provided by e.g. Sjöblom, M., Beith A. and Eichler R. (2012). *Performance-Based Incentives for Child Health: Taking Stock of Current Programs and Future Potentials*. Bethesda, MD: Health Systems 20/20, Abt Associates.

¹⁴ Bhutta, Z.A., Ahmed, T., Black, R.E., Cousens, S., Dewey, K., Giugliani, E., Hiader, B.A., Kirkwood, B., Morris, S.S., Sachdev, H.P.S., Shekar, M. 2008. What works? Intervention for maternal and child undernutrition and survival. *Lancet*: 371: 417-40.

¹⁵ The package of services by beneficiary group is described in Annex 2 Box 2.1.

will be contracted, through a results-based financing model, to provide the package of services. These service providers will be incentivized for their performance based on the quantity and quality of services delivered. At the community level, a network of community agents (*Kore Fanmi*¹⁶) will deliver certain basic preventive services, including hygiene and cholera prevention practices, including essential commodities, promote behavior change and provide households with the necessary information on their rights to access services and how to access them, and refer beneficiaries to service providers, serving as the link between demand and supply. This network intervenes in areas traditionally underserved to make services available to poor and vulnerable households through direct support or through coordination with services providers to bridge service coverage gaps.

14. On the supply side, improving coverage and quality of maternal and child health services may be partially addressed with a results-based financing mechanism. In a number of developing countries, including fragile states, results-based financing has proven to be an effective tool to improve coverage and quality of maternal and child health services, leading to better health outcomes of women and children.¹⁷ While evaluations of earlier experience with results-based financing in Haiti are lacking, there are indications that this mechanism can produce promising results in the Haitian context.¹⁸ Strengthening health systems to deliver quality care in an integrated manner with a focus on priority services (such as prenatal care, institutional deliveries, and management of pneumonia, cholera and other diarrheal diseases) is necessary to avert maternal, neonatal and child deaths. A results-based financing approach with adequate incentives can create a focus on results and change behavior in both the supply and demand dynamics of the system, so as to improve quality of care and ensure increased, equitable access to services.

15. The proposed Project also seeks to lay the foundation for a sector wide approach in health and a national social protection operational strategy, through better donor coordination and alignment with Government priorities. In health, the Bank is an active partner in the donor coordination group collaborating on implementation of the national health policy and the Cholera Elimination Plan while working closely with USAID to support the MSPP in the development of a results-based contracting mechanism for health service delivery, the first step towards a national model, a sector wide approach and a virtual pool of financing partners. The World Bank is also member of the Regional Coalition for Water and Sanitation to Eliminate Cholera Transmission in the Island of Hispaniola, for which PAHO serves as secretariat. Finally, programmatic coordination with the Centers for Disease Control will also be strengthened through use of joint implementing mechanisms. The Project will also be supported by a Grant from the Health Results Innovation Trust Fund (HRITF)¹⁹. *Kore Fanmi* also seeks to create the foundation for a cost-effective and sustainable social protection system for Haiti by providing a common platform to coordinate social interventions by all service providers.

¹⁶ *Kore Fanmi* (“family support” in Creole) is a pilot initiative financed by the Rapid Social Response multi-donor trust fund, seeking to improve service delivery through the use of polyvalent household agents.

¹⁷ Basinga, P., Gertler P.J., Binagwaho, A.Soucat, A.L.B, Sturdy, J. and Vermeersch, C.M.J. 2011. Effect on maternal and child health services in Rwanda of payment to primary health-care providers for performance: an impact evaluation. *Lancet* 377: 1421–28.

¹⁸ Eichler, R., Auxila P., Antoine U., and Desmangles B. 2009. Haiti: Going to Scale with a Performance Incentive Model. In Eichler, Rena and Ruth Levine. 2009. *Performance Incentives for Global Health – Potentials and Pitfalls*. Center for Global Development. Baltimore, MD: Brookings Institution Press.

¹⁹ The HRITF Grant will finance performance-based payments for the delivery of maternal and child health and nutrition services.

Through *Kore Fanmi*, priorities can be set, actions coordinated, and beneficiaries identified, tracked and supported, using a common set of tools. International NGOs, such as World Vision and Partners in Health, and United Nations Agencies, such as UNICEF and WFP, are already partners in the implementation of the initiative in the Central Department and a continued dialogue is in place to integrate other donors.

C. Higher Level Objectives to which the Project Contributes

16. **The proposed Project is consistent with the Bank's Interim Strategy Note for Haiti and its 2010 Reproductive Health Action Plan.** The proposed Project is consistent with the objectives of the World Bank Group's Interim Strategy Note FY13-14 (Report No. 71885-HT) discussed by the Executive Directors on September 27, 2012. The objectives of the ISN are to: (i) reduce vulnerability and increase resilience, (ii) encourage sustainable reconstruction, (iii) build human capital, and (iv) revitalize the economy. Strengthening the Government's capacity, stewardship of key sectors, and service delivery is a crosscutting theme. The proposed Project is also in line with the World Bank's 2010 Reproductive Health Action Plan, for which Haiti is one of the focus countries. The objective of the Plan is to provide support to ensure improved access to quality reproductive health services, skilled birth attendance, emergency obstetric care, and postnatal care for mothers and newborns.

II. PROJECT DEVELOPMENT OBJECTIVES

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

III. PROJECT DESCRIPTION

A. Project Components

18. **Component 1: Providing Maternal and Child Health, Nutrition and Social Services (US\$61 million equivalent IDA Grant; US\$20 million HRITF Grant; Total of US\$81 million).** This Component will finance two sub-components, namely: (i) Performance-based Maternal and Child Health and Nutrition Service Delivery; and (ii) Results-oriented Family Support for Poor and Vulnerable Families.

19. **Sub-component 1.1: Performance-based Maternal and Child Health and Nutrition Service Delivery (US\$44 million equivalent IDA Grant; US\$20 million HRITF Grant – Total of US\$64 million).** This sub-component will finance the following activities, namely: (a) improving the quality and supply of maternal and child health services of selected public health providers based on the eligibility criteria set forth in the MSPP Operations Manual through small-scale rehabilitation, equipment, medical supplies, essential health commodities and training of, and technical assistance to health personnel as well as the preparation of a communication strategy through the carrying out of works and the provision of goods, consultants' services and Training; (b) carrying out a program of activities to maintain and

strengthen external controls in relation to, including carrying out of, third-party verification of, the Packages of Maternal and Child Health and Nutrition Services in terms of quantity and quality through the provision of consultants' services; and (c) using Results-Based Payments in support of: (i) the delivery of a Package of Maternal and Child Health and Nutrition Services including: (A) preventive services, such as immunization, micronutrient supplementation, cholera prevention and promotion of insecticide-treated bed-nets; (B) promotion of health services, such as increasing prevalence of exclusive breast-feeding and use of family planning; (C) basic curative services, such as treatment of acute respiratory infections, cholera and other diarrheal diseases, other childhood illnesses, and tuberculosis; and (D) reproductive health services, such as family planning, prenatal care, emergency obstetrical care, and post-partum care; and (ii) the delivery of Packages of Health Service-Related Activities including a program of monitoring and supervision activities by select departmental health authorities and public health supervisory units for the delivery of the Packages of Maternal and Child Health and Nutrition Services. Results-based payment agreements will be signed with public and non public providers for the delivery of the Packages of Maternal and Child Health and Nutrition Services, and with departmental health authorities and public health supervisory units for the supervision and monitoring of service delivery. This sub-component will be implemented by the MSPP.

Box 1: *Kore Fanmi*

For a pre-defined number of families, *Kore Fanmi* agents are responsible for (i) providing certain essential social services and commodities; (ii) promoting positive behavioral change; and (iii) referring families to appropriate social services when required. Before initiating the family support activities, a mapping exercise of social programs and services available to the population in the area of intervention is undertaken, creating the Opportunity Map. In parallel, a Socio-Economic Survey is carried out at family level to collect information on demography, health, hygiene and environment, education and food security. Families are then classified into four groups based on a Vulnerability Analysis: extremely vulnerable; very vulnerable; vulnerable; and little vulnerable. Based on this analysis, a Family Development Plan is generated outlining a set of life objectives, progress against which is tracked by the agents and social workers over time. The type of Family Support varies depending on the needs and vulnerabilities of each family but in cases of extreme vulnerability and no availability of services or support to those families, the Project will also provide cash or in kind transfers to families²⁰.

20. ***Sub-component 1.2: Results-oriented Family Support for Poor and Vulnerable Families (US\$17 million equivalent IDA Grant).*** This sub-component will finance delivery of social services through family support to poor and vulnerable families through: (a) the carrying out of socio-economic surveys of families for generating the family development plans; (b) the mapping of available social programs and services to develop the opportunity map and identify the most needy families; (c) the recruitment and supervision of *Kore Fanmi* agents and of municipal teams and verification of results; (d) the provision of Training to the *Kore Fanmi* agents and municipal teams; (e) the setting-up of municipal offices; (f) the provision of necessary supplies to support basic social services at the household level as specified in the FAES Operations Manual; all through the provision of goods, consultants' services, Operating Costs and Training; and (g) the provision of Conditional Cash Transfer Grants to Conditional Cash Transfer Beneficiaries. This sub-component will be implemented by the *Fonds d'Assistance Economique et Sociale* (FAES).

²⁰ This will be done in collaboration with the different actors and partners, including UNICEF and WFP as well as emerging Government social programs.

21. **Component 2: Strengthening the Stewardship and Management Capacity of Government (US\$9 million equivalent IDA Grant).** This Component will finance two subcomponents: (i) Strengthening MSPP's Stewardship and Management Capacity; and (ii) Strengthening Social Protection Coordination and Management Capacity.

22. **Subcomponent 2.1: Strengthening MSPP's Stewardship and Management Capacity (US\$5 million equivalent IDA Grant).** This sub-component will support strengthening MSPP's stewardship and management capacity, increasing the capacity of the departmental health authorities in supervision and monitoring of health service delivery, conducting surveys and studies, and preparing a nationwide healthcare waste management strategy and plan, all through the provision of goods, consultants' services and training. The capacity of the Ministry to support the various contracting functions in the long-term will be strengthened through technical assistance and training. These functions include planning, budgeting, public expenditure tracking, coordinating and overseeing the effective provision of quality services, as well as medical waste management. Finally, the Project will also finance surveys and studies as necessary to measure the Project's results. This sub-component will be implemented by the MSPP.

23. **Subcomponent 2.2: Strengthening Social Protection Coordination and Management Capacity (US\$4 million equivalent IDA Grant).** This sub-component will support strengthening the institutional capacity of the Recipient at the central, municipal, and community levels, to enhance coordination, organization, management, and social service delivery to families, by (a) supporting the operation of *Kore Fanmi* and social protection steering and technical committee; (b) carrying out capacity building activities for central and departmental authorities, municipalities and major stakeholders at the municipal, departmental and national level in the delivery of services or programs; (c) expanding the management information system of the *Kore Fanmi*; (d) carrying out minor rehabilitation of municipal offices based on eligibility criteria set forth in the FAES Operations Manual; (e) setting up a unified national beneficiary registry for the identification and tracking of beneficiaries and social assistance programs; and (f) supporting FAES for the management, supervision, monitoring and evaluation, procurement, and financial management of sub-component 1.2 of the Project, through the carrying out of works and the provision of goods, consultants' services, training and operating costs. This sub-component will be implemented by FAES.

B. Project Financing

24. **The lending instrument will be Investment Project Financing.** The Project will be financed by an IDA Grant of US\$70 million and a HRITF Grant in the amount of US\$20 million for a total of US\$90 million over five years (Table 1).

Table 1: Project Cost and Sources of Financing

Project Components	Project Cost (USD)	IDA (USD)	HRITF (USD)
Component 1: Providing Maternal and Child Health, Nutrition and Social Services	81.0	61.0	20.0
Component 2: Strengthening the Stewardship and Management Capacity of Government	9.0	9.0	0.0
Total	90.0	70.0	20.0

C. Program Objective and Phases

25. **Implementation of the proposed Project will be phased to allow for lessons learned from implementation.** A phased approach will be used to ensure that the capacity of the implementing agencies is built and that the implementation arrangements are tested in an area to allow for lessons to be drawn so that a fine-tuned model can then be introduced gradually in the remaining departments. The Project will be rolled-out in at least three Departments, namely North East, Central Plateau and North West. The three Departments have been chosen by Government based on persistent food insecurity, high rates of malnutrition and poor health indicators as well as experience with results-based financing.

D. Lessons Learned and Reflected in the Project Design

26. **Results-based financing approaches have been effective in increasing the use and quality of high-impact, cost-effective maternal and child health interventions.** The Project design takes into account international evidence on low-cost interventions with significant impacts in morbidity and mortality for young women, expectant mothers, newborns, and children under five, especially in rural areas and among the poor. Experiences from Afghanistan, Argentina, Burundi, Mexico, and Rwanda²¹ have demonstrated the field-level effectiveness of linking performance to results. Evidence shows that these types of approaches: (i) provide clear signals to health workers about government priorities and ensure that providers maintain sufficient focus on them, such as preventive and pro-poor interventions; (ii) shift the focus from inputs to the production of tangible results; (iii) strengthen monitoring and evaluation systems; (iv) increase decentralized decision-making; and (v) enhance productivity and accountability in service delivery. All of these qualities are essential for both improving maternal and child health outcomes and strengthening the overall health system. Moreover, incentives tied to quality scores at the facility level have resulted in improved quality of service delivery, which consecutively affects health seeking behavior and the individual's relationship to the health system.

27. **The Project builds on successful international experience in using community agents, such as in Chile, Colombia and Madagascar and on experiences of social accountability.** The experiences show that an integrated and multisectoral family support approach which relies on the collaboration of all different actors can address multidimensional poverty and improve health outcomes by directly providing services and bridging the gap between the population and service providers. Many country experiences²² have shown that counseling and group training yield significant results in changing families' knowledge in critical areas²³. In the Haitian context of limited social services supply, effective family support requires a multi-pronged strategy, in which services are provided directly to vulnerable families. The Government and NGOs have used community agents to provide services to people living in remote areas. The proposed Project builds on these experiences as well as on the small-scale implementation of *Kore Fanmi* in three communes of the Central Plateau, which has allowed for the better knowledge of the population's demographics and needs in the area. Due to lack of identification of people in the area and outdated census data, the exact number of families and

²¹ www.rbfhealth.org.

²² Guatemala, Honduras, Madagascar, Nicaragua and Panama.

²³ In Madagascar, community nutrition workers contributed to significantly decreasing malnutrition rates among beneficiary children as the services coverage of the target communities increased from 50 percent to 87 percent.

individuals in these areas was unknown. The socio-economic survey of all the families in the intervention areas provides data on the exact number of families, their level of vulnerability and their profile, on the basis of which the family support response is adapted. Special emphasis will be put on establishing effective inter-ministerial coordination, public-civil society coordination, dialogue and social accountability, the creation of a unified national beneficiary registry to identify the poor and target social programs, and monitoring and evaluation mechanisms.

28. **The Project also builds on the lessons learned from the implementation of the Bank-financed Cholera Emergency Response Project (P120110) in six departments in Haiti.** Key lessons learned include the need for an integrated approach to facility-level treatment and community-level education and prevention campaigns and continued capacity building in all aspects of project implementation and management, including to implement integrated interventions at facility and community levels, improve coordination of service delivery, track results in real time and strengthen project and financial management.

IV. IMPLEMENTATION

A. Institutional and Implementation Arrangements

29. **Oversight of the institutional delivery of the package of maternal and child health and nutrition services will be undertaken by the MSPP and community and family support activities by FAES.** The MSPP will be responsible for signing agreements with public and non-public providers to deliver the defined package of maternal and child health services; ensuring payment of providers upon verification of results in a timely manner to avoid service interruption; monitoring and evaluation of performance of providers; managing participating donor funds; and supervising procurement procedures, including the preparation and supervision of tender processes. All funds will be managed using a single set of implementation, administration, financial management, procurement, environmental safeguards and monitoring and evaluation procedures, outlined in a MSPP Operations Manual available prior to effectiveness and the MSPP Accounting, Financial and Administrative Manual, approved prior to negotiations. The strategic guidance for the integrated family support will be provided by a steering committee, while community and family support activities will be implemented by FAES, which is an autonomous Haitian Governmental agency with more than twenty years of project management experience. FAES operates under the supervision of both the Ministry of Economy and Finance and a Board of Directors consisting of nine members. Specifically, FAES will be responsible for (i) management of the *Kore Fanmi* network and supervision of the quality of *Kore Fanmi* activities; (ii) partnership with municipalities and the Ministry of Interior for the execution of the Project, with the MSPP for the delivery of maternal and child health and nutrition services at community level, and with other Ministries for other social services; (iii) close collaboration with different ministries on the use of the unified national beneficiary registry; and (iv) financial management and procurement for community level activities. The FAES Operations Manual was updated prior to negotiations. However, a separate Manual for the implementation of the Conditional Cash Transfer Program will be developed as part of the design of the program and is a disbursement condition for the expenditure category linked to this program.

B. Results Monitoring and Evaluation

30. **The MSPP's health management information system and the *Kore Fanmi* MIS will form the basis of the performance report and an impact evaluation of the Project will be conducted.** The routine data of the Haitian Health Information System (HSIS) will be used as the basis for the performance reporting of the institutional service providers, following verification of the accuracy of the data, including at household level. The unified national beneficiary registry and MIS will be expanded to ensure that all the data and information generated by *Kore Fanmi* is accessible through a single platform. The socio economic survey will be collected by a consulting firm or NGOs under the close supervision of FAES and then inputted in the beneficiary registry. Data collected by the *Kore Fanmi* network at family level will be inputted into the MIS by municipal teams or directly by mobile devices and regularly updated. This data will be provided: (i) by level of service delivery, (ii) by type of activity, and (iii) by service provider. Specific roles, responsibilities and methods for data collection and analysis will be detailed in the Operations Manuals. Finally, an impact evaluation of the Project will be carried out to measure its outcomes and operational impact.

C. Sustainability

31. **The proposed Project is laying the foundation for transformational systemic improvements in maternal and child health and social service delivery.** The design of the Project addresses issues on both the demand and supply sides of maternal and child health and nutrition and social service delivery and includes institutional capacity building activities to build stronger MSPP systems. *Kore Fanmi* will help in objectively identifying vulnerable families, improving the targeting of social programs and providing comprehensive family support, becoming a key service delivery mechanism at the community level and serving as the cornerstone of the Government's national social protection strategy. It will also contribute to increasing the referral of pregnant women, children under five and vulnerable households to service providers. On the supply side, the introduction of results-based financing by the MSPP is expected to lead to improved use and quality of maternal and child health and nutrition services with reduced mortality and morbidity rates among pregnant women and children under five in the long run. The Government will be able to increase the efficiency of existing resources in the public health system, strengthen its stewardship function, better target social assistance, put more focus on results and improve donor coordination. Thus the Project will have significant returns in terms of better health and social outcomes as well as in restoring the confidence for the Government's ability to provide basic services to the population.

32. **Strengthened national systems and greater regulatory capacity of the Government will contribute to improved budget execution and increased levels of financing for the sector.** Strengthening of stewardship and regulatory functions at the central and decentralized level will result in improved capacities in overall management, procurement, financial, management and auditing; increased transparency, accountability and clarity of roles and responsibilities as well as greater capacities for planning, programming and budgeting at all levels. This may also break the vicious circle of donors directly financing providers in parallel to Government systems and can lead to increased efficiency in the service delivery resources.

V. KEY RISKS AND MITIGATION MEASURES

A. Risk Ratings Summary Table

Risk	Rating
Stakeholder Risk	Substantial
Implementing Agency Risk	
Capacity	High
Governance	High
Project Risk	
Design	Substantial
Social and Environmental	Substantial
Program and Donor	Moderate
Delivery Monitoring and Sustainability	High
Overall Implementation Risk	High

B. Overall Risk Rating Explanation

33. **The Project overall risk rating is high.** While the Government has demonstrated its commitment to the innovative project design, the main risk relates to the introduction of two new approaches (results-based financing and integrated family support) in a low-capacity environment. Moreover, disbursements of results-based payments are tied to the fulfillment of a number of key conditions, including the appointment of an independent verification agency, recruitment of the contracting team and submission of an impact evaluation plan. Thus there is a substantial risk that there will be a delay in disbursements should these conditions not be met in a timely manner. Although the IDA Financing Agreement is expected to become effective within three months, the HRITF Grant Agreement is not expected to become effective for nine months given appointment of an independent verification agency is an effectiveness condition.

