I. Introduction and Context

Country Context

Haiti remains the poorest country in the Americas and one of the poorest in the world with a GDP per capita of US$673 and a significant need for basic services. One of the most unequal countries in the world, with a Gini coefficient of 0.59, over half of Haiti’s population of 10 million lives on less than US$1 per day, and 78 percent live on less than US$2 per day. The country ranks 148 out of 172 in the 2010 Human Development Index and close to fifty percent of the population remains food insecure. Despite these difficult conditions, Haiti’s economy saw modest but stable growth in the 2000s, with an average real growth of 2.2 percent p.a. 2004-2009. However, repeated exogenous and political shocks have taken a major toll on the economy. In 2008, rising food and fuel prices led to riots and the fall of the Government, and tropical storms and hurricanes that year caused losses estimated at $900 million (15 percent of GDP). The devastating earthquake that struck on January 12, 2010 killed 220,000, wounded 300,000 and left 1.3 million homeless. The earthquake brought the entire economy to a halt, wiped out an estimated 120 percent of GDP, and exacerbated the poverty and vulnerability of Haiti’s entire population, further impacted by an outbreak of cholera in October 2010.

Sectoral and Institutional Context

State capacity for the provision of basic services has been further weakened since the January 2010 earthquake. State institutions mostly do not reach beyond the country’s major urban centers hindering the Government’s capacity to provide basic services to large parts of the population. While a diverse and vibrant non-state sector has filled gaps in sectors such as health and education, these efforts are largely unregulated and of uneven quality. The result is a patchwork of uncoordinated, small-scale interventions that have largely failed to improve social indicators and left significant gaps in services for many of Haiti’s most vulnerable populations. Around 40 percent of the population is estimated not to have a birth certificate, further hindering access to services that require identification.

Lack of access to services, both physical and financial, plays an important role in Haiti having poor maternal and infant health and nutrition outcomes, undermining the country’s ability to achieve the Millennium Development Goals (MDGs) in 2015. Financial access is the most important barrier to service utilization across socio-economic quintiles. Of those who were seriously sick in the 30 days preceding the Demographic and Health Survey in 2005 and did not seek treatment (24 percent of all those who reported being sick), almost half cited financial reasons and 20 percent physical accessibility. The problem is most acute in rural areas (48 percent). Physical access to health facilities is the second key barrier, again with the poorest and those living in rural areas at the greatest disadvantage. Prior to the earthquake, almost one in five Haitians (20 percent) had to travel 5 km or more to visit a health center when sick. Among the poorest, one in three had to travel further than 5 km and almost half (46 percent) traveled by foot. In rural areas, where health facilities are more dispersed, only half of the population (48 percent) has a health center within a 5 km radius of their home, and 13 percent within a 5-10 km radius.

Despite progress on some fronts, Haiti’s health outcomes remain far from the MDGs. 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 achieve MDG-4. There are wide differences across economic strata, with children from the poorest households facing a mortality rate that is more than double that of children from the richest households. Malnutrition rates have stagnated since 2000 and one quarter of children is born with a low birth weight (almost double the world’s average). Nearly one-third of all children under-five suffer from stunted growth and three-quarters of children 6-24 months are anemic. One out of three children is vitamin A deficient and almost 60 percent of school-aged children are iodine deficient due to lack of availability of iodized salt and appropriate
supplementation programs. Six out of ten Haitian children (12-23 months old) are not fully vaccinated, and one in ten receives no vaccine at all. Maternal mortality in Haiti is the highest in the region at 630 per 100,000 live births (six times the regional average) due to inadequate access to skilled staff at delivery, high unmet needs for contraception and poor nutritional status. While 46 percent of women of childbearing age are anemic, only 27 percent receive adequate iron supplementation (90 days or more) and more than 35 percent receive none. Access to family planning services is low: 40 percent of women who do not want any more children, or who would like to wait to have children, do not have access to modern methods of contraceptives.

