Project Information Document/
Integrated Safeguards Data Sheet (PID/ISDS)

Concept Stage | Date Prepared/Updated: 12-Oct-2018 | Report No: PIDISDSC24919
## BASIC INFORMATION

### A. Basic Project Data

<table>
<thead>
<tr>
<th>Country</th>
<th>Project ID</th>
<th>Parent Project ID (if any)</th>
<th>Project Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Haiti</td>
<td>P167512</td>
<td></td>
<td>Strengthening Primary Health Care and Surveillance in Haiti (P167512)</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Region</th>
<th>Estimated Appraisal Date</th>
<th>Estimated Board Date</th>
<th>Practice Area (Lead)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Financing Instrument</th>
<th>Borrower(s)</th>
<th>Implementing Agency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Investment Project Financing</td>
<td>Ministère de l'Economie et des Finances</td>
<td>Ministère de la Santé Publique et de la Population</td>
</tr>
</tbody>
</table>

### Proposed Development Objective(s)

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

## PROJECT FINANCING DATA (US$, Millions)

### SUMMARY

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount (US$ million)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Project Cost</td>
<td>55.00</td>
</tr>
<tr>
<td>Total Financing</td>
<td>55.00</td>
</tr>
<tr>
<td>of which IBRD/IDA</td>
<td>40.00</td>
</tr>
<tr>
<td>Financing Gap</td>
<td>0.00</td>
</tr>
</tbody>
</table>

### DETAILS

**World Bank Group Financing**

<table>
<thead>
<tr>
<th>Source</th>
<th>Amount (US$ million)</th>
</tr>
</thead>
<tbody>
<tr>
<td>International Development Association (IDA)</td>
<td>40.00</td>
</tr>
<tr>
<td>IDA Grant</td>
<td>40.00</td>
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</table>

**Non-World Bank Group Financing**

<table>
<thead>
<tr>
<th>Source</th>
<th>Amount (US$ million)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust Funds</td>
<td>15.00</td>
</tr>
<tr>
<td>Global Financing Facility</td>
<td>15.00</td>
</tr>
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</table>
B. Introduction and Context

Country Context

1. **Despite advances in recent years, poverty remains high, and Haiti is one of the most unequal countries in the world.** Due to the country’s long history of political instability, repeated fiscal crises, and extreme vulnerability to a wide range of shocks, slow economic growth punctuated by frequent contractions has yielded a per capita income equivalent to just US$760 (or US$1,815 in purchasing-power-parity terms). Between 2000 and 2012, the proportion of people living in extreme poverty has declined from 31% to 24% (based on purchasing-power-parity)\(^1\). However, poverty remains widespread. The poverty headcount at national poverty line is about 59 percent, reaching as much as 75% in rural areas. Almost 6.3 million Haitians are unable to meet their basic consumption needs, while 2.5 million cannot cover their essential food needs.

2. **The country continues to be vulnerable to recurrent natural disasters.** The latest major disaster happened in October 2016 when Haiti was struck by Hurricane Matthew, affecting over two million people. The cholera outbreak that followed spread to the Southern departments of Haiti and the Northwest and was only controlled after several months of intensified efforts. Post-hurricane reconstruction needs were assessed at 25% of gross domestic product (GDP), or US$ 2.2 billion.\(^2\) Meanwhile, GDP growth has remained weak. After a spurt following the 2010 earthquake, GDP growth began slowing in 2014, reached only 1.2% in 2017 and is projected to further slow down to 1% in 2018. Public expenditure increased to meet post-Matthew reconstruction needs, but resource mobilization continues to be a challenge, with internal revenues only reaching 12.9% of GDP.

3. **While macroeconomic stability was broadly preserved in the years immediately following the 2010 earthquake, a combination of domestic and external factors has steadily widened the fiscal deficit, and Haiti is now at high risk of debt distress.** In the aftermath of the quake, supported by strong donors’ assistance, the authorities reduced the fiscal deficit and managed to keep inflation in check.\(^3\) However, the return of international aid to more normal levels intensified fiscal pressure. Tighter fiscal constraints will not provide the Government with much room to meet social demands and could even lead to cuts in social spending.

4. **In August 2018, following the civil unrest, former presidential candidate and political opponent Jean-Henry Céant was appointed Prime Minister.** The February 2017 presidential elections brought relative stability and better conditions

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\(^1\) World Development Indicators (WDI) database, 2017.


\(^3\) The overall deficit including grants declined from 6.3% of GDP in FY2012-13 to 1.5% of GDP in FY2016-17. Inflation was kept in the single digits until 2015.
for Haiti’s development. For the first time since 2006, the country has an elected President with a five-year mandate, a fully-seated Parliament, and elected mayors running Haiti’s 140 communes.