VI. APPRAISAL SUMMARY

A. Economic and Financial Analysis

34. **The returns on investing in health, nutrition and social services are usually very high.** Poor health and malnutrition erode human capital by harming physical and cognitive development, affect children's educational outcomes and the economic productivity of adults. Globally, average productivity losses associated with malnutrition have been estimated at more than 10 percent of lifetime earnings²⁴. In Haiti, estimates of the cost of malnutrition in 2001 indicate that the losses in productivity were \$525 million, representing 14 percent of GDP²⁵. Annually, Haiti loses an estimated US\$56 million in GDP (0.5 percent of GDP) due to lost productivity resulting from micronutrient deficiencies alone²⁶. While the long-term economic effects of stable family structures are difficult to measure, productivity losses in the absence of support systems are likely to be substantial, resulting from lower learning and job performance, delinquency and crime. Improving access and quality of services will increase the demand for such services, especially

²⁴ World Bank 2006. Repositioning nutrition as central to development: A strategy for large scale action.

²⁵ Comisión Económica para América Latina y el Caribe / World Food Programme. 2009. Martínez R., and Fernández, A. El costo del hambre: impacto social y económico de la desnutrición infantil en el Estado Plurinacional de Bolivia, Ecuador, Paraguay y Perú. Estimates based on the 2001 Living Conditions Survey.

²⁶ World Bank 2010. Haiti Nutrition at a Glance. <http://siteresources.worldbank.org/NUTRITION/Resources/281846-1271963823772/Haiti.pdf>.

among poorer households, and reduce health risks for pregnant mothers and children. This in turn will decrease the effects of health risks (morbidity and mortality) on productivity, earnings, learning and household wellbeing, and also allow re-integration of at-risk individuals and households as productive members of society, while lowering the individual and social costs of dysfunctional behavior. These impacts can be substantial: according to a study in Guatemala, exposure to good nutrition during the first two years of life led to a 46 percent increase in adult male earnings²⁷ and elimination of anemia has been estimated to boost adult productivity by 5-17 percent²⁸. A more detailed analysis is included in Annex 6.

B. Technical

35. The Project has a technical design which builds on international and national best-practices. The rationale for the technical approach selected is based on both local and international experiences and evidence of its effectiveness. The Project finances proven high-impact cost-effective maternal and child health and nutrition services²⁹ and reflects the priorities outlined in the 2012 National Health Policy³⁰. It takes into account lessons from previous experiences in Haiti and with results-based financing in Afghanistan, Argentina, Burundi, Mexico, and Rwanda, showing the importance of introducing performance-based incentives at the primary care level. International best practice in results-based financing programs have also been incorporated in the technical design, such as the importance of including quality corrections, using indicators that can be controlled by the provider, and combining demand and supply-side incentives to ensure continuity of care³¹. All components of the Projects were thoroughly costed.

C. Financial Management

36. Financial management responsibilities under the Project will be undertaken by both FAES and MSPP³² using arrangements acceptable to the Bank; however the overall risk rating for financial management is substantial. FAES is already implementing two Bank-financed projects (Cholera Emergency Response Project-P120110 and the Household Development Agent Pilot-P121690) and is continuously provided implementation support by the Bank's financial management team, thus no separate financial management assessment is needed. After a period of managerial instability, FAES is now making progress in terms of financial reporting and accountability, and its financial management arrangements are acceptable to the Bank. Nonetheless, an action plan for strengthening FAES' financial management capacity was developed and is under implementation, including the appointment of financial management staff for Bank-financed projects. The public financial management systems of the MSPP have also been assessed³³. Based on this evaluation, a capacity building program has been developed and a MSPP Accounting, Financial and Administrative Manual produced with Bank support. The Manual is not specific to the management of Bank funds, however, these processes will satisfy the Bank's minimum financial management requirements specified in OP/BP 10.02 once the team is appropriately staffed, trained and equipped. Moreover, a specific financial management assessment of the MSPP team and MSPP systems that will in practice manage the funds has been

²⁷ Hoddinott, J., Maluccio, J.A., Behrman, J.R., Flores, R., Martorell, R. 2008. Long-term economic effect of early childhood nutrition. *Lancet* 371(9610):365-366.

²⁸ World Bank 2006. Repositioning nutrition as central to development: A strategy for large scale action.

²⁹ Lancet's Maternal and Child Survival Series 2003 and 2006.

³⁰ Ministère de la Santé Publique et de la Population (2012). Politique nationale de Santé, Port-au-Prince.

³¹ Sjoblom, M., Beith A., and Eichler R. (2012). *Performance-Based Incentives for Child Health: Taking Stock of Current Programs and Future Potentials*. Bethesda, MD: Health Systems 20/20, Abt Associates.

³² The MSPP fiduciary team will be built on the *Unité de Gestion de Project* (UGP) of PEPFAR.

³³ Ref. F. Bessette, A. Pezziardi, Evaluation des systèmes de gestion financière du MSPP, avril 2012.

conducted. Current financial management systems at the MSPP are deemed acceptable to the Bank provided training is undertaken and the recruitment of a dedicated Project accountant is completed.

37. A financial management plan specific to Bank funds will be agreed upon with the MSPP while additional measures will be taken no later than four months after effectiveness. The financial management plan will include recruitment of qualified and experienced fiduciary staff and maintenance of a qualified technical assistant to strengthen the financial management capacity and provide support to the supervision of all programs to be implemented by MSPP. The additional measures following effectiveness pertain to training given that management staff and accountants of the MSPP will have to be trained on the relevant financial management, disbursement and procurement procedures.

38. Designated accounts will be opened by each of the implementing agencies at the Banque de la République d'Haïti. The IDA financing for sub-components 1.1 and 2.1 will be placed in a designated account and managed by the MSPP while the IDA financing for sub-components 1.2 and 2.2 will be placed in another designated account managed by FAES. The HRITF financing managed by MSPP will be placed in a separate designated account. Each implementing agency will prepare annual financial statements and have them audited and transmitted to the Bank no later than six months after the end of the period.

D. Procurement

39. Procurement under the Project will be undertaken by both MSPP and FAES. Procurement for Project activities will be carried out in line with the “World Bank Guidelines: Procurement of Goods, Works, and Non-Consulting Services under IBRD Loans and IDA Credits & Grants” dated January 2011 and “Guidelines: Selection and Employment of Consultants under IBRD Loans & IDA Credits & Grants by World Bank Borrowers” dated January 2011, and the provisions stipulated in the Grant Agreement. For each contract to be financed by the Grant, the different procurement methods or consultant selection methods, the need for pre-qualification, estimated costs, prior review requirements and timeframe will be agreed between the Recipient and the Bank and reflected in the Procurement Plan for the first eighteen months. The Procurement Plan will be updated at least annually or as required to reflect the actual Project implementation needs and improvements in institutional capacity. Given the need for a single set of procurement procedures, the MSPP Accounting, Financial and Administrative Manual will outline the standardized procedures that will be used by the MSPP for procurement. Additional details are provided in Annex 3.

40. To improve MSPP and FAES capacity related to procurement, dedicated procurement staff is being recruited (MSPP) and/or assigned (FAES) for Bank-financed projects and international technical assistance will be recruited to provide support and training for at least the first eighteen months of implementation. The ongoing institutional capacity assessment of FAES is also expected to provide recommendations for streamlining processes and procedures within FAES to accelerate procurement activities. A procurement action plan will be developed based on the assessment. The MSPP fiduciary team³⁴ will include an international procurement expert, a procurement specialist and an assistant and be reinforced based on the recommendations of the procurement assessment. In coordination with other relevant units, both MSPP and FAES procurement teams will be responsible for ensuring the timely implementation of the Project procurement activities. A procurement technical assistant will be recruited during

³⁴ As mentioned above, the MSPP fiduciary team will be built on the UGP of PEPFAR.

the second quarter of 2013 and support the development of a procurement action plan for the MSPP, which will be updated on a quarterly basis.

E. Social (including Safeguards)

41. **The Project is expected to have a positive social impact by improving access and utilization of maternal and child health and other essential social services, and social accountability mechanisms will be tied into the Project.** The delivery of high-impact services for pregnant women and children under five in three departments as well as the use of a targeted family support system and performance-based incentives, especially in remote areas, will all contribute to increasing social equity. The *Kore Fanmi* mechanism will bridge the gap between the State and families through the provision of basic services and goods and referral to other critical services. Social accountability mechanisms will be tied to the specific activities of the Project and will be designed based on experience from other countries similar to Haiti, such as beneficiary satisfaction surveys and grievance redress mechanisms. Finally, to ensure that health providers comply with the minimum standards to provide health care services and protect the environment, only minor rehabilitation works will be undertaken in existing footprints, thus the Project will not trigger OP/BP 4.12 for Involuntary Resettlement as there will be no new land acquisition, property damage or new construction.

F. Environment (including Safeguards)

42. **The Project is classified as category B with regard to its potential environmental and social impacts.** Given the risks associated with the inappropriate handling, classification, transportation, disposal and elimination of medical and healthcare waste and infected materials, OP 4.01 Environmental Assessment is triggered. Given that the departments of intervention of the Project were initially not specified and the plan for phasing the Project was not yet defined, two Environmental and Social Management Frameworks (ESMF) were initially prepared, one for MSPP based on institutional delivery of services and the other for FAES focused on community delivery of services. The ESMFs prepared for the Project include measures to prevent, minimize and mitigate potential risks related to the inappropriate handling, classification, transportation, disposal and elimination of hazardous healthcare and pharmaceutical waste as well as the inappropriate use of pesticides for public health and the inadequate management of dump and disposal sites. Both ESMFs were consulted and disclosed in country and on the World Bank's website in November 2012. These instruments will be updated and specific Environmental Management Plans will be prepared by MSPP and FAES in line with the roll-out of the Project in the departments of interventions. Under Component 2 of the Project, capacity building activities for effective medical waste management and worker health and safety will be undertaken for both MSPP and FAES.

Annex 1: Results Framework and Monitoring

Country: Haiti

Project Name: Improving Maternal and Child Health through Integrated Social Services (P123706)

Results Framework

Project Development Objectives

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

Project Development Objective Indicators											
Indicator Name	Core	Unit of Measure	Baseline*	Cumulative Target Values					Frequency	Data Source/ Methodology	Responsibility for Data Collection
				YR1	YR2	YR3	YR4	End Target			
1. Children under five immunized	X	Percentage	46.60	46.60		48.00		49.00	Every two years	Household Survey/HSIS	MSPP & FAES
2. Institutional deliveries	X	Percentage	20.38	20.38		21.0		22.0	Every two years	Household Survey	MSPP
3. Contraceptive prevalence rate		Percentage	21.98	21.98		23.00		24.00	Every two years	Household Survey	External Firm
4. Decrease in percentage of families categorized as extremely vulnerable		Percentage	0.00	2.00	4.00	6.00	8.00	8.00	Annually	KF MIS	FAES

Intermediate Results Indicators											
Indicator Name	Core	Unit of Measure	Baseline	Cumulative Target Values					Frequency	Data Source/ Methodology	Responsibility for Data Collection
				YR1	YR2	YR3	YR4	End Target			
1. Children 0-24 months old weighed and measured by community agents on a monthly basis		Number	0.00	2000.00	3000.00	5000.00	8000.00	9000.00	Quarterly	KF MIS	FAES
2. Children 25-29 months old whose mid upper arm circumference has been measured by community agents		Number	0.00	2000.00	3000.00	5000.00	8000.00	9000.00	Quarterly	KF MIS	FAES
3. Children 6-59 months old receiving Vitamin A supplementation		Number	0.00	500.00	1000.00	2000.00	3000.00	4000.00	Quarterly	HSIS & KF MIS; Counter verification	MSPP & FAES
4. Pregnant women referred to health providers by community agents		Percentage	0.00	30.00	32.00	34.00	36.00	36.00	Quarterly	HSIS & KF MIS; Counter verification	MSPP & FAES
5. Children under five provided with oral rehydration salts by community agents to treat cholera and other diarrheal diseases		Percentage	0.00	15.00	20.00	25.00	30.00	30.00	Annually	HSIS & KF MIS; Counter verification	MSPP & FAES
6. Contracted service providers achieving the minimum quality score		Percentage	0.00	10.00	20.00	30.00	40.00	40.00	Annually	Verification and counter verification	MSPP

Intermediate Results Indicators											
7. Households registered in the <i>Kore Fanmi</i> MIS		Number	0.00	10000.00	30000.00	50000.00	70000.00	80000.00	Quarterly	KF MIS	FAES
8. Birth certificates issued for live births		Number	0.00	500.00	700.00	900.00	1100.00	1100.00	Quarterly	KF MIS	FAES
9. Contracted health providers supervised at least quarterly		Percentage	0.00	50.00		80.00		95.00	Every two years	Project data	MSPP
10. Health personnel receiving training	X	Number	0.00	100.00		150.00		200.00	Every two years	Project data	MSPP & FAES
11. <i>Kore Fanmi</i> Agents, Social Workers and Supervisors trained		Number	149.00	250.00		400.00		600.00	Every two years	Project data	MSPP & FAES
12. Providers using the contracting model		Percentage	0.00	20.00	30.00	40.00	50.00	50.00	Annually	HSIS & Counter verification	MSPP

* Note: The baseline values were calculated using weighted population averages for the North East, North West and Central Departments (using total population data for the departments). Data sources were the 2005/06 DHS and the 2012 estimates of population data from *Institute Haitien de Statistique et d'Informatique* (the 2012 DHS data was not yet official at the time of the finalization of the document). All target values are for the three target departments, which are currently the focus areas of the Project. If the areas of intervention change to cover other departments, the baseline and target values will be adjusted accordingly.

Project Development Objective Indicators / Description (indicator definition etc.)	
Indicator Name	Description (indicator definition etc.)
1. Children under five immunized	Numerator: Number of children under five that received immunization for BCG, Polio, DTC3 and/or Pentavalent and Measles on schedule in project interventions areas. This number will include children that received the correct doses on schedule. Data for this indicator will be collected with an annual household survey. Denominator: Estimated number of children under five in Project intervention areas*100.
2. Institutional deliveries	Numerator: Number of institutional deliveries in Project intervention areas. Data for this indicator will be collected with household surveys. Denominator: Estimated number of deliveries in Project intervention areas*100.
3. Contraceptive prevalence rate	Numerator: Number of women aged 15-49 in Project intervention areas who are practicing, or whose partners are practicing, any form of modern method contraception. Data for this indicator will be collected with an annual household survey. Denominator: Estimated number of women aged 15-49 in Project intervention areas*100.
4. Decrease in percentage of families categorized as extremely vulnerable	Numerator: Number of families classified as “extremely vulnerable” by the <i>Kore Fanmi</i> MIS in Project intervention areas. Denominator: Number of beneficiaries in <i>Kore Fanmi</i> in Project intervention areas*100.
Intermediate Results Indicators/ Description (indicator definition etc.)	
Indicator Name	Description (indicator definition etc.)
1. Children 0-24 months old weighed and measured by community agents on a monthly basis	Number of children 0-24 months old weighed and measured by community agents on a monthly basis in Project intervention areas.
2. Children 25-29 months old whose mid upper arm circumference has been measured by community agents	Number of children 25-59 months old having upper arm circumference measured by community agents in Project intervention areas.
3. Children 6-59 months old receiving Vitamin A supplementation	Number of children between the ages of 6 and 59 months old receiving Vitamin A supplementation.
4. Pregnant women referred to health providers by community agents	Numerator: Number of pregnant women in Project intervention areas referred by community agents to health providers and utilizing health services. Denominator: Estimated number of pregnant women in Project intervention areas*100.

Intermediate Results Indicators/ Description (indicator definition etc.)	
5. Children under five provided with oral rehydration salts by community agents to treat cholera and other diarrheal diseases	Numerator: Number of children under five provided with oral rehydration salts by community agents in intervention area. Denominator: Estimated number of total cases of cholera and other diarrheal diseases in children under five in the Project intervention areas*100.
6. Contracted service providers achieving the minimum quality score	Numerator: Number of contracted service providers having achieved at least 60 percent during the quality scorecard assessment undertaken by the internal verification entity. The quality score card 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 facilities and management of medical waste and others. Denominator: Number of contracted service providers in Project intervention areas*100.
7. Households registered in the <i>Kore Fanmi</i> MIS	Number of households in Project intervention areas registered in the <i>Kore Fanmi</i> MIS.
8. Birth certificates issued for live births	Number of birth certificates issued in <i>Kore Fanmi</i> intervention areas.
9. Contracted health providers supervised at least quarterly	Numerator: Number of health providers that have received a supervisory visit by the departmental health authorities at least quarterly. Denominator: Number of health providers*100.
10. Health personnel receiving training	Cumulative number of health personnel that have completed training sessions (including training on cholera prevention and case management).
11. <i>Kore Fanmi</i> Agents, Social Workers and Supervisors trained	Cumulative number of <i>Kore Fanmi</i> Agents, Social Workers and Supervisors in Project intervention areas having completed training on the delivery of contractual services.
12. Providers using the contracting model	Numerator: Number of providers using the contracting model in Project intervention areas. Denominator: Estimated number of total providers in Project intervention areas*100.

Annex 2: Detailed Project Description

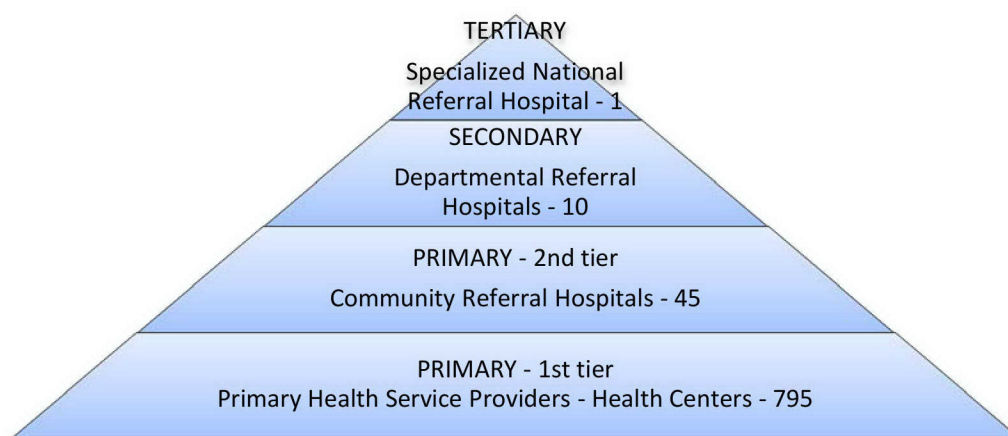
HAITI: Improving Maternal and Child Health through Integrated Social Services

1. The objective of the proposed Project is to increase the access and use of maternal and child health, nutrition and other social services in the Recipient's territory.

Health Sector Background and Organization

2. **Despite the progress made on some health indicators, Haiti is unlikely to achieve Millennium Development Goals 4 to reduce child mortality and 5 to improve maternal health.** While under-five mortality has decreased since the 1980s, it remains high at 87 per 1,000 live births (three times the regional average) and is not improving at a pace to allow Haiti to reach the MDG 4 target of 50 per 1,000 live births by 2015. Maternal mortality is the highest in the region at 630 per 100,000 live births (six times the regional average) and far from the MDG target of 155 deaths per 100,000 live births. In addition, a severe cholera outbreak started in Haiti in October 2010. The Ministry of Public Health and Population (MSPP) reported over 600,000 cholera cases (of which over 350,000 were hospitalized) and almost 8,000 deaths. This represents the largest epidemic ever recorded in a single country in the world. Although the in-hospital case fatality rate has decreased to 1.4 percent since the outbreak, the number of reported cases at the end of 2012 was higher than in 2011. Cholera is becoming endemic and the incidence of diarrheal diseases is high among children, especially those between six months and two years old (39 percent), and those living in rural areas (25 percent).

Figure 2.1 Health Service Delivery Pyramid



3. The health system includes (i) units and directorates at the central level of the MSPP; (ii) ten Departmental Health Directorates or *Directions Départementales Sanitaires*; and (iii) 41 District Health Units or *Unités d'Arrondissement de Santé*. Services are provided at different levels of the health system, which includes 908 facilities³⁵. The formal health service delivery system includes: (i) a first level made of 795 health centers with or without inpatient

³⁵ MSPP Unité de Planification et Evaluation. *Liste des institutions sanitaires, 2011*

beds called *Structures de Santé de Premier Echelon*, health centers providing primary care at the *Commune* level and 45 communal reference hospitals at the *Arrondissement* level; (ii) a second level made of 10 departmental hospitals providing secondary health care³⁶; and (iii) a third level made of national reference or teaching hospitals providing tertiary health care. With additional non-categorized health facilities providing specialized health care in the country, it is estimated that 278 are public facilities (or 31 percent), 419 are private facilities (46 percent) and 211 are mixed public-private facilities (or 23 percent)³⁷. The public health system has around 6.5 health professionals per 10,000 population³⁸ compared to the WHO standard of 25 for a 10,000 population.