Weak Government oversight of health services has resulted in a fragmented system. The delivery of health services in Haiti relies on a network of public, private non-profit, mixed non-profit (owned by state, but operated by non-governmental organizations), and private for-profit providers, resulting in a highly fragmented system with the State only providing an estimated 30 percent of health services. Even prior to the 2010 earthquake, the Ministry of Public Health and Population (MSPP) faced great difficulties in regulating the sector and providing essential public health functions. Poor coordination of these actors has sometimes led to overlapping of services in some areas and gaps in essential basic health services in others, particularly peri-urban and rural communities. This situation has been exacerbated by the large inflow of aid organizations since the earthquake.

Strengthening the stewardship role of Government to coordinate donors and non-state sector providers is key to improving health, nutrition and broad social outcomes in Haiti. Strategies are needed to improve access and quality of services, increase the efficiency of sector resources and effectively regulate service providers. Results-based financing can be a tool for both rapid expansion of essential health and nutrition services and longer-term development of stewardship and regulatory capacity. Furthermore, this will allow the Government to focus its attention on setting standards and improving quality rather than on day-to-day management of inputs, fostering stronger oversight of both public and private health service providers, and improving coordination of providers.

The new Government, appointed in October 2011, recognizes these issues and is attempting to better coordinate service providers through various mechanisms and programs, including the flagship Aba Grangou Program (or Down with Hunger). The President officially announced with a presidential decree on January 24, 2012 the creation of a multi-sectoral Commission and an Executive Council for the Government flagship program Aba Grangou to reduce hunger and malnutrition in Haiti, with three strategic axes: (i) improving access to food for the most vulnerable; (ii) increasing the productivity of the agricultural sector; and (iii) increasing access to essential social services, including health and nutrition. Two key Haitian programs support the third axe, the Manman ak Timoun an Santé program and the Kore Fanmi Initiative.

Firstly, Manman ak Timoun an Santé (“Mother and Child Health”), finances the delivery of a package of essential health and nutrition services, free of charge, for pregnant women and children under five, using results-based financing to improve utilization and enhance quality of services. Performance contracts are signed with individual public health facilities to link a proportion of their funding with performance, generally defined in terms of the number and quality of specific agreed-upon services delivered by the facility. The first phase of the Program included 70 health facilities in the ten departments of the country and resulted in an increase in institutional deliveries: 69 percent of the participating facilities showed an average increase of 59 percent over the baseline. Beneficiary satisfaction was 83 percent, with notable changes in behavior: 39 percent of the women who gave birth in participating facilities stated that their last delivery had taken place at home. Maternal deaths in the participating facilities numbered 22 out of the 22,103 deliveries entered in the Program database, resulting in a maternal mortality rate of 99.5 per 100,000 live births, a figure six times lower than the nationwide maternal mortality rate (630 per 100,000 live births). The Program seeks to: (i) strengthen the Haitian health care system through a balanced focus on health promotion, prevention and curative care; (ii) put more focus on results using performance-based financing mechanisms; and (iii) improve coordination and cooperation among health care institutions, thereby creating more effective referral systems. This Program is currently being financed by the Canadian Government with implementation and technical assistance from the World Health Organization (WHO)/Pan-American Health Organization (PAHO).

A second program, the Kore Fanmi model has been chosen to serve as the core service delivery mechanism for families under Aba Grangou. Kore Fanmi (“family support” in creole) is an innovative mechanism for improving the efficiency of service delivery in Haiti. The system is based around a network of community agents (Kore Fanmi agents) who are directly responsible for the overall well-being of the vulnerable families under their charge. Kore Fanmi agents can achieve this thanks to a comprehensive information system that analyses each individual family’s conditions and vulnerabilities, proposes key actions to be undertaken in the form of a Family Development Plan, and tracks progress over time. Based on the Plan, the agents: (i) provide information and awareness on key topics of the Plan (i.e. health, nutrition, food security, hygiene and sanitation, identification and civil rights, child education, protection, disaster preparedness and economic opportunities); (ii) deliver a package of basic commodities and services (i.e. distribution of mosquito nets, child growth measurements, immunizations, and micronutrient powders); (3) refer families to other existing social services and programs, including health, nutrition, education, identification, and economic opportunities. A municipal team, made up of qualified social workers, a coordinator and a data management specialist, provide supervision and guidance to the agents. Payments of different actors are performance-based to further enhance commitment to results. This model is currently being implemented in four municipalities in the Central Plateau, one of rural Haiti’s poorest and food insecure areas. President Martelly has announced that the network of Kore Fanmi agents will be increased to 7,000 by 2012 and 20,000 agents by end of 2013. Kore Fanmi: i) is a mechanism to reach poor and vulnerable families, ii) generates an objective way of identifying the most vulnerable families and analyzing their needs, iii) coordinates provision of services at the municipality level to improve family well-being, and iv) strengthens local government capacity to oversee service delivery in its territory.
II. Proposed Development Objective(s)

