I. Project Context

Country Context

Two and a half years after a massive earthquake ravaged Haiti, reconstruction remains urgent to address the impacts of the disaster. 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. The reconstruction process has also highlighted that increasing the capacity of institutions and improving overall governance are critical to achieving sustainable results in Haiti.

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 2001, 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.

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 births (three times the regional average) and is not improving at a pace to allow Haiti to achieve MDG 4 target of 50 per 1,000 live births by 2015. However, 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. An outbreak of cholera in October 2010 has further compromised the welfare and health status of the population. Cholera is becoming endemic and the incidence of diarrhea is high among children, especially those between six months and two years old (39 percent), and those living in rural areas (25 percent). 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.

Despite the efforts of the Haitian authorities to address maternal mortality, it is the highest in the region at 630 per 100,000 live births and far from the MDG target of 155 deaths per 100,000 live births. Maternal mortality decreased 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 childbirth. Although on the decline, Haiti has the highest fertility rate in the Americas and access to family planning services is low.

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 6.1 percent (around US$40 per capita) and the major sources of financing of the sector are (i) out of pocket expenditures (47 percent); (ii) external donors and not-for profit organizations (31 percent or around US$12 per capita), and (iii) the Government (22 percent or around US$9 per capita). 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 UN agencies, 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 both supply-side constraints, related to lack of access to quality health services, as well as demand-side constraints, such as financial barriers to access. By providing a financing of US$70 million over five years (US$14 million per year), the Project seeks to address both issues to improve outcomes.

II. Sectoral and Institutional Context
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 diarrhea and pneumonia. Routine immunization rates are low, with six out of ten Haitian children (12-23 months old) not fully vaccinated, and one in ten receiving no vaccine at all. Maternal mortality is largely attributable to poor nutrition, the high incidence of home deliveries and little post-natal care, and limited 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 birth, impacting post-natal follow up. Overall, 84 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 did not receive post-natal care. In Haiti, almost half of women (46 percent) of childbearing age are anemic, with urban (51 percent) and pregnant women (50 percent) affected disproportionately. Despite such a high prevalence of anemia, only one in five women (27 percent) receive adequate iron supplementation (90 days or more), and more than one out of three (35 percent) receive none. 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 contraceptives.

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 reduce the delay in problem recognition and accessing care 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 benefited from these standard tests.

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 of these interventions 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 mothers. Health and nutrition services for young children, such as vaccination, prevention and management of diarrhea, 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.

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 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. 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 function needs to be strengthened to ensure a focus on results and that resources are used efficiently to improve health outcomes.

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 heath 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.

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 evidence, 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 & 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) community nutrition programs targeting children under-five and pregnant and lactating women, and (iv) 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 regions.

The proposed Project supports the Government’s objective of increasing access and remove 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 services, free-of-charge, 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 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) will deliver certain basic preventive services, 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 though direct support or through coordination with services providers to bridge service coverage gaps.

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. While rigorous
The Project will also be supported by a grant from the Health Results Innovation Trust Fund (HRITF). 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. 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.

III. 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. The Project will support services to pregnant women and children under five and increase use of social services for vulnerable households in three Departments with a catchment population of around 1.81 million people, thus benefiting an estimated population of 420,000 women of child bearing age and 185,000 children under five. Progress on achievement of 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) number of pregnant/lactating women, adolescent girls and/or children under age five reached by basic nutrition services.

IV. Project Description

Component Name
Component 2: Strengthening Government’s Capacity to Manage Service Delivery.

V. Financing (in USD Million)

<table>
<thead>
<tr>
<th>For Loans/Credits/Others</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>BORROWER/RECIPIENT</td>
<td>0.00</td>
</tr>
<tr>
<td>IDA Grant</td>
<td>50.00</td>
</tr>
<tr>
<td>Results-Based Financing</td>
<td>20.00</td>
</tr>
<tr>
<td>Total</td>
<td>70.00</td>
</tr>
</tbody>
</table>

VI. Implementation

A. Institutional and Implementation Arrangements

1. Oversight of the institutional delivery of the package of maternal and child health and nutrition services will be undertaken by the contracting team of the MSPP and community and family support activities will continue to be implemented by FAES. A contracting team within 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. The contracting team will manage all funds – donor and state – using a single set of implementation, administration, financial management, procurement, environmental safeguards and monitoring and evaluation procedures, outlined in the MSPP Program Operational Manual and the MSPP Accounting, Financial and Administrative Manual. The strategic guidance for the integrated family support will be provided by the Commission Nationale de Lutte Contre la Faim et la Malnutrition (COLFAM), while community and family support activities will be implemented by FAES, which is an autonomous Haitian governmental entity 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) close collaboration with municipalities for the execution of the Project and with the MSPP for the delivery of maternal and child health and nutrition services at community level; and (iii) financial management and procurement for community level activities. A FAES Implementation Manual has been developed and will be reviewed prior to negotiations.

B. Results Monitoring and Evaluation

The MSPP’s health management information system and the Kore Fanmi MIS will report on the delivery of the package of maternal and child health and other social services and target social assistance programs. 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 Kore Fanmi 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 (institutional and community levels 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 Operational Manual. Finally, an impact evaluation of the Project will be carried out to measure its outcomes and operational impact.
C. Sustainability

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 the demand and supply sides of maternal and child health and nutrition and social service delivery while including institutional capacity building activities to build stronger systems. As Kore Fanmi becomes a key service delivery mechanism at the community level, it also serves as the cornerstone of the Government’s national social protection strategy in identifying and facilitating targeting of social programs to objectively identify vulnerable families. It will also contribute to increasing referral of pregnant women, children under five and vulnerable households to service providers. On the supply side, the introduction of results-based financing 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, and 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.

Strengthened national systems and greater regulatory capacity of the Government will ensure improved budget execution and high 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, expenditure 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.

VII. Safeguard Policies (including public consultation)

<table>
<thead>
<tr>
<th>Safeguard Policies Triggered by the Project</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Environmental Assessment OP/BP 4.01</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Natural Habitats OP/BP 4.04</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Forests OP/BP 4.36</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Pest Management OP 4.09</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Physical Cultural Resources OP/BP 4.11</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Indigenous Peoples OP/BP 4.10</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Involuntary Resettlement OP/BP 4.12</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Safety of Dams OP/BP 4.37</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Projects on International Waterways OP/BP 7.50</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Projects in Disputed Areas OP/BP 7.60</td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

VIII. Contact point

World Bank
Contact: Maryanne Sharp
Title: Country Operations Adviser
Tel: 458-5560
Email: msharp@worldbank.org

Borrower/Client/Recipient
Name: Ministry of Economy and Finance, MEF
Contact: Marie Carmelle Jean-Marie
Title: Minister of Economy and Finance
Tel: 011-509-2992-1023
Email:

Implementing Agencies
Name: FONDS D'ASSISTANCE ECONOMIQUE ET SOCIALE
Contact: Klaus Eberwein
Title: Directeur Général
Tel:
Email: klaus.eberwein@faes.gouv.ht

Name: Ministry of Public Health and Population
Contact: Florence Guillaume
Title: Minister of Public Health and Population
Tel:
Email: ministre@mspp.gouv.ht

IX. For more information contact:
   The InfoShop
   The World Bank
   1818 H Street, NW
   Washington, D.C. 20433
   Telephone: (202) 458-4500
   Fax: (202) 522-1500
   Web: http://www.worldbank.org/infoshop