4. Primary care is organized into two tiers linked in a counter-reference system between the primary health service providers and the community referral hospitals. At the community level, the first tier includes basic health care institutions delivering the minimum package of services, including health promotion, disease prevention and curative care. This package covers child, adolescent, and women's health, emergency medical and surgical care, communicable disease control, health education, and provision of essential drugs. The secondary tier in the health service pyramid network includes the community referral hospitals that offer four basic services, namely medicine, pediatrics, obstetrics and surgery. At the secondary level are the departmental referral hospitals that offer additional specialized services, including ophthalmology, orthopedics, urology, dermatology, etc. Since the cholera outbreak, some facilities at primary and secondary levels have put in place cholera treatment centers or units (depending on the number of beds) and generally in the form of tents. However, due to separate funds for cholera prevention and treatment, parallel emergency responses systems were put into place in an unstructured manner. The MSPP is now seeking to integrate these emergency responses to treat all acute diarrheal diseases. To this end, it has launched the Cholera Elimination Plan, with the support of the Regional Coalition for Water and Sanitation to Eliminate Cholera Transmission in the Island of Hispaniola³⁹. Finally, at the top of the health service delivery pyramid is the most specialized national referral hospital, the Hospital of the State University of Haiti (Figure 2.1).

5. At the community level, rally posts, mobile clinics, community agents and local birth attendants provide health services. Although not all communities have such services, where they exist, physical access to health care is improved considerably; for example, a dispensary and a health center are on average two hours away, while a rally post is 20 minutes away, a health agent, 40 minutes away, and a mobile clinic, an hour away⁴⁰. However, the services provided do not include all basic health services necessary for the community. Services also include oral rehydration points established in hard to reach areas to address mild cases of cholera and refer more complicated cases to the cholera treatment centers or units.

³⁶ Some facilities at primary and secondary level have added Cholera Treatment Centers or Units to respond to the cholera epidemic.

³⁷ MSPP *Annuaire statistique* in the National Health Policy 2012.

³⁸ MSPP National Health Policy 2012, p 18.

³⁹ The Coalition's role is to bring together technical expertise, raise new funds, and mobilize previously committed pledges to support governments in improving access to water and sanitation and to strengthen their health systems. PAHO serves as the Coalition's Secretariat and the World Bank is a Coalition member.

⁴⁰ Bergeron, G. and M. Deitchler (2003). Report on the 2002 Joint Baseline Survey in the Targeted Areas of the PL480, Title II Programs in Haiti. A. f. E. D. Food and Nutrition Technical Assistance Project. Washington, DC.

6. **Overall, challenges in the health system include both management of scarce resources and cumbersome procedures.** While each District Health Unit has the mandate to deliver a basic package of services to 80,000 to 140,000 people, District Health Units are not yet functional nationwide and their geographic area of coverage does not correspond to the national administrative organization. Every request of license needs to be submitted by the facility to the Departmental Health Authorities who forward it to the General Director before the Directorate of Organization of Health Services is formally requested to conduct an evaluation of the facility. The evaluation report is first submitted to the General Director for approval, then to the Minister for final approval, then returned to the Directorate of Organization of Health Services, forwarded to the Departmental Health Authorities and finally, to the facility. All public-funded investments in health infrastructure are under the responsibility of the Ministry of Planning and External Cooperation and thus, an authorization of its General Director and Minister is required.

7. **Planning takes place at both departmental and central levels, using a participatory planning process.** At the central level, the Planning and Evaluation Unit is responsible for monitoring and evaluating the implementation of health plans and programs in the sector, including the setting of reporting requirements and tracking of non-public funding sources. At the departmental level, Health Authorities are requested to produce integrated plans that include funds from different partners. However, the weak centralized and decentralized planning capacity results in an inefficient allocation of scarce resources. Different project- and donor-specific information systems, including the Directorate for Epidemiological Laboratory and Research System, are utilized in different departments; the information upwards to the MSPP is neither consistent nor systematic from one department to the other. While data for planning could be obtained from the HSIS, its utilization is compromised due to the lack of trained personnel and operational budget.

8. **The Directorate of Administration and Budget is responsible for developing the MSPP's budget,** managing the financial resources and ensuring accounting, procurement secretariat and public relations functions. However, several directorates in the MSPP manage their own funds and hold their own bank accounts. The Ministry of Finance manages all salaries and holds a special account for the MSPP and maintains a financial controller and a treasury accountant within the MSPP. Non-salary operational costs at the central level are managed by the Directorate of Administration and Budget. At the decentralized level, the Departmental Health Authority is the budget officer and an Administrator is responsible for managing the budget, unless some disbursements require the approval of the General Director or the Minister. At the central level, every requisition signed by the Director of Administration and Budget is submitted to the Minister's office for counter-signature before the Ministry of Finance issues a check drawn on the MSPP's account. The *Comité Ministériel des Marchés Publics* is the structure responsible for overseeing procurement.

Project Components and Phasing

9. **To address key sector challenges and support the achievement of the Project objectives, the proposed Project will finance two Components:** (i) Providing Maternal and Child Health, Nutrition and Social Services; and (ii) Strengthening the Stewardship and Management Capacity of Government. The allocations to each component are based on a costing analysis.

10. **The Project will be implemented in at least three departments with a phased implementation.** A phased approach will be used to ensure that the capacity of the implementing agencies is built and that the implementation arrangements are tested to allow for lessons to be drawn so that a fine-tuned model can then be introduced gradually in the remaining departments. An evaluation will inform the design as well as the pace of the roll-out of the adjusted model⁴¹.

Component 1: Providing Maternal and Child Health, Nutrition and Social Services (US\$61 million IDA Grant; US\$20 million HRITF Grant)

11. **The objective of this Component is to increase the use and quality of maternal and child health services and other social services.** The proposed Project supports the Government's objective of increasing access to essential social services for the poor and most vulnerable. Thus, this Component supports the delivery of a well-defined package of proven high-impact cost-effective maternal and child health and nutrition services⁴² at institutional, community and family levels using a results-based financing approach.

12. **The delivery of this package at institutional, community and family level will ensure a continuum of services at different levels of service delivery.** At institutional level, health providers will be motivated to provide more services and be more proactive to seek out potential beneficiaries as well as to improve the quality of service. Delivery of the package at community and household levels through the *Kore Fanmi* network will also ensure that critical maternal and child health outcomes are achieved. Through its integrated approach, *Kore Fanmi* supports families providing information and facilitating access to essential social services, whether agricultural, educational, sanitation, health, nutritional, disaster risk management or income-generating services. The integrated approach used in the program reduces the likelihood of occurrence of the three main delays in accessing effective interventions to prevent maternal and child mortality, namely delay in decision to seek care, delay in reaching care and delay in receiving appropriate care.

13. **Given the gap in access to services of families, strengthening demand and referral mechanisms for maternal and child health services at the community and family level is crucial.** The use of an integrated and multi-sectoral approach to effectively address the multidimensional problems of vulnerable households is well documented in Latin America in the form of *acompañamiento familiar* or family support. In countries like Chile and Colombia, where social services are directly financed and managed by government and are more available to the majority of the population, family support focuses on spreading knowledge and ensuring the utilization of services by poor and vulnerable households. In Haiti, most social services are not financed and managed by the Government and access and quality of services available to the population remains very low. For this reason, family support cannot limit itself to bridging the gap between poor people and existing services, but has to directly provide information, essential commodities, and a few select high-impact services to families and financial resources, when

⁴¹ Design adjustments for further scale-up of the Project will be developed and reflected in the MSPP Program Operations Manual.

⁴² UNICEF, UNFPA, WHO, World Bank (2010). Packages of interventions for family planning, safe abortion care, maternal, newborn and child health.

needed, to ensure that poor and most vulnerable families will use services. The Government of Haiti thus plans to scale up the *Kore Fanmi* initiative – a targeted family support through multisectoral community development agents – as the main service delivery vehicle to provide critical services, information and supplies as well as a referral mechanism for vulnerable households at community level. More specifically, with respect to the health sector, the agents will be incentivized, for instance, to refer pregnant women to primary level care for institutional deliveries and to treat or refer cholera patients. In the case of complications during delivery, the mother will be referred to the nearest facility that provides emergency obstetric care. The *Kore Fanmi* initiative intends to not only reach the most vulnerable households and track their access and utilization of social services, but also increase coordination among all actors and organizations working to improve the health, nutritional, and social status of the population.

14. Moreover, the community and the family have an important role to play in increasing prevention efforts, especially for health and nutrition. Many high-impact public health interventions to improve child and maternal survival and prevent communicable diseases (and non-communicable diseases, such as diabetes) can be delivered at low cost at household and community level, including immunization, health education, and environmental health activities. In a number of countries in the region and in Africa, this model has demonstrated good results (e.g. community nutrition approach in Madagascar). Interventions are usually prioritized in light of their substantial positive social externalities and the chronic under-spending by private service providers on such activities. In particular, preventing early chronic malnutrition and micronutrient deficiencies are among the first steps in creating and protecting human capital. The most deleterious effects of malnutrition occur during pregnancy and the first two years of life when nutrition requirements are greatest and vulnerability to inadequate caring behaviors, poor access to health services, and inappropriate infant and child feeding practices is high. Damage to physical and cognitive development and productivity accrued during this period is largely irreversible. These effects extend into later life and are transmitted to future generations. Such consequences are of critical importance in countries with high levels of poverty, vulnerability to natural disasters, and political unrest, such as Haiti. A recent evaluation comparing a preventive versus recuperative approach in Haiti found that the preventive approach had greater impacts on stunting, underweight, and wasting than the recuperative; after three years, the prevalence of stunting, underweight and wasting was lower in communities that were exposed to the preventive compared to the recuperative program⁴³. To be effective, this approach requires a family focus and support to improve their access to education, better hygiene, sanitation and agriculture practices, income-generating activities and microcredit, and in very specific cases, cash transfers.

15. Results-based financing is one approach to improve maternal and child health services through incentives for the provision of quality services to more beneficiaries. Studies on the effect of the use of this type of approach in Afghanistan, Haiti and Rwanda have demonstrated promising results in improving access and utilization of essential services and: (i) ensuring a focus on tangible results on the ground and on the strengthening of supervision and monitoring systems; (ii) providing a clear signal to health providers about the priorities of the

⁴³ Differences in favor of the preventive group were 4, 6, and 4 percentage points respectively. Menon, P. and M. Ruel. 2007. Prevention of Cure-Comparing Preventive and Recuperative Approaches to Targeting Maternal and Child health and Nutrition Programs in Rural Haiti. Final Report of the Evaluation. Washington, DC: IFPRI, Cornell University, World Vision-Haiti.

Government; (iii) decentralizing decision-making to facility staff to determine how to effectively use resources to improve utilization and quality of services; and (iv) encouraging better management practices, behavior change towards clients and improved public accountability on the part of the health provider. Some potential negative aspects of results-based financing include unintended consequences as a result of the use of incentives⁴⁴, cherry picking of patients and services to be delivered in order to increase performance bonuses, falsification of data as a way to cheat the system and achieve a higher performance bonus, and diminishing intrinsic motivation among health workers. These challenges can be overcome with appropriate program design and adequate mechanisms for monitoring during program implementation. Based on these experiences and lessons, results-based financing will be introduced for service delivery at all levels, from the community to the institutional level.

16. Moreover, results-based financing approaches allow the Government to focus on improving stewardship and coordination of the social sectors as well as increasing oversight, regulation and quality of services. Improving stewardship and increasing management capacities can break the vicious circle of donors directly financing service providers in parallel to Government systems and can lead to increased efficiency in service delivery. A single performance-based contracting mechanism, whether with public or non-public providers, a single monitoring platform and verification system, a single set of fiduciary and procurement procedures can ensure complementarity of donor financing, reduction in transaction costs for all actors and strengthening of the Government's capacity to manage donor funds. Leveraging donor funds with public resources increases sustainability as domestic resources can partially replace external resources when necessary.

17. Within this framework, this Component will finance two sub-components, namely: (i) Performance-based Maternal and Child Health and Nutrition Service Delivery; and (ii) Results-oriented Family Support for Poor and Vulnerable Families.

18. *Sub-component 1.1: Performance-based Maternal and Child Health and Nutrition Service Delivery (US\$44 million IDA Grant; US\$20 million HRITF Grant: Total US\$64 million).* To improve the availability and quality of maternal and child health and nutrition services, this sub-component will finance the following activities, namely: (a) improving the quality and supply of maternal and child health services of selected public health providers based on the eligibility criteria set forth in the MSPP Operations Manual through small-scale rehabilitation, equipment, medical supplies, essential health commodities and training of, and technical assistance to health personnel as well as the preparation of a communication strategy through the carrying out of works and the provision of goods, consultants' services and Training; (b) carrying out a program of activities to maintain and strengthen external controls in relation to, including carrying out of, third-party verification of, the Packages of Maternal and Child Health and Nutrition Services in terms of quantity and quality through the provision of consultants' services; and (c) using Results-Based Payments in support of: (i) the delivery of a Package of Maternal and Child Health and Nutrition Services including: (A) preventive services, such as

⁴⁴ For instance in Honduras, a conditional cash transfer program may have caused an increase in fertility of 2 to 4 percentage points, because only pregnant women were eligible for a subsidy. Stecklov G, Winters P, Todd J, Regalia F. *Demographic Externalities From Poverty Programs in Developing Countries: Experimental Evidence From Latin America*. Washington, DC: American University Department of Economics; 2006.

immunization, micronutrient supplementation, cholera prevention and promotion of insecticide-treated bed-nets; (B) promotion of health services, such as increasing prevalence of exclusive breast-feeding and use of family planning; (C) basic curative services, such as treatment of acute respiratory infections, cholera and other diarrheal diseases, other childhood illnesses, and tuberculosis; and (D) reproductive health services, such as family planning, prenatal care, emergency obstetrical care, and post-partum care; and (ii) the delivery of Packages of Health Service-Related Activities including a program of monitoring and supervision activities by select departmental health authorities and public health supervisory units for the delivery of the Packages of Maternal and Child Health and Nutrition Services.

Box 2.1: Package of Health and Nutrition Services by Beneficiary Group

Pregnant and Lactating Women

- Antenatal care (including routine lab tests, testing and treatment for syphilis and other sexually transmitted infections, HIV testing and prevention of mother to child transmission, tetanus vaccination*, de-worming*, treatment of anemia and other micronutrient deficiencies*, detection of hypertension, of albuminuria, of pre-eclampsia and eclampsia, appropriate referral of complicated pregnancies, detection of malnutrition* and supplementation as necessary, etc)
- Institutional Deliveries (including caesarians)
- Compensation for referral of poor and vulnerable pregnant women and traditional birth attendants
- Postpartum care (including vitamin A supplementation, promotion of exclusive breastfeeding)*
- Promotion* and provision of Reproductive Health and Family Planning Services
- Management of cholera and other diarrheal diseases and provision* of water treatment products
- Provision of long lasting insecticide-treated bed-nets*

Newborns (0-28 days)

- Comprehensive emergency care for newborns and management of neo-natal infections
- Vaccination for newborns (Polio*, BCG)
- Facilitation of access to birth certificate*

Children under Five

- Vaccination for children under 1 (DTC, Polio, Measles)*
- Micronutrient supplementation as necessary*
- Wellness checkups (including growth monitoring and nutrition counseling) *
- Prevention* and treatment of moderate acute malnutrition
- Integrated management of childhood illnesses including treatment of severe malnutrition
- Management of acute respiratory infections and diarrheal diseases
- Provision of long lasting insecticide-treated bed-nets*

*Services provided at community level through *Kore Fanmi*

19. **The Project will support the delivery of a package of maternal and child health and nutrition services proven to have an impact on maternal and child mortality.** Box 2.1 outlines the interventions included in the package of services by beneficiary group, including pregnant and lactating women, newborns and children under five. The package may be modified as necessary. This package has proven impact on maternal and child health and the introduction of results-based financing is expected to motivate service providers to improve the quality of services, thereby addressing two key barriers to maternal and child services, namely financial access and quality. This package is a sub-set of a larger package of essential health services, including communicable diseases, using the same results-based financing mechanism. Donors

will then be able to “buy” results for different health outputs, such as maternal and child health, HIV/AIDS, cholera, tuberculosis. Both the package of services and the defined beneficiary population can be expanded in the future based on available funding and participation of additional donors.

20. **The MSPP will enter into results-based payment agreements with eligible public and non-public providers for delivery of the package.** Public and non-public providers will be selected using different processes. Public providers will be selected according to clear eligibility criteria related to capacity to deliver services. These criteria will be outlined in detail in the MSPP Operations Manual. Non-public providers will be selected based on experience, capacity and proven results in delivery of maternal and child health services. The MSPP will furthermore contract the *Kore Fanmi* network to ensure the delivery of health and nutrition services at community level.

21. **The Project will finance results-based payments to participating health institutions and *Kore Fanmi* network for services delivered.** A fee-for-service payment system will be applied, where tariffs are set in advance. There will be no threshold for triggering payments; the tariffs will be paid starting with the provision of the first service. The more services the provider delivers the more resources it will receive. Payments will be made to providers and not to individuals.

Table 2.1: Example of Results-based Payment Calculation

Indicators	Unit Tariff⁴⁵ (US\$)	Number of Units	RBF payment (US\$)
Institutional Deliveries	15	30	450
Comprehensive emergency care for newborn	8	30	240
Integrated management of childhood illness	5	80	400
Management of acute malnutrition	3	100	300
Management of acute respiratory infection	3	100	300
Subtotal (I) results based financing payment			1690
Score on quality checklist ⁴⁶			60%
Subtotal (II) results based financing payment			1014
Equity bonus ⁴⁷			20%
Total results based financing payment to provider			1217

22. **The quality of services will be reflected in the payments.** In order to ensure that providers are focusing on the quality of the services that they provide, the payments given to the facility will be adjusted according to a quarterly quality score. The quality score will be based on a checklist assessed in health facilities and adjusted every year based on progress over time. These scores will be based on a broad variety of indicators such as, for example, the availability of staff and medicines (for providers), transparency measures, cleanliness and medical waste

⁴⁵ The unit tariff is a small percentage of the actual cost of providing the service.

⁴⁶ Quality adjustments are set so as not to exceed 100 percent of the subtotal.

⁴⁷ The equity bonus adjusts the payment upwards as a compensation for hardship in very remote areas.

management, and the quality of recordkeeping. Based on the results of this assessment, a quality score will be calculated and the payment to the health providers will be adjusted accordingly.

23. **An equity adjustment will be included in the results-based payments.** For example, remote health providers have a harder time attracting staff, these providers will receive an additional equity bonus, or a remoteness incentive, that will be a specified percentage of how much they have earned during the month. The criteria for selecting the providers to receive this higher tariff will include the current availability of staff at the facility and its physical remoteness. The tariff schedule, indicators to be incentivized and these equity criteria will be reflected in the MSPP Operations Manual. Table 2.1 provides an example of results-based payment calculations based on the principles stated above.

24. **The fixing of tariffs, and subsequent revision in later years, is an important exercise.** The methodology used for calculating the tariff is crucial to ensure economy, efficiency and long-term sustainability of the program. The final package of services and tariff schedule will be specified in the MSPP Operations Manual⁴⁸. The package of services and tariff schedule will be reviewed on a regular basis and adjusted as needed. Progress in project implementation may require adjustments in indicators and their relative tariff over time. The following steps will be followed when calculating the tariffs:

- **Costing of service package:** The results-based payments will contribute to operational costs related to providing the services and will compensate the user fees to the service providers, while some inputs to the production function for health (e.g. vaccines and contraceptives) will be borne by the MSPP, supporting NGOs and other donors. Other operational costs will be included in the costing to determine the payments. Salaries and capital costs will be excluded from the costing, since these will be paid from other sources.⁴⁹ A survey is being conducted to help determine the tariffs of the service package and will be completed by June 2013.
- **Forecasting:** For each of the indicators, forecasts of how many services will be provided per month are calculated on the basis of WHO population statistic guidelines and statistics are used as entry points. These determine, for instance an average birth rate per 1,000 population, which will then be adjusted according to specific public health characteristics of the target area (household surveys and facility based assessments will provide this information). The forecasting is important to define the public health objectives of the program as well as to estimate health service utilization.
- **Determining the tariff per service:** The tariff per indicator will be defined in a manner that reflects the relative public health priority. The core public health principle is to adjust pricing of the indicators on the basis of public health needs and create the correct incentives for

⁴⁸ The MSPP Program Operations Manual will describe the details of the results based financing model including (i) the approach to engaging providers (ii) the service package and tariff schedule, as well as mechanism and timing for periodic updating of tariffs, (iii) the quality checklist, (iv) roles and responsibilities for the verification of results, (v) penalties for misreporting, misuse of funds and other irregularities, and the (vi) the design and methodology of the impact evaluation. The Operations Manual is being developed by the MSPP in close consultation in such a way as to allow it to be a practical guide on results based financing implementation for different levels of actors involved. The Manual will be a living document that will be updated regularly based on lessons learnt during implementation.

⁴⁹ The definition of operational costs basically excludes items paid for from other sources – such as salaries, capital costs, vaccines, contraceptives and antiretrovirals. Included in the costing are items such as gloves, fuel, medical supplies and transport services/inputs to bring items from departmental depots to health facilities.

providers to perform well. Each indicator receives a relative weight based on coverage levels and time and cost to deliver the service. Based on the relative importance of each indicator, the final tariff is assigned to each service. The payments do not reimburse the full cost of a specific indicator. The payment for the total service package will be lower than the reasonable cost for the health provider to produce that activity. Thus, the tariff for the individual indicator in the package will be based on public health priorities, coverage as well as cost.