Proposed Development Objective(s)

The objectives of the proposed Project are to: (i) increase the use, access and quality of basic services; and (ii) strengthen Government’s capacity to manage and monitor service delivery. The Project seeks to scale up two key Government programs to increase the use of and gradually improve the quality of basic services, with a focus on maternal and child health and nutrition. The Project would also reinforce the stewardship role of the Government and build capacity to manage and monitor service delivery. Although the Project would have a national scope, special emphasis will be placed on ensuring access to services in under-served rural areas and in communities where the vulnerable are being relocated, including in poor areas of Port au Prince.

Key Results

Progress on achievement of the objectives of the Project will be measured by a series of indicators, including: (i) Percentage of births attended by skilled health staff; (ii) Percentage of children 6-24 months with anemia; (iii) Percentage of children under-one completely immunized (IDA Core Indicator); (iv) Percentage of children under five receiving micronutrients; (v) People with access to a basic package of health, nutrition, or population services (number and percent) (IDA Core indicator); (vi) Percentage of families who are no longer food insecure; (vii) Percentage of municipalities implementing the new model of Kore Fanmi family Timoun an Santé; and (viii) Percentage of families registered in the Program Management Information System.

III. Preliminary Description

Concept Description

To address key sector challenges and support the achievement of the PDO, the proposed Project would finance three Components: (i) Improving Access to Health and Nutrition Services; (ii) Improving Basic Living Conditions of Poor and Vulnerable Families; and (iii) Institutional Capacity Building.

Component 1. Increasing Use of Maternal and Child Health and Nutrition Services (US$23 million). The objective of this Component is to increase the use and quality of maternal and child health and nutrition services through the scaling up and enhancement of Manman ak Timoun an Santé, including the expansion of the Program to include non-public providers and integration of other performance-based contracting models to ensure a harmonized approach to the delivery of a national package of maternal and child health interventions. The Project seeks to ensure the provision of a clearly defined package of evidence based, high-impact and cost-effective interventions* to a well defined population, namely pregnant women and children under five. The MSPP, with the technical assistance of WHO/PAHO and in partnership with the Canadian Government, has identified and costed a package of services proven to have a significant impact on under-five and maternal mortality rates. The Government intends to deliver these services free-of-charge at the national scale, which should increase utilization, bringing the country closer to achieving the health-related MDGs. Box 1 outlines the current package of health and nutrition services. This package will be reviewed during project preparation and updated based on new costing studies. Both the package of services and the defined beneficiary population may be expanded in the future based on available funding. The size and locations of the beneficiary population will be determined during project preparation.

Box 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 STIs, HIV testing and prevention of mother to child transmission, tetanus vaccination, de-worming, treatment of anemia and other micronutrient deficiencies, detection of malnutrition and supplementation as necessary)
Sub-component 1.1: Delivery of the Health and Nutrition Package (US$13 million). This sub-component would finance payments to participating health institutions for the delivery of a costed package of health and nutrition services based on agreed upon targets. Service providers are reimbursed for each individual service provided. The payment system is output-based, that is, fees are set in advance and services are bundled to some degree. Fees have been calculated on the basis of a costing study analyzing the recurrent costs associated with the delivery of the service in question to the targeted population. Thus the Program’s financing scheme provides a subsidy for the delivery of an essential package of services. Quality of services is assessed through two separate tools. One, a checklist is used to verify availability of critical inputs, such as the key medical staff, supplies and medicines and the functionality of the infrastructure (including water and electricity). The checklist verification occurs in each participating health facility on a quarterly basis. Second, a patient satisfaction survey is undertaken on a sample basis by an external party with the objective of ensuring that the beneficiary did in fact receive services free-of-charge in line with the accepted protocols. The quality assurance system and implementation modalities, including enrollment of the beneficiary population, will be strengthened.

To this end, this Component would finance two subcomponents: (i) Delivery of the Health and Nutrition Package; and (ii) Strengthening the Quality and Supply of Services.

Sub-component 1.2: Strengthening the Quality and Supply of Services (US$10 million). This sub-component would seek to improve the quality and supply of services within selected health facilities through financing of small-scale rehabilitation, equipment, medical supplies, and drugs and training of health personnel. Prior to enrollment in the Program, an evaluation of whether the health provider has the requisite capacity to deliver the package of services is undertaken by the Contract and Program Management Unit, followed by a field visit to verify and confirm the information presented in the application. In certain priority geographic zones, such as slum areas, specific recommendations may be made to immediately address capacity weaknesses, such as the provision of additional equipment and medical supplies to the institution by the Program given that the goal is to retain as many health facilities in the Program as possible. Moreover, training is provided for all health personnel involved in the delivery of the package of services as necessary. The training program, which focuses on the correct application of service delivery protocols, is provided in three phases: (i) a two day general training on the basics of integrated management of childhood illnesses and obstetrical care; (ii) an on-site training on application of the protocols over a three to six-month period; and (iii) monthly on-site coaching throughout the life of the Program. Additional training would be provided on administrative and financial management of health institutions and support to medical waste management would be provided. This sub-component will therefore finance the investment of costs related to small-scale rehabilitation of existing infrastructures, the acquisition of equipment, medical supplies, and drugs as well as training of health personnel.

Additionally, this sub-Component would support the strengthening of the verification of results, a critical element of results-based financing, as well as monitoring and supervision of delivery of services. Manman ak Timoun an Santé employs a combination of approaches for monitoring and verification of results, through (i) routine verification to ensure reliable reporting and confirm that patients who were reported to have received services actually received them; and (ii) an independent verification process to ensure the accuracy and consistency of reporting on the volume and/or quality of services provided. Random patient satisfaction surveys are undertaken on a quarterly basis to verify if services have actually been provided: the contracted firm reviews health facility registers, randomly selects a sample of patients and surveys them at their households to collect information regarding services rendered, quality of care provided, and overall patient satisfaction. Moreover, given that results-based financing represents a fundamental shift in behavior, moving the risk from the purchaser to the provider, training and capacity building 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.

Component 2. Improving Basic Living Conditions of Poor and Vulnerable Families (US$20 million). The objective of this Component is to reduce the vulnerability of poor families through the preparation of a Family Development Plan based on the family's vulnerability and living conditions and the fulfillment of the family's Life Objectives outlined in the Plan, with the support of the Kore Fanmi agents and municipal teams. Through the proposed Project, and in support of the flagship Aba Grangou, the Kore Fanmi initiative will be scaled up in terms of both coverage and types of interventions provided in order to cover a larger array of social services progressively and enhanced. Kore Fanmi agents are locally recruited and assigned a manageable number of families (100 families per agent on average). Agents are responsible for (a) distribution of a package of essential goods and services; (b) promotion of positive behavioral change; and (c) referral to appropriate social services when required. To do so, they first assess family needs through a beneficiary survey to establish a detailed socio-economic profile based on family demographic, health, nutrition, food insecurity, housing conditions, education and economic data. 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 provided by the Kore Fanmi agent. Finally, a Family Development Plan is created to match each family's specific conditions with Life Objectives that include health, nutrition, civil rights, nutrition and food security, education, economic opportunities, living conditions and violence prevention. The municipal team supervises, trains and guides Kore Fanmi agents in their tasks and is responsible for improving cooperation between partners and service providers and for keeping local authorities informed on social services at the municipal level (map of opportunity for services and programs available to families). The municipal team is composed of a full time coordinator, one social worker for every 15 Kore Fanmi agents and a data management specialist. For families detected to be in extreme vulnerability, Kore Fanmi will provide support through an emergency fund.