- **Testing of suggested tariffs:** Initially, the proposed tariff schedule will be tested in practice. This is important to ensure that the individual cost assignment of each service adds up to the calculated cost of the delivery of the package of services.
- **Revisions of tariffs:** Tariff setting in a results-based financing program is a dynamic process and needs to be reviewed on a regular basis. This process is part of the project monitoring and supervision and will be captured in the MSPP Operations Manual.

25. **Providers will be able to decide how to spend the results-based payments following some guidelines outlined in the MSPP Operations Manual.** The results-based payments will be deposited in the facility's bank account and will be undistinguishable from its other sources of funds, mainly patient fees for other services not included in the Project and/or proceeds from sales of medicines. The facility will have substantial autonomy over how to use the funds they receive, although the MSPP will set some general guidelines in the MSPP Operations Manual to ensure improvements in overall allocation of resources, management, governance and accountability. For example, there will be a limit on what percentage of its funds a health provider can spend on performance incentives to staff. The providers may also reinvest these funds into the facility and/or buy medicines.

26. **A single monitoring platform and a single system for verification of results will be utilized.** In addition, a single MSPP Operations Manual and single MSPP Accounting, Financial and Administrative Manual will be developed. *Kore Fanmi's* MIS will contribute data on results for MSPP reports.

27. **The MSPP Operations Manual will describe the implementation details for the contracting model,** including: (i) the description of services to be delivered under the Packages of Maternal and Child Health and Nutrition Services and the Packages of Health Services-Related Activities; (ii) the schedule of Results-Based Payments which shall be calculated on the basis of a methodology acceptable to the Association and designed to ensure that the Results-based Payments do not exceed the reasonable unit cost of the services to be provided; and are scaled to reflect the quality of the service delivered, the conditions of the locations where the services are to be provided, and the need to ensure a balance between the Packages of Maternal and Child Health and Nutrition Services and other maternal and child health and nutrition services that need to be made available in the targeted area concerned; (iii) the procedures and methodology for the evaluation and updating of the Results-Based Payments; (iv) the eligibility criteria for, and terms and conditions of, Results-Based Payments Agreements; (v) the procedures for monitoring and evaluation of Results-Based Payments Agreements; and (vi) the procedures and criteria for development and delivery of training under the Project. The Operations Manual will be a working document that will be regularly updated on the basis of recommendations from the monitoring process, external verification reports and Joint Implementation Support Missions.

28. **Disbursements of IDA and HRITF funds for these Results-Based Payments will be conditional on the following:** (i) appointment of an independent verification agency for the Results-Based payments; (ii) appointment of a contracting team, with qualifications and terms of reference acceptable to the Association, to play a coordination and stewardship role for the Results-Based payments and more generally for the health sector (see Annex 3); and (iii) submission of a plan for impact evaluation, satisfactory in form and in substance to the Association, of the Results-Based payments program.

29. **This sub-component also seeks to improve the quality and supply of services of contracted public health providers,** through financing of small-scale rehabilitation, equipment, goods, medical supplies, essential health commodities, drugs and training of health personnel based on eligibility criteria defined in the MSPP Operations Manual. Participating public health providers must meet certain eligibility criteria in order to participate in the results-based financing program. As such, an assessment of the capacity of the public health provider to deliver the package of services will be undertaken by the MSPP, resulting in a ranking of providers within each department: (i) those public providers that meet the eligibility criteria; (ii) public health providers that require some basic support to meet the criteria, such as the provision of additional equipment and medical supplies; and (iii) those public health providers that require more substantial investment to be functional or do not meet the eligibility criteria. In addition, training on the correct application of service delivery protocols will be provided for health personnel involved in the delivery of the package of services as necessary. Additional training and support will be provided on administrative and financial management of health institutions and support to medical waste management will be provided.

30. **To ensure accurate reporting and payments, several mechanisms have been put in place for counter-verification of the results.** The verification of results, both in terms of quantity and quality, is a critical element of results-based financing. Verification will be carried out on a quarterly basis by independent external agents to ensure the accuracy and consistency of reporting on the volume and/or quality of services provided. To this end, the contracted firm/s will review health facility registers as well as the *Kore Fanmi* MIS and randomly select a sample of beneficiaries to conduct a survey at household level on services rendered. Finally, independent health facility and household surveys will be carried out to ensure that there is progress in strengthening the quantity and quality of health services, that there are no unintended consequences from results-based financing mechanisms, and to confirm the results reported by the health management information system.

31. **This component will also finance technical assistance in results-based financing, financial management and procurement to ensure proper execution of the Project.** Technical assistance will be provided at the central, departmental and facility level to key staff in the execution of the results-based financing processes to build capacity of the contracted institutions as well as to monitor performance at all levels.

32. **Capacity of MSPP at the departmental level is uneven resulting in poor supervision and lack of coordination of health providers, weak management of scarce human and financial resources and lack of ability to show results.** This sub-component will also provide results-based payments to the ministry's departmental health authorities as well as other public health supervisory units within MSPP to support the implementation of their annual work plans, including supervision and monitoring of service delivery. Annual results-based payment agreements will be signed outlining roles and responsibilities, performance indicators and milestones, amount of financing, disbursement mechanisms and verification of performance.

33. **Given that results-based financing represents a fundamental shift in behavior, moving the risk from the purchaser to the provider, training and communication campaigns will need to be undertaken at all levels** on purchaser responsibilities, triggers for payment, roles of decentralized health authorities and local government, fund flow mechanisms, accountability mechanisms, verification and supervision. Thus, a comprehensive communication strategy will need to be developed and implemented.

34. ***Sub-component 1.2: Results-oriented Family Support for Poor and Vulnerable families (US\$17 million IDA Grant).*** To create a bridge between families and services and provide family support and essential information, goods and services to poor and vulnerable households, this sub-component will finance delivery of social services through family support to poor and vulnerable families through: (a) the carrying out of socio-economic surveys of families for generating the family development plans; (b) the mapping of available social programs and services to develop the opportunity map and identify the most needy families; (c) the recruitment and supervision of *Kore Fanmi* agents and of municipal teams and verification of results; (d) the provision of training to the *Kore Fanmi* agents and municipal teams; (e) the setting-up of municipal offices; (f) the provision of necessary supplies to support basic social services at the household level as specified in the FAES Operations Manual; all through the provision of goods, consultants' services, operating costs and training; and (g) the provision of Conditional Cash Transfers to Conditional Cash Transfer Beneficiaries.

35. ***Kore Fanmi is an innovative mechanism for improving the efficiency of service delivery in Haiti.*** The system is made up of a network of community agents and municipal teams who are responsible for (i) providing certain essential social services and commodities, (ii) promoting positive behavioral change, and (iii) referring families to appropriate social services when required (Box 2.2 includes the detailed package of interventions, which may be modified as necessary). *Kore Fanmi* agents are locally recruited and assigned a manageable number of families. The number of families assigned to each *Kore Fanmi* agent depends on the family's level of poverty and vulnerability and the topography in the area of intervention, as specified in the FAES Operations Manual.

36. **Family needs are first assessed based on a Socio-Economic Survey to establish a detailed family socio-economic profile** based on family demographic, education and economic data, and health, nutrition, food security, housing and environment conditions. In parallel, an Opportunity Map of the commune of intervention is established to identify all social services available to the population. Based on the Socio-Economic Survey, a Vulnerability Analysis is then undertaken to create a detailed profile of each family's conditions and produce an objective

measure of its vulnerability, which in turn determines the intensity of the support to be provided by the *Kore Fanmi* agent and the social workers. Families are categorized into four classes of vulnerability. On the basis of the family profile and vulnerability level, a Family Development Plan is created to match each family's specific conditions with Life Objectives that include health, personal and environmental hygiene, nutrition and food security, economic opportunities, education, civil rights and domestic violence prevention. The Opportunity Map guides the *Kore Fanmi* agents and the municipal team in the referral of families to existing services. It also allows the identification of gaps in the provision of services. Where families are deemed extremely vulnerable and there is no support available to them, the Project will also provide cash or in kind transfers to the most vulnerable families⁵⁰. A separate Conditional Cash Transfer Manual will be developed by FAES during Project implementation detailing the conditions, responsibilities and procedures as a condition for disbursement of this category.

37. The *Kore Fanmi* agents are supported by a municipal team, responsible for supervising training and guiding them in their tasks. The team is also responsible for improving cooperation between partners and service providers at different levels (municipal, departmental and national level) and for keeping local authorities informed of and engaged in social services at the municipal level in their areas of responsibility.

38. To deliver their package of interventions, *Kore Fanmi* agents and the municipal teams will be trained using a curriculum shifting from a pure service delivery approach to a family support one. The content and structure of the training is developed with *Kore Fanmi* partners, such as UNICEF and WFP, and validated by the Government, on the basis of the best practices and protocols identified at international level (for example, *Facts for Life*⁵¹ for training modules promoting positive behavioral changes). Agents will be regularly assessed to test their knowledge and capacity to transmit the knowledge to families.

39. The data and information generated by *Kore Fanmi* is processed through a state of the art MIS that has been developed based on the experiences of Latin American countries, adapted to the Haitian context and is compatible with other Government management information systems. *Kore Fanmi* agents, social workers and supervisors collect data at family, community and service provider levels, and data management experts in a first phase will input and manage the information, regularly updating its different components (in a second phase, mobile devices will be used to collect and monitor progress at family level). Each family and each individual is provided a unique identification number, which is automatically generated by the beneficiary registry in the MIS. This number will allow the close monitoring of the services received and progress over time. While the privacy of individual data is rigorously protected, aggregate indicators and information on services are available to the public, institutions and political authorities as well as service providers to help better plan activities. The MIS will be interoperable with the Health Management Information System, as well as with information

⁵⁰ Cash transfers will be financed in collaboration with Government and donors using the *Kore Fanmi* beneficiary registry to target the poorest and most in need or directly under the Project. The United Nations will be responsible for in kind transfer to most vulnerable families (i.e.WFP for food).

⁵¹ Facts for Life is a joint publication of UNICEF, WHO, UNESCO, UNFPA, UNDP, WFP, UNAIDS and the World Bank to provide families and communities with the information to save and improve the lives of children. <http://www.factsforlifeglobal.org/>

systems of other Ministries, to report progress and track services received by beneficiaries. The MIS will also provide an objective way of targeting poor and most vulnerable families for in kind and conditional cash transfers and other social assistance programs as well as to follow up family progress over time.

Box 2.2 Package of Kore Fanmi Interventions
All intervention groups
- Personal hygiene promotion - Distribution of products for water treatment and safe drinking water promotion - Support to household building of latrines - Waste management promotion - Support family food security - Prevention of malaria and cholera - Sexually transmitted infections and HIV/AIDS prevention and screening - Referral to food aid programs for TB/HIV patients from poor and food insecure households - Ensure treatment for TB and HIV infected people, through promotion and referral - Registry of births and identification promotion - Facilitate access to economic opportunities - Intervention for improvement of living standards - Promotion for the elimination of intra-family violence - Encourage and support the return of abandoned children - Promotion for the diagnosis, treatment and stimulation of disabled people - Follow up of people with chronic diseases
Pregnant & lactating women
- Promotion of antenatal care and referral - Promotion of institutional delivery or delivery assisted by skilled attendant and how to prepare for delivery - Promotion of healthy nutrition habits, monitoring of weight gain/loss during pregnancy - Detection of and response to malnutrition - Micronutrient supplementation - Promotion of exclusive breastfeeding until 6 months, breastfeeding until 2 years and beyond - Vaccination update - De-worming - Postpartum care promotion - Promotion of healthy reproductive practices
Children (0-14 years)
- Promotion and monitoring of growth - Promotion of early stimulation and child development - Under five health cards - Promotion of adequate diet according to age - Promotion and distribution of micronutrient powders and supplementation - Detection and referral of child infection and malnutrition - Promotion of access to education - Promotion of education/school attendance and access to school meals - School health - Vaccination and vaccination update

40. **In the absence of sufficient state capacity at the commune level, the Government of Haiti has, for the first phase of the initiative, contracted the execution of *Kore Fanmi* to NGOs with an established presence in the intervention areas.** NGOs are responsible for recruiting, equipping and training *Kore Fanmi* agents and municipal teams. The initiative is now successfully implemented in three of the poorest and most food insecure municipalities of the Central Department and will be expanded to other Project areas. In the first phase of the initiative, a partnership agreement has been signed with UNICEF and WFP (active participants in the development of *Kore Fanmi*) who are responsible for providing essential hygiene, sanitation, health and nutrition commodities, technical assistance and problem-solving to the program. In view of the expansion of the initiative, the United Nations Agencies will play an important role, in terms of development of the network as well as provision of services to vulnerable households identified through *Kore Fanmi*. The municipal supervisor and the social workers are based in the municipality building to ensure close coordination with the locally elected officials and development of a new role for the municipality in the human capital building of its constituency. A new initiative of the Ministry of Interior, aimed at strengthening the capacity of the municipalities and increasing their accountability, will permit a greater oversight by the mayors of the *Kore Fanmi* network in the near future. FAES will work in close collaboration with the Ministry of Interior in the set up and execution of this component of the Project and test the direct execution of *Kore Fanmi* at the municipal level.

41. **An innovative feature of the *Kore Fanmi* is the introduction of performance-based payment of the agents, social workers, supervisors, and data management specialists.** Payment of the agents is based on a wage that has a variable portion based on performance. The variable portion of the payment will be paid every three months after verification of the achievement of the life objectives of the families during the agreed time-frame, and of progress on milestones leading to their achievement. Emphasis will be placed in a first phase on the life objectives linked to maternal and child health; thus results on vaccination, growth monitoring and referral of pregnant mothers to pre-natal visits and the promotion of institutional delivery and their achievement will be directly linked to payment of the agents. Verification will be undertaken on a quarterly basis by a team composed of FAES, NGOs and municipality representatives to verify the achievement of life objectives through the MIS, and at the family level through satisfaction surveys. Counter-verification of results will be carried out annually by an independent external verification entity in tandem with the counter-verification of the institutional supply of services in sub-component 1.1. A detailed methodology of performance-based payments is included in the FAES Operations Manual.

42. ***Kore Fanmi* has been implemented at a small scale in three communes since May 2011 and the methodology of interventions detailed in the FAES Operations Manual takes into account lessons learned from this implementation experience.** Several workshops have been conducted to assess the adequacy of the design of *Kore Fanmi*. As a result, the overall concept of *Kore Fanmi* has remained the same based on results, but some of the instruments have been improved, in particular the socio-economic survey, the principle of distribution of agents on the territory, the training, and the strengthening of the link with the municipality. Based on this experience and an analysis of costs and expenditures, set-up costs were identified, such as the installation of *Kore Fanmi* offices within FAES central and regional offices and within the municipalities (financed under Component 2.2), start-up costs, namely the socio-

economic survey of families, the opportunity mapping and initial training, and recurrent costs linked to the payment of personnel and continued training and operational costs, which guided the allocation of funds under this Project for the expansion of *Kore Fanmi*.

43. **The FAES Operations Manual describes the methodology for the implementation of the *Kore Fanmi* model.** This Manual includes: (i) the administrative and financial management arrangements for the implementation of *Kore Fanmi* by FAES; (ii) the methodology for family support, including the methodology and questionnaires for the socio-economic survey and the opportunity map, modules to be included in the training of agents and municipal teams, and activities to be carried out by the municipal teams; (iii) the eligibility criteria for public and non-public entities responsible for the set-up and operations of the *Kore Fanmi* network in each commune; (iv) the eligibility criteria for minor rehabilitations to be financed in selected municipalities; and (v) the procedures for monitoring and evaluation of *Kore Fanmi* activities.

44. ***Kore Fanmi* will work in close partnership with the MSPP, other Ministries and new Government initiatives,** for the delivery of services, the development of the curriculum and provision of training, the definition and update of the Opportunity Maps, the set up and use of the unified national beneficiary registry to target social assistance programs and monitor improvements in family conditions, so as to provide feedback on the coverage and gaps in services to the population for a better planning. FAES will sign Memoranda of Understanding on collaboration for *Kore Fanmi* with key ministries. Government has introduced a conditional cash transfer program targeted to poor and vulnerable families in pre-identified priority geographic communes. The unified national beneficiary registry may be used in the future to objectively identify the poor and most vulnerable families, using family support and information in the MIS for monitoring family progress. The same may apply for other Government new social safety nets initiatives.

45. **In order to provide the necessary support to lift extremely vulnerable households out of poverty, a Conditional Cash Transfer program will be put in place and financed under this subcomponent.** The cash transfer will need to be carefully designed in order to clearly define criteria to select poor and vulnerable beneficiaries, tools to be used and procedures to follow. The Conditional Cash Transfer Manual will include the selection criteria, related to vulnerability (linked to economics, hygiene, housing among other indicators) and additional specific criteria, as well as the procedures to be followed and the tools to be used for payment. Therefore, in a first phase, FAES will recruit a consultant to support FAES in the design of a separate Conditional Cash Transfer Manual and operational tools for the carrying out of the Conditional Cash Transfer Program. Once this manual is available, Conditional Cash Transfers will be provided to eligible beneficiaries. Moreover, FAES institutional capacity to manage the Conditional Cash Transfers Program will need to be strengthened before funds under this category can be disbursed.

Component 2: Strengthening the Stewardship and Management Capacity of Government (US\$9 million IDA Grant)

46. **The objective of this Component is to strengthen the capacity of Government to effectively regulate and manage the delivery of services at all levels.** Although the Government of Haiti will still require external assistance in financing the social sectors for the foreseeable future, its capacity to oversee and regulate service delivery at all levels is critical to ensure increased utilization and improved quality of service delivery. To this end, this Component will finance two subcomponents: (i) Strengthening MSPP's Stewardship and Management Capacity; and (ii) Strengthening Social Protection Coordination and Management Capacity.

47. ***Subcomponent 2.1: Strengthening MSPP's Stewardship and Management Capacity (US\$5 million IDA Grant).*** This sub-component will support Strengthening MSPP's stewardship and management capacity, increasing the capacity of the departmental health authorities in supervision and monitoring of health service delivery and conducting surveys and studies and preparing a nationwide healthcare waste management strategy and plan, all through the provision of goods, consultants' services and Training.

48. **The objective of this sub-component is to support the development of adequate stewardship and management capacity of MSPP.** To effectively put in place, manage and supervise the relevant contracting and monitoring arrangements, a team is being put in place within the Ministry staffed by both Ministry personnel and competitively recruited consultants. The objectives of this team are to: (i) help expand and coordinate the delivery of a standardized essential package of health and nutrition services through the management of health service contracts with public and non-public providers; (ii) strengthen the MSPP's stewardship role in the health sector so it can ensure sector priorities are realized; (iii) integrate donor, multilateral, and NGO efforts into the national health system; (iv) develop the capacity of the MSPP to work effectively with stakeholders in establishing an effective and efficient public/private mix; and (v) manage participating donor funds. Strengthening the capacity, in parallel, of the technical departments of the Ministry to perform the various contracting functions in the long-term is essential. Although donor-financed contracts will be overseen by this team, the technical departments of the Ministry each play an important supportive role in the contracting process. Significant technical assistance will be provided to build capacity and support the implementation of the Project.

49. **Increasing resources to the sector will not necessarily improve health outcomes, especially for the poor, unless resource allocation and public expenditure management become more efficient.** It is difficult to increase the efficiency of very low public spending as it is mostly used to finance running costs in general and staff salaries in particular. Thus, this sub-component will provide support to build capacity at all levels of the delivery chain, including planning, budgeting and tracking public expenditures, defining policies, clarifying roles and responsibilities of the decentralized levels in planning and coordinating effective provision of services to the population.

50. **A key concern in health care is medical waste management and worker health and safety, especially in a country prone to epidemics and cholera outbreaks.** Therefore, this sub-component will support the preparation and adoption of a nationwide healthcare and waste management strategy, Environmental Management Plans and additional contractual staff as needed. Technical assistance will be provided to: (i) analyze the current strategy and the carrying capacity of existing and planned infrastructure for both medical and excreta management and disposal; (ii) identify and put in place the most appropriate tools to ensure a healthcare waste management system for Haiti; (iii) prepare Environmental Management Plans in line with the roll-out of the Project; (iv) establish adequate standards for worker health and safety under normal primary healthcare conditions and under epidemics; and (v) train staff at all levels on healthcare waste management, worker safety and safeguards processing and supervision.

51. **This sub-component will also finance capacity building initiatives to facilitate inter-departmental exchanges of experience and lessons learned,** such as creating coaching teams to support the departments in public finance reforms, utilizing the “learning by doing” methodology in conducting internal audits at the departmental levels, and holding staff meetings in well-performing departments so that the best performers can serve as examples and role models. Support to the Departmental Health Authorities and other decentralized levels will also be provided in the form of coaching and mentoring. The expected result of this sub-component will be an increase in supervision of health providers by departments and overall improvement in management of the health department.