This Component will finance the Kore Fanmi agents and the municipal teams, essential commodities and goods, and operational costs. To support the scaling up of the Kore Fanmi model, this Component will finance: (a) payments, based on performance, of the Kore Fanmi agents and municipal teams; (b) essential commodities and goods to support basic service delivery at the household level; (c) operational costs of the agents and teams; and (d) emergency funds for extremely destitute families.

Component 3. Institutional Strengthening (US$7 million). The Government, while still requiring external assistance for financing the social sector in the foreseeable future, must strengthen its capacity to effectively regulate and manage the delivery of services at the local levels. This Component will finance two subcomponents: (i) Strengthening MSPP’s Stewardship and Management Capacity; and (ii) Support to Management of Aba Grangou and Kore Fanmi.

Subcomponent 3.1: Strengthening MSPP’s Stewardship and Management Capacity (US$4 million). The objective of this sub-component is to support the development of adequate capacity of MSPP to effectively put in place, manage and supervise the relevant contracting and monitoring arrangements. In order to do this, a Contract and Program Management Unit (CPMU) is being created within the Ministry for this purpose and staffed by Ministry personnel as well as competitively recruited local consultants. The objectives of the CPMU are to: (i) help expand the delivery of a standardized essential package of health and nutrition services; (ii) strengthen the MSPP’s stewardship role in the health sector so it can ensure sector priorities and policies 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. This Unit will be firmly embedded within the MSPP to manage funds and coordinate and oversee the activities and sector programs of various donors, particularly related to the country wide provision of an essential package of health and nutrition services through standard procurement procedures, financial and technical management of health service delivery contracts, in coordination with corresponding MSPP departments and relevant stakeholders.

Strengthening the capacity of the technical departments of the Ministry and the departmental health authorities is essential, given their important role in the supervision of the respective technical aspects. Although donor-financed programs and contracts would be overseen by the CPMU, the technical departments of the Ministry and the departmental health authorities play an important role in the supervision of the respective technical aspects. The CPMU staff would liaise regularly with the relevant technical departments and staff of the CPMU will be twinned with staff in the technical departments to ensure longer-term capacity building and transfer of experience and skills. In an effort to facilitate inter-departmental exchanges of experience and lessons learned, the CPMU could put in place different mechanisms, 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. It would be critical to provide support to build capacity at all level of the delivery chain, including planning, budgeting and tracking public expenditures, defining policies, clarifying role and responsibilities of the decentralized levels in planning and coordinating effective provision of services to the population. Finally, this sub-component would support strengthening of capacity of MSPP for medical waste management and worker health and safety capacity. This sub-component will therefore finance technical assistance in a number of areas, training and small goods and equipment at central and decentralized levels of service provision.

Subcomponent 3.2: Support to Management of Aba Grangou and Kore Fanmi (US$3 million). This sub-component will provide support to the coordination office of the National Commission on Fighting Hunger and Malnutrition (Aba Grangou) and to the Kore Fanmi team in the Fonds d’Assistance Economique et Sociale (FAES). The Aba Grangou coordination office will be responsible for developing standards and policies on social protection, tracking families’ vulnerabilities and social initiatives, providing technical support, and monitoring and evaluation to social initiatives in Haiti. Support will be provided under this sub-component to the set-up and functioning of the municipal offices implementing the new model of family support in the country. Moreover, the identification of citizens is a fundamental responsibility of the state, a basic prerequisite for effective service delivery and an essential tool to promote inclusion and accountability. Therefore, this sub-component would provide technical assistance for: (i) the development of
the regulatory framework for an national identification system, including facilitating the issuance of numbers and the gathering, updating, and usage of data; (ii) the design and deployment of technologies and facilities for the system; (iii) the enhancement of the national identification database and strengthening of coordination among actors providing IDs and services using IDs as an accountability mechanism, and (iv) the adoption of e-ID verification services and the linkage of national identification, Birth registration and National Population Register databases. Finally, this sub-component would finance monitoring and evaluation, procurement, financial management, internal auditing and oversight costs of Component 2, including annual financial audits, through FAES.

IV. Safeguard Policies that might apply

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