52. **Finally, good monitoring and evaluation systems in place are critical to tracking progress on maternal and child health outcomes.** The 2012/13 DHS will be used as the baseline for the Project as well as a Service Provision Assessment financed by USAID. The Project will also finance, as necessary, household surveys to measure the Project’s outcomes and periodic health facility surveys to measure progress on the quality of care, absenteeism, and patient satisfaction. In case of a financing gap, the Project will contribute to the financing of the DHS in 2017/18, which will serve as the endline survey for the Project.

53. **The Project will be evaluated through impact and process evaluations.** As per the requirement of the HRITF, the Project will be evaluated through a quantitative impact evaluation, which will focus on measuring the impact of the Project and respond to pertinent operational research questions to better understand how the program can be improved. A process evaluation will also be conducted to increase the understanding of why and how the Project reached its specific outcomes. The design and methodology of the impact evaluation will be specified in the MSPP Operations Manual.

54. **Subcomponent 2.2: Strengthening Social Protection Coordination and Management Capacity (US\$4 million IDA Grant).** Support under this sub-component will be provided to strengthen institutional capacity of the Government at the central, municipal, and community levels, to enhance coordination, organization, management, and social service delivery to families, by (a) supporting the operation of *Kore Fanmi* and social protection steering and technical committee; (b) carrying out capacity building activities for central and departmental authorities, municipalities and major stakeholders at the municipal, departmental and national level in the delivery of services or programs; (c) expanding the management information system of the *Kore Fanmi*; (d) carrying out minor rehabilitation of municipality offices based on

eligibility criteria set forth in the FAES Operations Manual; (e) setting up a unified national beneficiary registry for the identification and tracking of beneficiaries and social assistance programs; and (f) supporting FAES for the management, supervision, monitoring and evaluation, procurement, and financial management of Component 1.2 of the Project, through the carrying out of works and provision of goods, consultants' services, training and operating costs. This sub-component will be implemented by FAES.

55. The Steering Committee⁵² will be responsible for developing standards and coordinating interventions on social protection, tracking families' vulnerabilities and social initiatives. In the pilot phase of the initiative *Kore Fanmi*, this role has been played by the National Commission Against Malnutrition and, in the future it may be replaced by a Central Social Protection Unit under the Prime Minister. The technical working group will continue to provide guidance on the technical aspects of *Kore Fanmi*. The Project will provide technical assistance to enable the committee to fulfill its catalytic role in ensuring that each of the ministries concerned with social protection deliver the expected results in a timely fashion.

56. Capacity building activities will be undertaken at different levels to improve capacity and coordination to deliver social services and reduce families' vulnerabilities. The delivery of social services is often uncoordinated and does not respond effectively to the real needs of the population. The Project will finance training and other capacity building activities for central, departmental and municipal authorities and major stakeholders at different levels to improve their capacity and coordination in the delivery of social services to the population and in reducing families' vulnerabilities. The Opportunity Map and the information in the MIS of *Kore Fanmi* will be used as key elements to improve coordination, ensure effective planning and respond to population needs. Capacity building activities will be undertaken regularly throughout the Project.

57. The current MIS will be improved to enable the scale up of the initiative and will constitute the main pillar for an Integrated Social Information System. An integrated information system includes interrelated components that capture, store, process and distribute information to support decision-making processes in social programs. The current need to make rapid decisions in response to increasingly complex situations requires on the one hand, immediacy of information processed and on the other, quality of the information generated. Throughout this development process, organizations must define the information, make it flow and interpret it according to their decision-making needs. In recent years, the use of information technology in the administration of social programs has produced extraordinary changes that have resulted in the acceleration and simplification of activities and processes, improvement in information access and use, ultimately generating value for both the beneficiaries and the Government. Furthermore, advances in the interoperability of information systems require not only the incorporation of technology, but also the development of a collaborative environment among institutions to ensure a more efficient Government. This sub-component will finance improvements to the *Kore Fanmi* MIS, including investment in mobile technologies in the collection and processing of information and in ensuring functional interoperability of the system.

⁵² The steering committee will be multi-sectoral and represent the different ministries and donors involved in the initiative.

58. **Municipalities will benefit from minor rehabilitation when needed and investments to increase functionality.** The social protection municipal team is based at the municipality and serves the population catchment area. FAES signs agreements with the municipalities on the roles and responsibilities of each entity in *Kore Fanmi*. Some municipalities will require minor investments to ensure that they can adequately serve the population. Where deemed necessary, this sub-component will finance minor rehabilitation of the municipalities (in line with eligibility criteria defined in the FAES Operational Manual) and investments to ensure functionality of the municipalities (i.e. electricity, internet connection).

59. **The development of a unified national beneficiary registry will ensure better targeting and tracking of beneficiaries in the country.** The unified national beneficiary registry will register all potential beneficiaries, identify needs, and track the provision of services and benefits. Interoperability of the unified national beneficiary registry with other Ministerial information systems is a crucial element. Dedicated personnel, in charge of the development, management and maintenance of the system will be recruited, trained and paid for under this sub-component, in addition to the initial investment in software development and the purchase of needed equipment, including the server. While a presidential decree will announce the creation and the role of the unified national beneficiary registry, the FAES Operational Manual will define its objectives and modus operandi. Inter-institutional agreements related to the unified national beneficiary registry and the social programs will be signed before it becomes fully operational.

60. **FAES will also be supported with the technical assistance necessary to carry out the Conditional Cash Transfers Program.** An international consultant will be recruited to prepare the Conditional Cash Transfers Program Manual, including conditions, responsibilities and procedures. As a condition for disbursement for the Conditional Cash Grants category, an institutional assessment of the capacity of FAES to implement the Cash Transfers Program will be carried out by the World Bank and an action plan will be developed to strengthen this capacity. Component 2.2 will finance the implementation of this action plan for FAES.

61. **FAES will recruit a dedicated team to support the execution of the Project and will work in close collaboration with key ministries to ensure effective collaboration.** FAES will recruit and train key personnel at central and departmental level for the execution of *Kore Fanmi*. At national level, a project coordinator, an expert in training, a senior social worker, an expert in management information systems and monitoring and evaluation, and an information technology programmer will be recruited and trained. At FAES Regional Office, a Project departmental manager, a social worker and an expert in monitoring and evaluation will be recruited and trained. FAES management, supervision, monitoring and evaluation, procurement, and financial management for sub-component 1.2 and 2.2 will also be financed under this sub-component and will include the financing of provision of goods, equipment, works, consultants' services, training and operating costs.

Annex 3: Implementation Arrangements

HAITI: Improving Maternal and Child Health through Integrated Social Services

A. Project Institutional and Implementation Arrangements

1. **Oversight for the proposed Project will lie with both the MSPP and the multi-sectoral *Kore Fanmi* Steering Committee.** Within the MSPP, a Steering Committee will be created to oversee implementation of the performance-based delivery of maternal and child health services and monitoring of progress in achieving its development objectives, and specifically to: (i) ensure consistency of activities with the MSPP's policy and strategy and review policy issues relevant to the achievement of Project development objectives; (ii) approve annual action plans and budgets, (iii) review annual monitoring reports and audits to validate recommendations for improvement and take appropriate actions in support of implementation. The Steering Committee shall be chaired by the Minister of Health, with membership consisting, *inter alia*, of representatives of the technical departments and units within MSPP as set forth in the MSPP Operations Manual. With respect to *Kore Fanmi*, the multi-sectoral Steering Committee will ensure participation of all concerned Ministries in the strategic orientation of *Kore Fanmi*. In particular, the role of this committee will be to ensure compliance of *Kore Fanmi* with the guidelines provided by all Ministries and coordinate the response to the needs of the vulnerable households identified through *Kore Fanmi*. As of now, the National Commission Against Hunger and Malnutrition is playing the role of the steering committee for *Kore Fanmi*. The Steering Committee will be progressively replaced by a centralized social protection unit responsible for tracking social initiatives, providing guidance, developing standards and policies, providing technical support, and monitoring and evaluation of social initiatives in Haiti.

2. **The proposed Project will be managed by both the MSPP and FAES.** Day-to-day implementation of the proposed Project will be undertaken by the MSPP for the delivery of the package of maternal and child health services at institutional level and by FAES for the delivery of the package at community level through *Kore Fanmi*. In order to ensure harmonized execution of the Project, MSPP and FAES signed a Memorandum of Understanding prior to negotiations defining their responsibilities and setting-up a coordination mechanism. In particular, this memorandum outlines the principle of contracting of *Kore Fanmi* for the delivery of health services at community level, and defines MSPP's oversight on these activities as well as the training of the agents.

3. **Delivery of the package of maternal and child health services at institutional level will be implemented by MSPP through the newly created contracting team.** A contracting team is being put in place within the MSPP reporting to the Office of the Minister and the Steering Committee. The mandate and objectives of the team are to: (i) expand and coordinate the delivery of a standardized essential package of health and nutrition services through the management of health service contracts with public and non-public providers; (ii) strengthen the MSPP's stewardship role in the health sector so it can ensure sector priorities are realized; (iii) integrate donor, multilateral, and NGO efforts into the national health system; and (iv) develop the capacity of the MSPP to work effectively with stakeholders in establishing an effective and efficient public/private mix.

4. **Among other things, this team will manage contracts with service providers and ensure coordination with actors at all levels of service delivery.** It will be responsible for (i) ensuring coordination and communication with all entities involved in implementing contracts, including technical units of the MSPP at central and decentralized levels; (ii) administering the Results-Based Payments Agreements; (iii) ensuring payment to Beneficiaries upon verification of agreed results in a timely manner to avoid service interruption; and (iv) monitoring and evaluation of performance of the Beneficiaries and identification of implementation bottlenecks and corresponding solutions.

5. **The MSPP will contract with eligible public and non-public providers at different levels for delivery of a package of maternal and child health services.** A single monitoring platform to track data on key indicators, namely the MSPP's health management information system, and a single system for verification and counter verification of results will be utilized. This platform will be interoperable with the *Kore Fanmi* MIS. Public and non-public providers will be selected into the Program using different processes. Public providers will be selected according to clear eligibility criteria related to capacity to deliver quality services and availability of equipment and medicines. Non-public providers will be selected based on experience, capacity and proven results in delivery of maternal and child health services.

6. **To ensure accurate reporting and payments, several mechanisms have been put in place for verification and counter verification of the results.** The verification of results, both in terms of quantity and quality, is a critical element of performance-based financing. Verification will be carried out on a quarterly basis and subsequent results submitted to central level to ensure timely payment. Counter verification of results will be undertaken on annual regular basis. An independent verification agent will be recruited competitively to ensure the accuracy and consistency of reporting on the volume and/or quality of services. To this end, the contracted firm will review health facility registers and randomly select a sample of patients to conduct a household survey on services rendered, quality of care provided, and overall patient satisfaction. Draft terms of reference of the external verification agent will be developed as an Annex of the MSPP Operations Manual. The detailed verification system will be described in the MSPP Operations Manual. Finally, independent health facility and household surveys will be carried out to ensure that there is rapid overall progress in strengthening the quantity and quality of health services and to confirm the results reported in the health management information system.

7. **Annual results-based payment agreements will be signed with the departmental health teams.** Financing under these agreements will be provided on a performance basis to support the implementation of the annual work plans, including supervision and monitoring of service delivery. The annual agreements will outline roles and responsibilities, fix performance indicators and milestones and define amount of financing as well as disbursement mechanisms and verification of performance. Performance indicators will be defined, such as the number of supervision visits per facility, to trigger payment. The indicators and the process for verification of achievement of the indicators will be outlined in the MSPP Operations Manual.

8. **The MSPP will manage all funds supporting the MSPP's performance-based service delivery program** using a single set of implementation, administration, financial management, procurement, environmental safeguard, and monitoring and evaluation procedures, which will be outlined in the MSPP Accounting, Financial and Administrative Manual and MSPP Operations Manual. The latter will also include the roles and responsibilities of all actors at all levels of service delivery and include model contracts to be used.

9. **Community and family support activities will be implemented by FAES given its mandate to implement Government social inclusion programs.** FAES is an autonomous Haitian governmental entity with more than twenty years of multi-sectoral and community project management experience. It operates under the supervision of both the Ministry of Economy and Finance and a Board of Directors consisting of nine members (three ministers, five representatives of civil society and the FAES General Director). FAES has six regional offices and a national office in Port-au-Prince with a staff of around 250 employees. The Government seeks to reduce poverty and vulnerability and improve social inclusion in the country and thus has recently launched several social assistance programs (i.e. a conditional cash transfer and a food basket distribution program). FAES has been mandated by Government with the mission to develop and execute a consistent agenda for improved social inclusion in the country.

10. **FAES has capacity and experience with Bank-financed projects including implementing the pilot phase of *Kore Fanmi*.** FAES has implemented over the past year a number of World Bank financed projects. The *Kore Fanmi* pilot is currently being managed by a FAES-based Project team under the Direction for Promotion and Institutional Strengthening, based in the Central Plateau, and made up of a program manager, a monitoring and evaluation expert, a senior social worker and a team assistant. The dedicated team will need to be expanded, thus a management team, composed of a program coordinator, a monitoring and evaluation expert, a beneficiary registry expert, a senior social worker, a training coordinator, an informatics engineer and a team assistant will be placed at FAES headquarters in Port-au-Prince. In each department, a smaller team will be recruited to supervise the implementation of activities in their territory.

11. **FAES will be responsible for the delivery of an integrated package of family support for poor and most vulnerable families.** Specific tasks of FAES include: (i) conducting or supervising a socio economic survey of families in the area of intervention⁵³; (ii) conducting or supervising a mapping exercise of available social programs and services; (iii) managing NGO (or other entities) contracts and supervising the quality of NGO (or other entities) in the delivery of the integrated family support at municipal level, including verifying results; (iv) collaborating with MSPP and other decentralized ministries for the delivery of services at community level; (v) collaborating closely with the Ministry of Interior, the municipalities, development partners and all other actors for the execution of the Project; (vi) setting up the *Kore Fanmi* MIS and guaranteeing its interoperability with other programs; (vii) setting up and using of the unified

⁵³ In some areas in which UNICEF will finance the implementation of the socio-economic survey and opportunity map, FAES will be responsible for providing the methodology and tools and ensure good quality of execution of the survey. The roles and responsibilities of UNICEF in the collection of the socio-economic survey and opportunity maps in jointly agreed areas of intervention are clearly specified in a memorandum of understanding which will be signed between the World Bank and UNICEF before negotiations.

national beneficiary registry to target other government social safety nets interventions; (viii) conducting and updating regularly the opportunity map; (ix) updating regularly the MIS for the initiative; (x) developing a mechanism to ensure provision of support in cash or in kind to extremely poor and vulnerable families⁵⁴; (xi) maintaining records and separate accounts for all transactions related to the Project; (xii) preparing, consolidating and producing the project financial statements and other financial information; (xiii) preparing quarterly Project progress reports to be submitted to the Bank team; and (xiv) monitoring of compliance with World Bank environmental safeguard policies. FAES already has some procurement, financial management, environmental safeguard and monitoring staff; however, the Project will finance the recruitment of additional staff as needed as well as capacity building of the institution more broadly given recent institutional weaknesses. FAES will report on a quarterly basis to the Steering Committee.

12. To oversee and implement the network in the intervention areas, FAES will contract with NGOs and other entities. The NGOs and other entities will ensure recruitment, equipment, training and oversight of *Kore Fanmi* agents and the municipal teams made up of social workers, supervisors, and data management specialists. *Kore Fanmi* agents are responsible for (a) the provision of essential social services, (b) the distribution of a package of essential goods, (c) the promotion of positive behavioral change, and (d) the referral to appropriate essential social services when required. The municipal teams supervise, train and guide *Kore Fanmi* agents in their tasks and are responsible for improving cooperation between partners and service providers at different levels (municipal, departmental and national level) and for keeping local authorities informed of and engaged in social services at the municipal level (opportunity map for services and programs available to families) in their areas of responsibility. NGOs or other entities implementing this Component will submit reports on a quarterly basis to FAES.

13. The United Nations agencies are actively involved in the implementation of *Kore Fanmi*. A partnership agreement has been signed with UNICEF and WFP (active participants in the development of *Kore Fanmi*) in the first phase of the pilot, and an expanded partnership agreement will be signed for the expansion of the network. These agencies are responsible for providing *Kore Fanmi* with essential hygiene, sanitation, health and nutrition commodities, technical assistance and problem-solving strategies to ensure the promotion activities on hygiene, sanitation, health and nutrition and direct provision of other services including food distribution and will continue to do so for the foreseeable future. A revised partnership agreement will be signed and will include inputs for the community agents and collaboration in the financing of the socio-economic survey and opportunity map.

14. The FAES Operations Manual was updated and approved prior to Project negotiations. This Manual includes the administrative and financial management arrangements for the implementation of *Kore Fanmi* by FAES.

⁵⁴ In close collaboration with development partners, particularly UNICEF and WFP, a manual will be developed detailing the conditions, responsibilities and procedures as a condition for disbursement of this disbursement category.

B. Financial Management and Risk Assessment

15. **The MSPP and FAES will be responsible for the financial management of the respective parts of the Project.** With respect to MSPP, the authorizer of expenditures for sub-components 1.1 and 2.1 will be nominated by the Minister. The MSPP will keep records of all Project-related expenditures in order to prepare financial statements that will be audited annually by independent auditors acceptable to the Bank. The MSPP will also prepare Interim un-audited Financial Reports (IFRs) on a quarterly basis due to be submitted to the Bank no later than 45 days after the end of every quarter. With respect to FAES, the finance department in the national office will be responsible for the day-to-day financial management of *Kore Fanmi* under sub-components 1.2 and 2.2 and its regional offices will coordinate arrangements as necessary with the service providers on behalf of the Controller. The Director of Finance will be responsible for financial management and for preparing financial reports using systems and procedures acceptable to the Bank. The Deputy Director General will be the authorizer of expenditures at the Project level. The FAES will keep records of all Project-related expenditures in order to prepare financial statements that will be audited annually, by independent auditors acceptable to the Bank. The FAES will also prepare IFRs on a quarterly basis due to be submitted to the Bank no later than 45 days after the end of every quarter.

16. **The Project will be financed by IDA with a specific investment grant of US\$70 million and a HRITF Grant in the amount of US\$20 million for a total of US\$90 million over five years.** Disbursements of IDA and HRITF grant resources will be made throughout the life of the Project so as to ensure a similar rate of disbursement of both financing instruments. Table 3.1 outlines the cost by Project component and sub-component as well as source of financing. HRITF grant resources will be managed by MSPP exclusively in line with the Grant Agreement signed with the Recipient for the use of this grant. Funds proceeding from the IDA grant and to be managed by FAES will be the subject of a subsidiary agreement to be signed between FAES and the Ministry of Economy and Finance.

Table 3.1: Project Cost and Sources of Financing (millions of US\$)

Project Components	Project Cost	IDA	HRITF
Component 1: Providing Maternal and Child Health, Nutrition and Social Services	81.0	61.0	20.0
Sub-component 1.1: Performance-based Maternal and Child Health and Nutrition Service Delivery	64.0	44.0	20.0
Sub-component 1.2: Results-oriented Family Support for Poor and Vulnerable families	17.0	17.0	0.0
Component 2: Strengthening the Stewardship and Management Capacity of Government	9.0	9.0	0.0
Subcomponent 2.1: Strengthening MSPP's Stewardship and Management Capacity	5.0	5.0	0.0
Subcomponent 2.2: Strengthening Social Protection Coordination and Management Capacity	4.0	4.0	0.0
Total	90.0	70.0	20.0

17. The allocation of grant proceeds and disbursement categories are presented in Table 3.2.

Table 3.2: Allocation of proceeds

Disbursement Categories	Amount of IDA Grant (US\$ million)	Amount of HRITF Grant (US\$ million)	Percentage of Amount to be financed
(1) Goods, works, non-consultant services, consultants' services, including audit, training and operating costs for sub-components 1.1 (a) and (b) and 2.1 of the Project	29.0	3.00	100%
(2) Results-Based Payments under sub-component 1.1 (c) of the Project	20.0	17.0	100% of the amounts disbursed*
(3) Goods, works, non-consultant services, consultants' services, including audit, training and operating costs for sub-components 1.2 (a), (b), (c), (d), (e) and (f) and 2.2 of the Project	19.5	0.0	100%
(4) Conditional Cash Grants under sub-component 1.2 (g) of the Project	1.5	0.0	100% of the amounts disbursed**
TOTAL	70.0	20.0	100%

*Amounts corresponding to the amounts of results-based payments to eligible health providers.

** Amounts corresponding to the amounts of transfers provided to eligible beneficiaries.

18. **The accounting software used by FAES is FINPRONET (TOMPRO).** This system is based on an accounting package capable of producing all the accounting and financial data required, including financial statements, bank reconciliation statements, and all financial reports, such as IFRs. The MSPP will have to procure and install software with comparable capabilities. It will include the following modules: budgeting, general accounting, cost accounting, reporting, monitoring and evaluation, fixed assets management, preparation of withdrawal applications, and tracking of disbursements by donors.

Internal Controls

19. The Implementing Units will maintain a solid system of internal controls and procedures that will be documented in the Financial, Accounting and Administrative Manuals to enable all stakeholders of the various components of the Project to be familiar with the detailed Project operating guidelines necessary to implement the program. The Financial, Accounting and Administrative Manuals will be drafted before Project negotiations.

20. **Financial Reporting.** The Implementing Units will be responsible for the preparation of periodic financial reports for the Project. They will prepare IFRs on a quarterly basis, and the annual financial statements. The IFRs will be submitted to the Bank no later than 45 days after the end of the quarter.

21. **External Audits.** The Project annual financial statements will be subject to external audits and the Implementing Units will be primarily responsible for ensuring that the auditor's recommendations are implemented. The external audit will be undertaken by a private firm selected in accordance with independence and competency criteria acceptable to IDA. The audit report will be submitted to the Bank no later than six months after the end of each Project financial year. The audit report will include a management letter containing findings and recommendations relating to the Project's internal controls at the Implementing Unit level. Terms of Reference for the audit will be prepared by each Implementing Unit and submitted to the Bank for its no-objection by the time of Project negotiations. The selection of the auditor should be completed prior to Project effectiveness.

22. **Financial Management Action Plan.** Table 3.3 outlines the agreed upon actions to strengthen the financial management arrangements for the Project.

Table 3.3: Financial Management Action Plan

	Actions	Deadline	Intermediate Milestones	Responsibility
1	Preparation of terms of reference for the External Auditor	By Negotiations		FAES and MSPP
2	Recruitment of adequate financial management staff	Prior to Effectiveness		FAES and MSPP
3	Drafting of the Accounting, Financial and Administrative Manuals	By Negotiations		FAES and MSPP
4	Selection and Appointment of External Auditor	Prior to Effectiveness	Selection process started immediately after Negotiations	FAES and MSPP

23. **Supervision plan.** Given the high risk of the Project, close supervision of the financial management system will be required. Supervision missions will be conducted twice a year. The missions will notably focus on the strengthening of the financial management capacity of the MSPP. The IFRs and annual audit reports will also be reviewed.

Flow of Funds and Disbursement Arrangements

24. **Proceeds of the Grant will be disbursed from the Bank on the basis of withdrawal requests by the Recipient using the Statement of Expenditure method.** This is based on summary reports in the form of Statements of Expenditures for all categories, and where relevant, applications for direct payments to Service Providers and Financial Agents. A separate designated account will be opened by each implementing unit at the Central Bank (*Banque de la République d'Haïti*).

25. **The Direct Payment, Reimbursement Advance and Special Commitment methods will also be retained as disbursement options.** Under the Direct Payment method, and at the request of the implementing agency, direct payments may be made by the Bank to contractors based on the requirements as specified in the Accounting, Financial and Administrative Manuals. The Disbursement Letter will stipulate the minimum application size for Direct Payments, Reimbursements and Special Commitments as US\$1,000,000 equivalent for MSPP and

US\$800,000 for FAES and for Advances, the ceiling will be US\$9,000,000 for MSPP and US\$4,000,000. Withdrawal applications for such payments will be accompanied by relevant supporting documents as follows:

- a) Statement of Expenditures:** Necessary supporting documents will be sent to the Bank in connection with contracts that are above the prior review threshold, except for expenditures under contracts with an estimated value of (a) US\$1,000,000 or less for works; (b) US\$150,000 or less for goods; (c) US\$100,000 or less for consulting firms; and (d) operational costs or training of US\$50,000 or less for individual consultants. The documentation supporting expenditures will be retained at each Implementing Agency and will be readily accessible for review by the external auditors and Bank supervision missions. All disbursements will be subject to the conditions of the Financing Agreement and disbursement procedures as defined in the Disbursement Letter.
- b) Reporting of Grant Proceeds:** Supporting documentation should be provided with each application for withdrawal as set out below:
- For reporting eligible expenditures paid from the Designated Account: (a) Records evidencing eligible expenditures (e.g., copies of receipts, supplier invoices) for (1) payments for Goods and Works for contracts valued at US\$200,000 equivalent or more; (2) payments for Consulting Firms for contracts valued at US\$100,000 equivalent or more; and (3) payments for Individual Consultant services against contracts valued at US\$50,000 equivalent or more under Parts A.1(a) and (b); A.2(a), (b), (c), (d), (e), and (f); B.1; and B.2 of the Project; (b) Statement of Expenditure for all other expenditures/contracts below the thresholds indicated in the previous subparagraph, and for Non-consulting services, Training and Operating Cost; (c) Customized Statement of Expenditure for expenditures under Part A.1(c) of the Project - Results-Based Payments and Part A.2(g) of the Project – Conditional Cash Transfer Grants; (d) List of payments against contracts that are subject to the Association’s prior review; and (e) an activity reconciliation statement and bank statement for Designated Account.
 - For requests for Reimbursement of eligible expenditures paid from the Designated Account: (a) Records evidencing eligible expenditures (e.g., copies of receipts, supplier invoices) for (1) payments for Goods and Works for contracts valued at US\$200,000 equivalent or more; (2) payments for Consulting Firms for contracts valued at US\$100,000 equivalent or more; and (3) payments for Individual Consultant services against contracts valued at US\$50,000 equivalent or more under the Parts A.1(a) and (b); A.2(a), (b), (c), (d), (e), and (f); B.1; and B.2 of the Project; (b) Statement of Expenditure for all other expenditures/contracts below the thresholds indicated in the previous subparagraph, and for Non-consulting services, Training and Operating Cost; (c) Customized Statement of Expenditure for expenditures under Part A.1(c) of the Project - Results-Based Payments and Part A.2(g) of the Project – Conditional Cash Transfer Grants; and (d) List of payments against contracts that are subject to the Association’s prior review).
 - For requests for Direct Payment: Records evidencing eligible expenditures, e.g., copies of receipts, supplier invoices.

26. **Retroactive financing for the Project will be used as necessary.** US\$10 million of the Grant proceeds may be used for retroactive financing purposes. This financing may be used during the period from appraisal, completed on December 14, 2012 to the date of signature of the Agreement, provided this period does not exceed 12 months.

C. Procurement

27. **Procurement for the institutional delivery of the package of maternal and child health services will be carried out by the MSPP with the support of the *Unité de Gestion (UGP)* of PEPFAR,** including contracting with public and non-public providers and the delivery of services and goods. The Project will support technical assistance and training for the procurement team as well as for the Ministerial Committee for Public Procurement to ensure strengthening of capacity. Given the need for a single set of procurement procedures, the MSPP Administrative, Financial and Accounting Manual will outline the standardized procedures that will be used by the MSPP for Project activities.

28. **Procurement of goods, equipment, works, non-consulting services and services for community and family support activities will be carried out by FAES.** All procurement undertaken by FAES will be carried out in accordance with the World Bank's "Guidelines: Procurement under IBRD Loans and IDA Credits" dated January 2011, and "Guidelines: Selection and Employment of Consultants by World Bank Borrowers" dated January 2011, and the provisions stipulated in the Financing Agreement. All procurement of goods, works and non-consulting services by FAES will be done using the Bank's Standard Bidding Documents and the Bank sample document for non-consultant services while selection of consulting firms for services of intellectual and advisory nature will be undertaken using the Bank's Standard Requests for Proposals. Project implementation will be carried out in accordance with the "Guidelines on Preventing and Combating Fraud and Corruption in Projects Financed by IBRD and IDA Credits and Grants" dated October 15, 2006 and revised January 2011 (the Anti-Corruption Guidelines). For each contract to be financed by the Grant, the various procurement and consultant selection methods, the need for prequalification, estimated costs, prior review requirements, and time frame will be agreed upon by the Recipient and IDA in the Procurement Plan.

29. **Procurement for the Project will be focused primarily on the contracting of public and non-public service providers** who will be responsible for implementing the activities under both the MSPP's performance-based service delivery program (sub-component 1.1) and results-oriented family support for poor and vulnerable families (sub-component 1.2). In addition, procurement of service providers (non-consulting services), consulting services for technical assistance and of goods, medical supplies and equipment will be required for Components 1 and 2. Performance-based contracts will be signed with selected experienced non-public service providers based on a competitive bidding process. The description of the services to be provided and model of bidding documents to be used will be prepared in parallel to the drafting of the Manual to allow for the tender process to be launched by March/April 2013. The FAES Operations Manual and the MSPP Operations Manual will include the procurement processes to follow, standard bidding documents and draft model contracts to be used. For *Kore Fanmi*, project funds will be channeled to the selected service providers by FAES through the Bank's

standard consultant services contract, which will include a detailed breakdown of the budget for all goods and services to be procured with the grant funds. With respect to the MSPP's performance-based service delivery program, project funds will be channeled to the service providers using an agreed upon standard performance-based contract that will be developed and included in the MSPP Operations Manual. Contracts will include clearly defined roles and responsibilities as well as expected results, incentives and sanctions.

30. The Project will also finance consultant services required to strengthen the capacity of the MSPP at all levels, of FAES and of other Government Ministries to effectively regulate and manage the delivery of services at all levels. Most of this technical assistance is expected to be provided by individual consultants; however, more specialized technical assistance will be provided by firms, such as development of training material and supporting communication tools for agents and social workers for scale up, development of a communication strategy for the MSPP's performance-based service delivery program, support to the development of the unified national beneficiary registry, the *Kore Fanmi* MIS and its interoperability, monitoring and evaluation, and recruitment of the independent external verification agency. In the event that consulting firms are contracted for Project activities, short lists of consultants for services estimated to cost less than US\$200,000 equivalent per contract may be composed entirely of national consultants in accordance with the provisions of paragraph 2.7 of the Consultant Guidelines.

31. Goods, works, medical supplies, and equipment, including, inter alia, computers, printers, internet connections and vehicles, will be procured by the Government. This procurement will be done using standard bidding documents for all International Competitive Bidding. In cases where the number of suppliers of critical health-related goods is limited, including vaccines, drugs and pharmaceuticals, preventive health and contraceptives devices, and biomedical equipment, and United Nations specialized agencies are uniquely or exceptionally qualified to procure such goods, procurement from them, acting as suppliers, pursuant to their own procedures consistent with paragraph 3.10 of the Bank Procurement Guidelines, can be considered. These may include the United Nations Office for Project Services, UNICEF and WHO/PAHO, which already have experience with the supply of health sector goods and services in Haiti. The form of contract between the Government and the United Nations agency will be subject to prior review by the Bank. The items to be procured from United Nations agencies will be agreed on in the procurement plan if and when required.

32. Procurement capacity assessments were undertaken of FAES and MSPP. To improve FAES capacity related to procurement, dedicated procurement staff has been assigned to Bank-financed projects. The on-going institutional capacity assessment of FAES is also expected to provide recommendations for streamlining processes and procedures within FAES to accelerate procurement activities. Additional measures deemed necessary based on the conclusion of the assessment will be developed with the assistance of the Project. With respect to the MSPP, the procurement team will be built on the existing team in the UGP-PEPFAR as strengthened following the recommendations of the procurement assessment, in particular, experienced staff will be recruited including an international procurement expert and two national staff. In coordination with other relevant MSPP units, the procurement team will be responsible for ensuring the timely implementation of the Project procurement activities. International technical assistance will be recruited to provide support and training for at least the

first eighteen months of implementation. A procurement action plan will also be developed for the MSPP, which will be updated on a quarterly basis. The Project's procurement plan will be prepared based on the first year of implementation and updated as needed. As part of supervision missions and in addition to regular post procurement reviews, independent procurement and technical audits will be carried out as needed. The overall Project risk and Project risk for procurement is high.

Procurement Plan, Thresholds for Procurement Methods and Bank Review

33. The procurement plan for implementation of the proposed Project was agreed between the Recipient and the Bank on April 12, 2013 and is presented in Table 3.4. The plan will be updated annually or as required to reflect actual Project implementation needs and improvements in institutional capacity.

Table 3.4: Procurement Plan

Ref No	Description of Assignment	Estimated Cost (US\$) ¹	Selection Method	Review by Bank	Expected Proposals Submission Date
1	Contract firm to train service providers (including training on waste management)	\$510,000	QCBS	Prior	May-13
2	Procure equipment, medical supplies, and pharmaceuticals for health facilities (cholera inputs)	\$1,800,000	ICB/NCB	Prior	May-13
3	Recruit contracting team staff	\$92,400	IC	Prior	Jun-13
4	Recruit project staff (accountant, administrator, contracting staff, incl. staff for cholera activities)	\$312,000	SS ²	Prior	Jun-13
5	Contract technical assistance to provide training to MSPP (TA on waste management and supply chain management)	\$98,000	IC	Prior	Jul-13
6	Recruitment of <i>Kore Fanmi</i> staff at Central level	\$1,414,400	IC	Prior	May-13
7	Contracts with service providers to implement <i>Kore Fanmi</i>	\$13,500,000	ICB/NCB	Prior	May-13
8	Procurement of Office Equipment	\$750,000	NCB	Prior	May-13
9	Contracts with firms to provide training to <i>Kore Fanmi</i> and major stakeholders	\$4,000,000	QCBS	Prior	May-13
10	Contracts with firm to carry out Economic Survey & Opportunity Map	\$350,000	CQS	Prior	Jun-13
11	Contracts with firm to provide identification cards to <i>Kore Fanmi</i> beneficiaries	\$500,000	CQS	Prior	May-13

Ref No	Description of Assignment	Estimated Cost (US\$)	Selection Method	Review by Bank	Expected Proposals Submission Date
12	Contract technical assistance to provide training to FAES	\$150,000	NCB	Prior	May-13
13	Recruit consultant/firm to develop the unified national beneficiary registry and recruit manager of the registry	\$150,000	IC	Prior	May-13
14	Recruit a statistician for the National Beneficiary Registry	\$100,000	IC	Prior	May-13
15	Hire firm to carry out annual household surveys	\$800,000	ICB	Prior	Jul-13
16	Recruit consultant to analyze project survey data	\$120,000	IC	Prior	Jul-13
17	Contract firm to develop and implement communications strategy	\$80,000	Shopping	Prior	May-13
18	Contracts with service providers to verify quality of implementation	\$3,400,000	ICB/NCB	Prior	May-13
19	Procurement of vehicles for project implementation & supervision (incl. supervision of cholera activities)	\$214,840	NCB	Prior	May-13
20	Contract consultant / firm to perform independent financial audit	\$200,000	LCS	Prior	Oct-13
21	Recruits of Staff at Central and Departmental level for activities related to Cholera response	\$2,405,100	IC	Prior	Dec-13
22	Contract consultant to carry out analysis of SPA	\$100,000	IC	Post	May-13
23	Household surveys for impact evaluation (baseline)	\$1,300,000	QCBS	Prior	Jul-13
24	Contract Technical Assistance for health system strengthening	\$100,000	IC	Post	Jul-13
25	Contract Technical Assistance to MSPP at the facility level	\$1,800,000	QCBS	Prior	Jul-13
26	Contract firm to verify results	\$2,100,000	QCBS	Prior	Jul-13

Note:

[1] Where it is written contracts (plural) in the description of assignment, the estimated cost is the aggregate amount.

[2] Indicates that SS has been selected because these contracts are continuing from previous period.

34. **The recommended thresholds for the use of the procurement methods, specified in the Grant Agreement, are presented in Table 3.5.** Supervision of procurement will be carried out primarily through prior review supplemented by supervision missions at least twice a year.

Table 3.5: Thresholds for Procurement Methods and Bank prior review

Expenditure Category	Contract Value (Threshold) US \$ thousands	Procurement Method	Contracts Subject to Prior Review US \$ thousands
1. Works	>1,000	ICB	All
	100-1,000	NCB	First three contracts regardless of value and all the contracts above 500
	≤1,000	Shopping	First three contracts and all above 500
	Regardless of value	Direct Contracting	All
2. Goods, Medical Supplies and Equipment	>500	ICB	All
	100-500	NCB	First three contracts and all above 200
	≤500	Shopping	First three contracts
	Regardless of value	Procurement from United Nations agencies	First three contracts regardless of value and all contracts above 200
	Regardless of value	Direct Contracting	All
	Regardless of value	Direct Contracting	All
3. Non consulting services	>1,000	ICB	All
	200-1,000	NCB	All
	<1,000	Shopping	First three contracts regardless of value and all contracts above 200
	Regardless of value	Direct Contracting	All
4. Consulting Services - 4.A Firms	> 200	QCBS, QBS, FBS, LCS	All
	100-200	CQS	All
	Regardless of value	Single Source	All
	Regardless of value	Comparison of 3 CVs in accordance with Chapter V of the Guidelines	All single source, the first three contracts regardless of value and all the contracts above 100

Abbreviations:

ICB = International Competitive Bidding

NCB = National Competitive Bidding

DC = Direct Contracting

LCS = Least-Cost Selection

CQS = Selection Based on Consultants' Qualifications

SSS = Single Source Selection

QCBS = Quality- and Cost-Based Selection

QBS = Quality-Based Selection

FBS = Fixed Budget Selection

D. Environmental and Social Safeguards

Environmental Safeguard Rating and Issues

35. The Project is classified as category B with regard to its potential environmental and social impacts due to risks associated with medical waste management and the use of sanitation products by service providers. The Project is not expected to generate any major adverse impacts and potential negative effects of Project activities can be adequately mitigated. Activities likely to trigger safeguard policies are mainly associated with the delivery of healthcare and essential social services as well as the management of healthcare and medical waste. The assessment and prevention of potential risks takes into account the impact of waste management infrastructure and policies in peri-urban and isolated rural areas, water and

sanitation systems, and hygiene practices as these affect the management of healthcare and medical waste. As such, OP 4.01 Environmental Assessment is triggered. The Project thus incorporates worker safety and security measures to mitigate risks associated with the inadequate management of healthcare and hazardous medical waste, inappropriate use of pesticides for public health, and disposal of waste in both urban and rural areas where domestic and medical waste may often be mixed.

36. Given that the departments of intervention of the Project were initially not specified and the plan for phasing the Project was not yet defined, two Environmental and Social Management Frameworks (ESMF) were initially prepared, one for MSPP based on institutional delivery of services and the other for FAES focused on community delivery of services. The ESMFs prepared for the Project include measures to prevent, minimize and mitigate potential risks related to the inappropriate handling, classification, transportation, disposal and elimination of hazardous healthcare and pharmaceutical waste as well as the inappropriate use of pesticides for public health and the inadequate management of dump and disposal sites. Both ESMFs included WHO/PAHO protocols and good practices identified in the International Finance Corporation Environmental, Health and Safety Guidelines for Health Care Facilities.

37. The two ESMFs were consulted and disclosed in country in November 2012. These instruments will be updated during Project implementation as part of the activities for capacity strengthening and specific Environmental Management Plans will be prepared by MSPP and FAES in line with the roll-out of the Project in the departments of interventions. To this end, an experienced environmental specialist will provide the required technical support to develop and coordinate the inclusion of the Environmental Management Plans as well as improve the implementation of Bank's safeguard policies and instruments.

38. The management of healthcare waste (both human excreta and medical waste) is a significant issue for healthcare providers and for cholera treatment centers that are hard-to-reach, particularly in terms of final disposal and elimination. Indiscriminate dumping has, in many ways, fueled the epidemic of cholera, the transmission of diseases and the contamination of the environment, putting at risk already vulnerable households in isolated areas. The lack of financial and human resources impedes the proper and regular assessment of waste generation (in terms of volume and categories) which will contribute to plan, design and put in place effective systems to manage waste from health care and medical activities. To reduce potential risks, healthcare and medical waste management systems need to be designed for each type of health facility and put in place according to the volume and type of waste produced. Alternative opportunities (behavior change) for waste minimization exist and can provide more cost-effective solutions to manage waste and ensure worker safety. Positive behavior changes will be encouraged through different technical, pedagogical and informational activities at all levels.

39. No other Safeguards policies are triggered by the Project as defined under the policy. Indigenous peoples are not present in Haiti and no sub-projects will be financed that require involuntary resettlement or acquisition of land. Similarly, the Project will not involve any damage on natural habitats, forests, cultural and physical resources, involuntary resettlement, security of dams, international waterways or disputed areas to trigger these specific policies. To

ensure that health providers comply with the minimum standards to provide health care services and protect the environment, only minor rehabilitation works will be undertaken in existing footprints.

Implementing Agencies and Environmental Safeguard Issues

40. **The Project will be implemented by two implementing agencies, MSPP and FAES.** The Project will ensure the delivery of a well-defined package of maternal and child health and nutrition interventions at both institutional and community level in addition to a broader set of multi-sectoral interventions at the community level. The delivery of this package will ensure a continuum of services at different levels of service delivery. Community and family support activities will be implemented by FAES given its capacity and experience with Bank-financed projects, while institutional delivery of the package of maternal and child health services will be implemented by the newly created contracting team of the MSPP.

41. **The *Direction de la Promotion de la Santé et de la Protection de l'Environnement* (DPSPE) is the unit responsible for overseeing the implementation of environmental safeguard policies within the MSPP.** The DPSPE is responsible for the coordination between ministries, public institutions (such as the *Comité National de Sécurité des Injections* and FAES) and key MSPP units to ensure that environmental policies are adequately implemented and supervised for health sector activities. The DPSPE is therefore responsible for ensuring environmental screening and impact evaluations at the central level. At the departmental level, a technician or focal point supports the Departmental Health Authorities with environmental protection-related activities. While each service provider should be responsible for the on-site management of waste produced with the delivery of healthcare services, departmental focal points will be responsible for the supervision of service providers and promote adequate problem-solving measures. External supervision will be carried out by the Ministry of the Environment and/or an independent audit firm. However, given the lack of human and financial resources, there is no system currently in place within the Ministry of Environment or the MSPP to ensure regular monitoring and supervision to mitigate negative environmental impacts or ensure the implementation of strategic plans.

42. **Within FAES, the Environmental Unit is responsible for the supervision and management of environmental and social safeguards for all Projects implemented by FAES.** With the support of the institutional strengthening directorate or *Direction de Promotion et de Renforcement Institutionnel*, the Environmental Unit is in charge of ensuring the screening and environmental risk evaluations for all 18 projects implemented by FAES countrywide. FAES has successfully prepared and implemented safeguards activities under other World Bank projects, including the Household Development Agent Pilot Project (*Kore Fanmi*) and the Cholera Emergency Response Project. The Environmental Unit was initially staffed with a single environmental specialist. However, given the increase in donor financing, the recruitment of two additional environmental specialists has been effective in ensuring regular site supervisions and capacity building at all levels. In addition to the recruitment of personnel, the existing instruments for training, monitoring and evaluation and supervision activities will be revised. FAES personnel participated in safeguards management training provided by the World Bank in September 2010. FAES also provided training on the environmental impacts of health care waste management in May 2011.

43. **Capacity for effective medical waste management and worker health and safety by both MSPP and FAES will continue to be strengthened as part of the Project capacity building activities.** The MSPP and FAES currently jointly participate in supervision missions of the Bank's Cholera Emergency Response Project, including the monitoring of both human and medical waste management. Based on the needs assessed by the DPSPE and the Environmental Unit of FAES, both ESMFs outline further training and capacity building activities. The Project will ensure that regional and departmental authorities, service providers and healthcare administrators receive sufficient training on health care waste management, worker safety and environmental and social safeguard policies. During Project implementation, technical assistance will also be provided to guarantee that adequate policies, tools and capacities are in place. Both DPSPE's and FAES's Environmental Unit personnel will then be responsible for ensuring environmental management functions, inter-institutional coordination, informational campaigns and training workshops for all workers involved in environmental management activities and biomedical waste management at the departmental level.

Social Safeguards

44. **The Project is expected to have a positive social impact by improving access and utilization of essential social services, especially among the poor and most vulnerable households.** The delivery of high-impact services, the scaling up of targeted family support and an integrated information system as well as the use of performance-based incentives, especially in remote areas, will all contribute to increasing social equity. *Kore Fanmi* will bridge the gap between the State and families through the provision of basic services and goods and referral to critical social services. The Project design allows a certain flexibility to leverage partnerships within Bank teams and between development partners to encourage new initiatives for social inclusion and protection.

45. **The Project will also support increased social accountability through a variety of instruments.** Social accountability mechanisms will be tied into the specific activities of the Project and will be designed based on experience from other countries similar to Haiti, such as community or citizen scorecards. Beneficiary satisfaction surveys and grievance redress mechanisms will allow for a two-way information flow to more effectively address consumer concerns. Given the weakness of country diagnostics and the insufficient attention to gender, the Project includes communication campaigns and awareness raising actions for both service providers and vulnerable populations. Mechanisms for data collection, analysis, reporting, and dissemination included in the Project will make available cross-sectoral data and improve the social accountability and quality of delivered services. This will increase transparency and empowerment at all levels. Additionally, a unified national beneficiary registry will provide the capacity to objectively target beneficiaries and gather information about the services and programs beneficiaries receive and use.

46. **Finally, the Project design reflects a comprehensive approach for increased social equity with gender-based initiatives and informing on disabled-friendly services.** Providing family support and information on civil rights, gender-based violence, reproductive health and income generation opportunities, *Kore Fanmi* contributes to increase gender equity and referral to social services including maternal and child health, nutrition, education and other social

protection services for the vulnerable. The Project will contribute to better gender-informed policy making by raising awareness and demand for gender equality interventions, increasing the global understanding of gender-informed policies in multiple sectors and supporting the availability of gender-relevant services, data and evidence.

E. Monitoring and Evaluation Arrangements

47. **In order to ensure that Project development objectives and intermediary results indicators are met, a solid system of data collection and analysis is necessary.** At present, the HSIS is the main health information system in the country and is used in most public and mixed institutions, tracking a mix of outpatient service data morbidity, mortality, inpatient care and aggregated revenue and expenditure data. A readiness assessment of the MSPP indicated, however, that although the system is well established, reporting tends not to be produced in full or delivered on time, which may present challenges.

48. **A number of sub-health information systems also exist.** For example, basic epidemiological data is reported in parallel, including reporting of disease-specific information. Similarly, additional data requirements by donors, NGOs, and other development partners presents a challenge to providing consolidated data – some examples include the system for the United States President Emergency Plan for AIDS Relief data and the USAID system for its project data. While these parallel systems certainly present challenges, lessons can be learned from the process of putting them in place. Specifically, use of these systems has shown that linking funding to reporting, including providing financial incentives for timely reporting, has been very successful and has allowed for the development of a rich pool of data not available from other parts of the health information system in Haiti. These challenges and lessons need to be better managed to move towards a more consolidated and more trustworthy system maintained by MSPP.

49. **Beyond the quality of health information systems, it is also important to note that use of the data generated is not yet systematic.** For example, delays in publishing the 2010 MSPP annual statistical report (nearly a year late) suggests that the data and information may not be effectively used for strategic health planning or monitoring. In turn, this sends a message that health information is not necessary and perhaps creates negative incentives to produce and deliver quality information in an efficient manner. Furthermore, there are no earmarked financial resources within MSPP for the HSIS, thus limiting the ability to ensure regular and accurate reporting.

50. **Strengthening the health information system is a critical component of this Project, both for tracking performance-based incentives, as well as collecting health information from community and facility levels.** The Project will ensure financing for technical assistance and capacity building in the area of health information systems at both the central and departmental level in order to move towards a single, coordinated information system for the health sector managed by MSPP and used by development partners. This will be complemented by a large scale technical assistance investment by USAID to revamp the HSIS and introduce electronic medical records. Initial challenges of integrating existing health information systems should not be understated, however there is broad commitment from partners (including the

United States Government) to move towards a unified system. In particular, within the Project, interoperability between HSIS and the *Kore Fanmi* MIS will be ensured.

51. **Improving information on families' vulnerabilities and on target achievements can be undertaken via *Kore Fanmi* and its MIS.** The collection of data from the opportunity map and socio-economic survey as an initial step of the *Kore Fanmi* initiative then followed by continued collection of data on family utilization of services allows Government to monitor target results and be better informed on the population needs. Mobile collection of data, in particular for community level activities, will ensure faster and more precise collection, and instant treatment of the data by the *Kore Fanmi* MIS.

52. **The base-line for the indicators of this Project will be taken from the 2012/13 DHS and from the *Kore Fanmi* socio economic survey.** The results of these surveys will be used to establish baselines and set project targets. In order to ensure that this information is accurately tracked over the course of the Project, donors have committed to invest in carrying out a DHS-lite at mid-term and ensuring that a follow-on DHS goes forward in 2017 as well as in continuing collecting information via the *Kore Fanmi* agents. In addition, capacity within the MSPP to track this data and information will continue to be strengthened over the course of the Project. Use of the DHS data will be particularly useful for the Project impact evaluation, which is currently in the design phase. It is expected that the impact evaluation will highlight the quantitative and qualitative impacts of the program based on a matched approach to comparison of intervention and control areas under the Project.

Impact Evaluation and Process Evaluation

53. **An impact and process evaluation of the Project will facilitate learning throughout implementation and ensure that the impact of the intervention is documented.** Impact evaluation demands that any observed change in outcomes in areas where the interventions/treatments are implemented is compared with a valid counterfactual representing the course of events that would have occurred in the absence of the intervention. The impact evaluation team will work closely with the implementing agencies to ensure that an appropriate methodological approach is selected that satisfy the condition of a valid counterfactual comparison while not compromising the operational design and implementation. A separate Bank executed impact evaluation grant of US\$1.5 million will finance the impact evaluation. In addition to the impact evaluation, a process evaluation, using qualitative methods, will be designed to complement and enrich the findings of the impact evaluation and provide the implementing agencies with crucial interim data during implementation that will allow for immediate learning, monitoring of risks and progress and taking corrective measures if warranted. The process evaluation will provide data on e.g. why certain institutions perform better than other under the same incentive scheme, innovative approaches developed at the facility level to improve performance, and unintended consequences of the program.

Annex 4: Operational Risk Assessment Framework (ORAF)

Haiti: Improving Maternal and Child Health through Integrated Social Services (P123706)

1. Project Stakeholder Risks						
1.1 Stakeholder Risk	Rating	Substantial				
Description: 1. Lack of coordination and division of responsibilities among implementing agencies could have a negative impact on implementation progress undermining Project performance.	Risk Management:					
	1.1 A memorandum of understanding between the two implementing agencies outlining roles and responsibilities will be signed before negotiation.					
	Resp: Both	Stage: Both	Recurrent:	Due Date:	Frequency:	Status:
	Risk Management:					
	1.2 The two implementing agencies will undertake joint preparation and implementation support missions in order to improve coordination of activities.					
2. Momentum for results based financing (RBF) is not sustained. It should be noted, in this context, that the Minister, the driving force behind the RBF, resigned in October 2012 but her resignation was not accepted and she is now back in her post. However, this shows that political environment in the health sector is volatile and there may be future changes. The clear vision and commitment to change as well as the use of RBF expressed by the Minister of Health may not be consistent with the views and capacities of implementing entities thereby undermining project execution.	Resp: Both	Stage: Both	Recurrent:	Due Date:	Frequency:	Status:
	Risk Management:					
	2.1 Training on the principles of RBF will be taken at all level for all stakeholders, including the MSPP and health providers.					
	Resp: Client	Stage: Both	Recurrent:	Due Date:	Frequency:	Status:

However, technical assistance, mainly financed by USAID will be placed in the MSPP for support on a day-to-day basis of project preparation and implementation. 3. FAES is implementing a number of emergency response cash and in kind social assistance programs with questionable design, targeting, and monitoring mechanisms and sustainability which could affect FAES reputation and Kore Fanmi’s credibility.	Risk Management:					
	3.1 A communication campaign will be undertaken to differentiate FAES-implemented emergency responses initiatives from the longer term social assistance initiative, Kore Fanmi.					
	Resp: Client	Stage: Both	Recurrent:	Due Date:	Frequency:	Status:

2. Implementing Agency (IA) Risks (including Fiduciary Risks)						
2.1 Capacity	Rating	High				
Description: 1. Capacity of the two implementing agencies to manage the Project needs to be strengthened, especially with respect to financial management and procurement: (i) With respect to the MSPP, the World Bank has not financed the Ministry directly in some time and thus it lacks experience with implementation of Bank-financed projects both at the central and departmental levels. (ii) With respect to the Fonds d’Assistance Economique et Sociale (FAES), currently managing the implementation of the Kore Fanmi pilot in Plateau Central and designated as the implementation agency for its scale up, the agency has experience in implementing Bank-financed Projects but with substantial delays. Moreover, giving	Risk Management:					
	1.1 A financial management action plan has been developed for both agencies and will be implemented throughout project preparation and implementation.					
	Resp: Both	Stage: Both	Recurrent:	Due Date:	Frequency:	Status: In Progress
	Risk Management:					
	1.2 Regular training of key staff of both agencies on financial management, disbursement and procurement will be undertaken throughout the Project.					
	Resp: Both	Stage: Both	Recurrent:	Due Date:	Frequency:	Status: In Progress
Risk Management:						
1.3 Technical assistance will be provided to reinforce the capacity of FAES to design and implement a well functioning conditional cash transfer program.						
Resp: Client	Stage: Implementation	Recurrent:	Due Date:	Frequency:	Status: In Progress	

the rapid growth in business and financing that it has received in the last year; delays are likely to persist if capacity is not strengthened. (iii) FAES has recently launched a number of conditional and unconditional cash transfer initiatives financed through other donors. The Project seeks to support the Government in developing a well functioning and operating conditional cash transfer, including creating clear procedures, defining the methodology to objectively target beneficiaries, define tools to be used and process to follow. However, FAES may not have the sufficient capacity to manage a conditional cash transfer program which is satisfactory to the Association.						
2.2 Governance	Rating	High				
Description: 1. Recently launched social initiatives suffer from poor coordination between Ministries and other Government bodies. Despite having Kore Fanmi as the foundation of a national Social Safety Net Program, the institutional framework for the social safety nets is not in place.	Risk Management:					
	1.1 The Kore Fanmi Steering Committee will be progressively replaced by a centralized Social Protection Unit responsible for tracking social initiatives, providing guidance, developing standards and policies, providing technical support, and monitoring and evaluating to social initiatives in Haiti.					
	Resp: Client	Stage: Implementation	Recurrent:	Due Date:	Frequency:	Status: In Progress
	Risk Management:					
	1.2 The unified national beneficiary registry will be used to target and keep track of beneficiaries increasing equity in resource allocation.					
	Resp: Client	Stage: Implementation	Recurrent:	Due Date:	Frequency:	Status: In Progress

	Risk Management: 1.3 Recruit a third party technical verification agency to verify results and put in place a public financial management and procurement system that ensures harmonized procedures for contracting health providers and new donors and ability to track expenditure.					
	Resp: Client	Stage: Implementation	Recurrent:	Due Date:	Frequency:	Status: In Progress
3. Project Risks						
3.1 Design	Rating	Substantial				
Description: There is a risk that essential and other inputs in the health care production function (e.g. drugs) do not keep up with the increase in the demand for services.	Risk Management: A memorandum of understanding will be signed with partners to ensure coordination of Kore Fanmi with other initiatives (especially donors that provide other inputs to the production function for health) and that adequate supply of inputs is available in the target departments.					
	Resp: Client	Stage: Both	Recurrent:	Due Date:	Frequency:	Status: In Progress
3.2 Social and Environmental	Rating	Substantial				
Description: MSPP has little experience working with World Bank safeguards and the Project trigger safeguard policy Environmental Assessment OP/BP 4.01 due to the medical waste. The Bank will support the strengthening of the national capacity to manage and dispose medical waste in accordance to internationally recognized practices and in partnership with other development partners and Government agencies.	Risk Management: Technical assistance will be provided to ensure that adequate policies, tools and capacities are in place and that norms are applied to each type of health center and at community level.					
	Resp: Bank	Stage: Both	Recurrent:	Due Date:	Frequency:	Status: In Progress

3.3 Program and Donor	Rating	Moderate				
Description: 1. Critical path dependencies exist between the Project and certain USAID investments in the sector (e.g. investments in the HMIS system, Technical Assistance etc.). This might result in duplication of activities or large delays of activities. 2. The success of Kore Fanmi requires close coordination between design and implementation partners, in order to timely finance and implement kick-off activities, and also use the Kore Fanmi network to target existing and new programs. Absence of agreed upon action plan and coordination mechanisms between organizations might impede successful implementation of Kore Fanmi.	Risk Management:					
	1.1 Joint missions and workshops will be held with USAID and other partners to ensure that all activities are sequenced well and to avoid duplications or delays in activities that are path dependent.					
	Resp: Both	Stage: Implementation	Recurrent:	Due Date:	Frequency:	Status: In Progress
	Risk Management:					
	2.1 A memorandum of understanding will be signed with partners to ensure coordination of Kore Fanmi with other initiatives.					
	Resp: Client	Stage: Both	Recurrent:	Due Date:	Frequency:	Status: In Progress
3.4 Delivery Monitoring and Sustainability	Rating	High				
Description: 1. The existing HMIS system will be used. This system as well as the recent DHS survey will provide baselines for the Project. While the mechanisms for reporting are well established there is a risk that the data in the HMIS system is of variable quality. 2. The sustainability of the Kore Fanmi network lies in the common understanding and acceptance that sectoral network of	Risk Management:					
	1.1 USAID is providing technical assistance to re-vamp and strengthen the existing health management information system. This support will focus on improving the quality of HMIS data and build adequate capacity in oversight and monitoring throughout the system. In support to the client and the Bank, USAID will be also responsible to manage this risk.					
	Resp: Client	Stage: Implementation	Recurrent:	Due Date:	Frequency:	Status: In Progress
	Risk Management:					
	2.1 Memoranda of understanding will be signed between FAES and key ministries outlining the roles and responsibilities of each party.					

agents need to be replaced by a single network of polyvalent agents. Lack of coordination and clear political will to adopt this single model might compromise the sustainability of this initiative.	Resp: Client	Stage: Both	Recurrent:	Due Date:	Frequency:	Status: In Progress
4. Overall Risk						
Implementation Risk Rating: High						
Comments: This Project is high risk high return for implementation.						

Annex 5: Implementation Support Plan

HAITI: Improving Maternal and Child Health through Integrated Social Services

Strategy and Approach for Implementation Support

1. **The strategy for Project Implementation Support lays out the activities that the Bank team will implement**, as well as the project design and monitoring features that it will adopt, in order to mitigate the most significant risks identified in the Operational Risk Assessment Framework (ORAF). Such risks relate to: (i) project management capacity (including fiduciary arrangements) of implementing agencies; (ii) reliability of data; (iii) coordination with relevant development partners; and (iv) weak/fragile government and socio-political environment, commitment to results-based financing and potential corruption. The strategy is indicative and flexible, and will be revisited during Project implementation based on the progress made on the ground. The strategy will focus on strengthening the capacity of the two implementing agencies (MSPP and FAES).

2. **Project management capacity (including fiduciary arrangements) of implementing agencies.** The capacity of the two implementing agencies to coordinate and manage the Project needs to be strengthened, especially with respect to financial management and procurement. With respect to coordination of implementing agencies, both FAES and MSPP are involved in project design and have defined roles and responsibilities. A Steering Committee and clear communication channels will be established to improve day-to-day coordination. In addition to this, a contracting team will be established in the MSPP and responsible for strengthening MSPP's stewardship functions in the health sector. The team will receive regular technical assistance, particularly from experts in results-based financing. At FAES, a program coordinator will be designated to oversee administrative aspects of the project. Regular training will be provided to FAES and MSPP staff on financial management, disbursement and procurement and will be undertaken throughout the duration of the project.

3. **Reliability of Data.** While the mechanisms for reporting are well established, quality and reliability of data may not be universal. As a result, clearly defined indicators, specific data collection methods and information management capacities will be specified in the MSPP Operations Manual. In addition, USAID will continue to provide technical assistance to strengthen the existing HSIS, with an emphasis on improving the quality of HSIS data and building capacity in oversight and quality assurance in the system. The MIS of *Kore Fanmi* and the unified national beneficiary registry and its interoperability will also benefit from continued technical assistance.

4. **Coordination with relevant development partners.** Given the array of development partners involved in the social sectors, it will be critical to both ensure the capacity of the implementing agencies to coordinate donors and other partners (such as NGOs) as well as to set clear priorities for the health sector. The Project will ensure that there is a continued policy dialogue with different key actors in the strategic vision and implementation of the Project through the use of a communication strategy. Project activities will be closely coordinated with the key partners in the health and social protection sectors and both technical components will be implemented in collaboration with or by some of those key partners. The key development

partners are actively involved in the design of the Project, in particular, the Brazilians, the United Nations, the United States Government and some of the major NGOs. A relatively large share of project resources will be devoted to management and coordination of the activities of the implementing agencies, but particularly the central Project team. In addition, financing partners in the health and social protection sectors will continue to be consulted in the preparation phase and joint preparation and implementation support missions will be undertaken in order to improve coordination of activities as much as possible.

5. Weak/fragile government and socio-political environment, commitment to results-based financing and potential corruption. Government decision-making is difficult with political tensions remaining high and President Martelly presiding over an opposition senate. This may impact project implementation. Social tensions and unemployment remain very high and living conditions are poor, sometimes resulting in rioting and political activity. In addition, the political environment in the sector is also volatile – the Minister of Health has already resigned once and, once more, the commitment to the use of performance-based financing is not consistent with the views and capacities of implementing entities. Finally, there are indications that health sector staff are recruited based on patronage rather than merit. While mitigation of socio-political risks falls outside of the scope of World Bank action, such developments will be closely monitored and the program will be adjusted if and when necessary. With respect to commitment to performance-based financing, project implementers at both central and departmental level will be trained in performance-based financing; champions will be identified early on and provided extra support and encouragement in order to instill confidence in the performance-based approach. Finally, recruitment of staff under the Project will be supervised carefully to ensure that they are based on merit. While these mitigation efforts will be put in place, it is beyond the scope of the Project to stop the practice of recruiting based on patronage in the sector.

Implementation Review Support

6. The Bank will routinely review Project implementation on (at least) a quarterly basis by Bank implementation review missions, which will be complemented by short/regular visits by individual team members to follow-up on specific issues as needed. The implementation support strategy will be based on a combination of site visits and proactive follow-ups on relevant information from multiple sources.

7. During implementation support missions, the task team will thoroughly review overall implementation progress, confirm that plans for implementation and the necessary institutional mechanisms are in place and in accordance with the agreed design of the Project. To assess this, the team will: (i) undertake a detailed review of each Project component; (ii) engage in detailed dialogue to identify key issues and agreed upon actions to achieve the outcomes envisaged for the coming period; (iii) conduct a review of fiduciary aspects including disbursements and procurement; and (iv) verify compliance of Project activities with the Bank's environmental and social safeguard policies. During field visits, the mission will visit selected Project sites to assess and physically verify work financed under the Project. During site visits, government and mission members will interact with health providers, community agents, and firms/organizations involved in project implementation. Fiduciary reviews during supervision missions will include reviews of a sample of contracts and spot checks of accounting records and

financial reporting systems at the central, regional, departmental, and site levels. Report of the projects internal auditors will be reviewed and meetings held with them to gain additional perspective. Issues identified will be recorded in the aide-memoires and following up post-mission.

8. **Fiduciary requirements and inputs:** The Bank specialists will assist the implementing agency to identify any capacity building needs to strengthen its financial management capacity and the procurement specialist will provide timely support on procurement issues. Financial management support will be provided by an in-country Bank financial management specialist and a Washington based senior financial management specialist; procurement support will be provided from the Bank office in Washington, D.C. The fiduciary team will have regular interaction with their Government counterparts and will provide regular assistance to the implementing agencies as required.

9. **Environmental Safeguards:** The Bank environmental and social specialists will provide detailed inputs into the draft safeguards documents during preparation, and training sessions will be organized before and during implementation. Field visits to the Project sites will be organized (at least) biannually.

10. **Governance and Capacity Building:** The Project task team, with the team in USAID, will be jointly responsible for working with implementing agencies and contracted organizations to build capacity throughout the life of the Project.

Staffing Resource Plan

11. **The task team will be comprised of members with long-term experience in health, nutrition, and population, social protection, performance-based contracting, data collection and management, monitoring and evaluation,** and other areas, as well as staff with significant experience working in Haiti. The following table summarizes the proposed skill mix and number of staff weeks during the initial phase of project implementation. It is expected that demand will increase and change with time.

Table 5.1: Skill Mix Required

Skills Needed	Number of Staff Weeks per year	Number of trips	Comment
Health Specialist/Operations Officer (1)	15	4-5 per year	Washington based
Social Protection Specialist (1)	15	4-5 per year	Washington based
RBF Expert	15	4 per year	Washington based
Operations Officer (3)	15	4-5 per year	Washington based
Financial Management Specialist (1)	6	2 per year	Port au Prince based
Procurement Specialist (1)	6	2-4 per year	Washington based
Environmental Specialist (1)	6	2 per year	Washington based

Annex 6: Economic and Financial Analysis

HAITI: Improving Maternal and Child Health through Integrated Social Services

Economic Analysis

1. **Global micro economic evidence shows high social returns to investments in maternal and child health and nutrition services.** Poor health and malnutrition erode human capital, by harming physical and cognitive development, and result in reduced educational outcomes and economic productivity. Under nutrition can cause structural damage to the brain and maternal and child under nutrition results in shorter adults, less schooling, lower productivity, and lower birth weights⁵⁵. There is also a link with adult cancer, lung disease, and mental illness, all of which compromise productivity and earnings. Studies demonstrate that low birth weights significantly affect longer-run outcomes such as adult height, intelligence quotient, earnings, and education⁵⁶. For instance, a recent 35-year longitudinal study of the long-term impacts of nutrition intervention during early childhood in Guatemala provides striking results⁵⁷. The study randomly assigned two nutrition supplements to low-income children in rural Guatemala: children who consumed the protein-rich supplement achieved dramatically better educational performance and labor force earnings. Women who received the protein-rich supplement during their first three years of life attained 1.17 more years of schooling, their infants' birth weight was 179 grams heavier, and their children were a third taller than those of women who consumed the calorie-based supplement as children. Men who consumed the high-protein supplement in the first two years of their childhood earned an average wage 46 percent above that of men who consumed the calorie-based supplement.

2. **The returns to investing in health and nutrition services are likely to be high in Haiti.** In Haiti, large numbers of families have been displaced, lost livelihoods and face the risk of permanent marginalization as a result of the earthquake in 2010. Health indicators, especially those pertaining to maternal and child health and nutrition, are lagging behind other countries in the region, resulting in high mortality and morbidity. Globally, productivity losses associated with malnutrition have been estimated at more than 10 percent of lifetime earnings⁵⁸. In Haiti, the economic impact is even greater. Estimates of the cost of malnutrition in 2001 indicate that the losses in productivity associated with malnutrition in Haiti were \$525 million, which represents 14 percent of GDP⁵⁹. Annually, Haiti loses an estimated US\$56 million in GDP (0.5 percent of GDP) due to productivity losses associated with micronutrient deficiencies alone⁶⁰.

⁵⁵ 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

⁵⁶ Black, R.E, Cousens, S., et al. 2010. Global, regional, and national causes of child mortality: an updated systematic analysis. *Lancet*: 375: 1969-87

⁵⁷ Melgar, P., Ramírez, L.F., McNiven, S., Mejía, R.M., DiGirolamo, A., Hoddinott, J., and Maluccio, J.A. 2008. "Resource Flows among Three Generations in Guatemala Study (2007–08): Definitions, Tracking, Data Collection, Coverage, and Attrition." Working Paper Series 0803, Middlebury College, Department of Economics, Middlebury, VT.

⁵⁸ World Bank.2006. Repositioning nutrition as central to development: A strategy for large scale action.

⁵⁹ Comision Económica para América Latina y el Caribe / World Food Programme. 2009. El costo del hambre: impacto social y económico de la desnutrición infantil en el Estado Plurinacional de Bolivia, Ecuador, Paraguay y Perú. Estimates based on the Living Conditions Survey in 2001.

⁶⁰ World Bank, 2010. Haiti Nutrition at a Glance.

<http://siteresources.worldbank.org/NUTRITION/Resources/281846-1271963823772/Haiti.pdf>.

3. **The main Project benefits will be improved health and nutrition status of women of child-bearing age and children as well as increased well-being of at-risk families.** Benefits are based on improved access to and use of cost-effective essential social, health and nutrition services, and increased efficiency in health management and administration. Benefits are critically dependent on adequate financial resources, especially continued donor support for investments and higher levels of recurrent spending generated by the Project.

4. **Benefits.** In the first instance, benefits will be derived from the following:

- a) ***Better and more affordable maternal and child health and nutrition services will be available.*** The package of services incentivized under the Project has been carefully selected based on the cost-effective services listed in the Lancet neonatal survival series. The services include a community-based newborn care package, antenatal care, skilled attendance at birth, first level maternal care and emergency obstetric and neonatal care after birth⁶¹. Evidence from similar countries indicates that improved coverage with this type of packages has a cost-effectiveness ranging from US\$80 to US\$140 per disability adjusted life years averted.⁶² Nutrition interventions are included in the incentivized package since these are highly cost-effective. As mentioned, recent evidence show that exposure to good nutrition during the first two years of life led to a 46 percent increase in adult male earnings⁶³ and elimination of anemia has been estimated to boost adult productivity by 5-17 percent.⁶⁴ The provision of micronutrients, which is one intervention included in the Project, has been ranked as the most cost-effective development investment by the 2008 Copenhagen Consensus, with a rate of return on investment of 625 percent. The availability of better maternal and child health and nutrition services is expected to increase the demand for such services, especially among poorer households, and reduce health risks for pregnant mothers and children. Direct benefits include lower morbidity and mortality and reduced effects of health risks on productivity, earnings, learning and household well-being. There is also likely to be fewer inappropriate hospital referrals and treatment costs will be lower as the case-mix among patients will be less severe.
- b) ***Outreach reintegrates families at risk of social exclusion into mainstream society.*** Outreach services offer a range of interventions that have proven effective in addressing needs of vulnerable families by assessing, counseling and referring, and providing care and rehabilitation plans. Direct benefits at the household level include reduced costs from dysfunction (chronic poverty, unhealthy lifestyles, low educational attainment, delinquency, crime, etc.) improved responsiveness to risk and opportunity, as well as enhanced productive potential. Indirect benefits arise from positive spillover effects associated with reduced dysfunction. The burden this places on social services, public safety and public health is reduced as returns to human capital among beneficiary families improve and through greater social cohesion that reduces political risk.

⁶¹ Adam, T., Lim, S.S., Mehta, S., Bhutta, Z.A., Fogstad, H., Mathai, M. Zupan, J., Darmstadt, G.L. 2005. Cost effectiveness analysis of strategies for maternal and neonatal health in developing countries. *BMJ*; 331:1107-10

⁶² Disease Control Priorities in Developing Countries 2nd Edition – Disease Control Priorities Project

⁶³ Hoddinott et al., 2008. Long-term economic effect of early childhood nutrition. *Lancet* 371(9610):365-366.

⁶⁴ World Bank, 2006.

5. **Cost-benefit analysis.** A cost-benefit analysis was carried out to estimate the economic and financial impact of the Project. Calculations were based on a five and fifteen-year horizon, including the incremental opportunity costs of the Project (capital costs and recurrent expenditures). Due to difficulties in estimating benefits of the institutional component of the Project, only benefits of the maternal and child health and nutrition service delivery component (sub-component 1.1) and the family support component (sub-component 1.2) were estimated. These components cover 89 percent of Project costs. However, even in those instances, the analysis was limited: in health, it only looked at the mortality effects of the Project; and in social services, it only considered potential income gains from *Kore Fanmi* interventions. There are other gains that were not measured such as the quality-of-life effects from births averted to lower morbidity and improved nutritional status of mothers and children, as well as long term economic effects of improved learning potential from better nutrition and reduced social constraints on access to education. Institutional improvements, while not measured, are directly reflected in the performance of *Kore Fanmi* agents, and their outreach activities include maternal and child health and nutrition and healthy lifestyle messages, as well as social care-type support to families at risk. The cost benefit analysis uses several key assumptions (Table 6.1):

- a) ***Benefits of reduced mortality.*** It is expected that outreach activities, better affordability and access, and better quality of maternal and child health and nutrition services will lead to reduced mortality of pregnant women, mothers and children. Accordingly, drawing on mortality rates from the Demographic Health Survey, each averted death results in five life years saved. The monetary value of each life year saved is determined by using discounted (5 percent) annual per capita income over ten years. Benefits are assumed to begin to materialize in year two of project implementation.
- b) ***Increase in hospital bed days.*** It is assumed that there will be an increase in hospital bed days due to better detection of at-risk pregnancies and deliveries, and of clinical malnutrition, as well as the introduction of free services, including referrals.
- c) ***Averted productivity losses.*** It is assumed that these would mainly arise from social care. Productivity is valued based on a minimum daily wage of US\$2 at a labor participation rate of 40 percent.

Table 6.1: Key assumptions for the cost-benefit analysis

Average length of in-patient stay	Six days
Cost per bed per day	US\$1.56
Increase in admissions per year due to Project	10% in year 2 to 2% in year 5, 1% in year 6 and 0% in subsequent years
Daily wage	US\$2/day
Households reentering the labor market	40% of supported households part-time (6 months)
Reduction in mortality rate	Based on Results Framework (Annex 1)
Marginal years of life saved	Five

6. **The cost benefit analysis was estimated based on total Project costs of US\$70 million and assuming benefits due to reduced mortality and increased earnings among participating households.** Costs were generated by Project investments (including incremental recurrent costs) and increased institutional and referral care. Subsequent recurrent costs beyond the final project year were estimated at slightly above spending during the final project year – US\$ 12 million. Estimates of reduced mortality were based on past maternal and child health and nutrition related mortality in the country, population growth and a 1.8 percent annual reduction in the mortality rate, drawing on trends in Project indicators. Life years saved due to less mortality were 5 years (drawing on the Demographic Health Survey). *Kore Fanmi* supported households were expected to peak at 400,000 during the final year of the Project, and gradually stabilizing at 100,000 per annum. Some 40 percent were assumed to return into the labor force part-time (working six months per year) at a daily wage of US\$2. The Table below sets out the present value of costs and benefits. The effects are estimated using a 5 percent discount rate over five years and 15 years. Over the longer term, the benefit-cost ratio improves, indicating that benefits increase faster over time than costs.

Table 6.2: Cost benefit analysis

Benefits and costs	Present Value (US\$)	
	5 years	15 years
Benefits		
Effects of reduced mortality	4,768,311	14,307,156
Annual earnings	162,090,007	282,588,092
Costs		
Project costs	60,464,212	136,926,824
Project-generated costs (Maternal and Child Health and Nutrition related)	602,774	629,867
Net benefits	234,148,203	436,865,223
Benefit-cost ratio	0.3	2.2
Cost per beneficiary	13.7	19.6

7. **Important market imperfections in terms of health seeking behavior imply that there is a strong case for using public resources for this investment.** Having seen that there is high rate of return for the investment in the long term, it could be argued that the investment could crowd out private sector investments, and therefore, there needs to be a clear rationale for using public funds for this type of Project in the health sector. There are gains to public intervention in a sector when the pure market equilibrium is sub-optimal from the perspective of society and when such an intervention corrects market failures. In the case of health, a recent review⁶⁵ of micro-economic studies of health seeking behaviors in low-income settings provides compelling evidence that there are important market imperfections that warrant public intervention. Evidence show that households systematically underinvest in preventive health care due to:

- a) ***Lack of information*** (or ability to process information due to low education level) on illness prevention or on the cost-effectiveness of preventative behaviors;

⁶⁵ Dupas, P., 2011. Health Behavior in Developing Countries. Annual Review of Economics; Vol. 3: 425-449.

- b) **Credit constraints** due to malfunctioning financial markets which affects people's ability to invest in health; and
- c) An important share of people exhibit *time-inconsistent preferences*. This implies that even if it is more beneficial for an individual to adopt healthy behaviors (e.g. seek preventive care) in the long run, s/he might not be willing to sacrifice pleasure today to do so, and instead end up seeking sub-optimal and more expensive remedial care). This phenomenon, causes procrastination in adoption of healthy behavior.

These findings point to the important role for public interventions in health in developing countries.

8. **The design of the Project draws on micro-economic evidence of appropriate interventions to increase adoption of healthy behaviors.** The recent review referred to above, recommends the following key interventions that will contribute to the adoption of healthy behavior: *credible information efforts* that trickle down to rural and poor communities (community agents will provide this service under the Project), *sticks*, such as mandates by the governments, and *carrots*, such as incentives and price subsidies. The latter will be provided as health services to mothers and children will be provided at a subsidized price under the Project and health facilities will be able to incentivize mothers and children to come to their facilities by using performance bonuses for such purposes.

9. **The equity-focused approach of the Project is more cost-effective than an alternative use of funds for a 'mainstream' approach.** The Project focuses on preventive primary health care specially targeted to the most deprived communities. Features of the program include community-based interventions, including community-based case management, as well as a focus on maximizing outreach through the expansion of a selected package of life-saving maternal and neonatal clinical interventions. Furthermore, performance-based incentives are used to motivate health workers and enhance supervision. Health care is provided at a subsidized rate to all mothers and children. This type of program represents "an equity-focused approach to maternal and child health"⁶⁶. A recent study compares this kind of equity-focused approach, which this Project represents, to a "mainstream approach", which invests in training and deployment of health workers, infrastructure, and mass communication to encourage deprived populations to seek care. Through a mathematical modeling approach, the study shows that in countries, such as Haiti, where a large share of the population live below US\$1 dollar a day, the equity-focused approach performs much better, in terms of increasing coverage of high impact interventions among the poor as compared with the least deprived. Comparing this Project's equity approach to the mainstream approach, it is concluded that US\$1 million invested with the equity-focused health program avert 81 under-five deaths and 244 cases of stunting. This equivalent numbers for the "mainstream approach" is 49 under-five deaths and 84 cases of stunting. Moreover, the proportion of expenditure borne by households would decrease twice with the equity-focused approach compared with the mainstream approach. This study gives clear evidence, that should an alternative more traditional investment approach have been chosen, fewer lives would be saved, little progress in decreasing health inequities would be made and the strategy would not be as cost-effective.

⁶⁶ 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). Please note that this paper assumes zero user-fees.

10. **There are large income inequalities in the utilization of social services in Haiti, partly due to poor physical access to health and education services in isolated rural areas, and partly to financial and cultural barriers to utilizing services.** The recurrent budget of the Ministry of Health and other social ministries is unequally distributed across departments, and in general, does not reflect the level of poverty and vulnerabilities in the Department. This also reflects an unequal distribution of qualified personnel, which benefits richer urban areas, and somewhat the higher concentration of health centers in better-off Departments. The Project will seek to address this unequal distribution of resources by financing interventions in underserved, rural areas where poverty rates are highest. Moreover, the Project will focus on cost-effective interventions to prevent and treat the illnesses that can be delivered at household, community and health center level. By improving coordination and harmonization among donors, the Project will also improve allocative efficiency by diminishing transaction costs and thus diminishing administrative costs of the Ministry of Health when handling different donor-supported Projects.

Financial Analysis

11. **The long-term sustainability of the Project will critically depend on maintaining donor funding or reallocating domestic resources.** Total spending on social services and health in Haiti is estimated at less than 15 percent of GDP. Some 30 percent is from Government sources, 40 percent from official external sources and 30 percent out-of-pocket. The remainder, largely unrecorded by the authorities, is provided by NGOs and private sources. Government spending as a proportion of the overall budget is about 22 percent for health and 3 percent for social safety nets. In nominal terms, spending on social services and health have increased largely in early 2000 and then reduced in the second half of 2000-2010. Official donor financing has grown at higher pace, particularly for the period after the earthquake, when it increased by some 50 percent. Estimates suggest that the elasticity of Government social expenditures⁶⁷ with respect to GDP when development partner funds are included is about 1.7 percent and 2.15 percent when development partner funds are excluded⁶⁸. Consequently, the fiscal space for health derived from economic growth projections in Haiti is likely to critically depend on maintaining donor funding or reallocating domestic resources if donor funding declines. The International Monetary Fund projects economic growth in Haiti to rise by 4 percent per year in real terms for the medium term. Assuming that Government social spending will continue to respond in the same way to growth as indicated above, Government health expenditures will increase by 4.4 percent between 2012 and 2015. Project benefits will critically depend on adequate financial resources being available, especially continued donor support for expansion of programs and higher levels of recurrent spending.

12. **In the medium to longer term, the fiscal space may increase.** The underlying rationale for the Project is the continued need for the Government of Haiti to improve budget sustainability by incrementally increasing public financing for the health and other social sectors,

⁶⁷ Consider that Government social spending is a normal good, a luxury or primary necessity good depending whether elasticity is greater or less than one.

⁶⁸ Ravallion (2002) finds that the elasticity of social spending to total spending during times of fiscal expansion and recession varies drastically. During times of macroeconomic shocks and negative GDP growth, expansionary fiscal policy can help to compensate for declines in income through public spending, especially for vulnerable portions of the population. Ravallion, M. (2002b). "Are the Poor Protected from Budget Cuts? Evidence for Argentina." *Journal of Applied Economics*, Vol. 5 (1): 1, pp. 95-121.

mitigating allocative and technical inefficiencies, and improving targeting of resources for vulnerable groups and high priority health programs. The Project is expected to generate further benefits by adopting a programmatic approach that will reduce the fragmentation of donor support, improve targeting and strengthen linkages between ministries.

13. The social sector faces many challenges and at the current level of expenditures, the country will not be able to achieve the health-related MDGs. Given the Government's macroeconomic constraints, the financing gap in the health sector cannot be bridged with internal resources. Therefore, donor assistance, financing a large share of the sector's investment budget, will continue to be relied upon.

14. The proposed Project is expected to raise revenue needs for operating and maintaining the improved system at an estimated annual cost of some US\$12 million per year. While projected growth for the medium term may increase fiscal space somewhat, it is unlikely to suffice without a reallocation from other sectors or through increased donor support. Some savings – an estimated US\$3 per person is likely to be generated from efficiency improvements and reduced demand for social assistance and curative health services. In the longer term, improvements in life expectancy and a reduced disease burden would stimulate growth. This would happen through lower fertility rates, higher investments in human capital, increased household savings, increased foreign investment, and thus, greater social and macroeconomic stability. A pro-poor bias approach is expected to reduce disparities in the distribution of resources and inequalities in recurrent budget distribution. The Project's emphasis on strengthening of institutional capacities and results-based mechanisms for financing and performance would allow the Government to benefit from a greater capacity to improve efficiency of budget execution and financial sustainability to move towards better human development outcomes.