Sectoral and Institutional Context

5. **Haiti’s health outcomes are poor, even when compared to other low-income (and many poorer) countries.** Haiti lags behind other low-income countries (LICs) for several basic health indicators. Despite some progress over the past two decades, both infant and child mortality remain high. Since 2012, the rate of fully vaccinated children has been stagnating at around 40%, and this has contributed to a number of outbreaks of preventable diseases such as diphtheria. Negative health outcomes are linked in part to very low levels of utilization of services. For example, the outpatient utilization rate is only around 0.5 visits per person per year.

6. **Health inequalities are very high, reflecting far lower service coverage for people in the poorest wealth quintiles and for those living in areas where access to services of adequate quality is low.** Only 13% of women from the lowest wealth quintile give birth at a health facility, compared to 79% for those in the highest wealth quintile. The stunting rate among under-five children in the lowest wealth quintile is 34% compared to 9% in the highest wealth quintile. Access to health services is significantly affected by user fees. About 35% of households in the lowest wealth quintile do not seek care from a health provider even when they have health problems; of these households, two-thirds simply cannot afford to seek care. User fees are one factor leading to an especially low percentage of women giving birth at health facilities in Haiti.

7. **While international evidence shows that investing in primary health care (PHC) is an efficient way to achieve Universal Health Coverage (UHC), low priority is given to PHC in Haiti. Taking steps to prioritize PHC is critical for Haiti’s health sector – as emphasized by the HFA report.** Currently, Haiti only spends 19% of its total health expenditure on preventive care, whereas 54% is spent on curative care. Compared to other countries and the norms of the Ministry of Public Health and Population (MSPP), the number of dispensaries (the lowest level of PHC facilities) is low relative to the population size, compared to other countries and to MSPP norms. At the same time, on a per-capita basis, the number of hospitals is very high compared to other low-income countries and it exceeds the norms set by MSPP.

8. **Key health sector challenges include:**
   - Although multiple community health approaches coexist, they are uncoordinated, weakly integrated with the rest of the health system, and not cost-effective.
   - The MSPP lacks effective tools to address organizational deficiencies in the service delivery structure for primary care.
   - There are also major organizational deficiencies in the financing of the system. Weak coordination of external aid, as well as lack of a prioritized benefit package, have led to significant overlaps between different streams of financing, while some priority areas – especially at the primary care level – remain underfinanced.
   - Weaknesses in Public Financial Management (PFM) hinder front line service delivery, especially at the primary care level.
   - Health worker productivity is very low – due, in part, to low accountability and poor incentives to perform well.
   - Patient care at hospitals is hindered by critically low levels of resources for providing basic services and by regulatory weaknesses and inefficient management.
   - Eight years after the start of the cholera epidemic in Haiti, cholera incidence is at a historically low point. But underlying drivers persist – including weak water and sanitation, and fragile surveillance capacity.
9. Linking financing for individual staff and facilities to the production of results through results-based financing (RBF) mechanisms is one way to strengthen accountability for results and increase human resource productivity. Since 2014, MSPP has been implementing an RBF program at the primary care level that is showing promising results. The program is co-financed currently by the World Bank⁴, USAID and Canada. It covers 135 dispensaries, health centers and community hospitals (out of a total of 966 in the country).⁵ The results show that over a period of 6 quarters, vaccinations for under-5 children at target health facilities rose by 24%; births at health facilities rose by 15%; utilization of contraceptives at health facilities rose by 44%; the number of young children receiving nutritional screening rose by 57%; and the average quality score at health facilities rose from 56% to 66%. These results, among others, were verified by an external verification agency, and have encouraged MSSP to consider scaling up the program to additional health facilities.

10. As highlighted in a 2017 WB cholera response assessment report⁶, 8 years of experience battling cholera have enabled the Government and its partners to draw key lessons for future interventions: 1) The approach implemented under the medium-term phase of the National Plan for the Elimination of Cholera (PNEC) has been very effective at reducing cholera incidence; 2) However, the surveillance and response mechanisms should progressively evolve towards a broader, less cholera-specific approach to infectious diseases surveillance and response. Years of activities focused on combatting cholera have led to verticalized structures that are now firmly established, such as: (i) cholera treatment centers (with their dedicated staff, equipment, supply chains, etc.) disconnected from the rest of the health system; (ii) cholera-specific rapid response teams throughout the country; and (iii) cholera-specific surveillance systems, including for laboratory testing. In the context of highly constrained resources and with the epidemic being at a low point, partners and the Government are now aiming to achieve efficiency gains by integrating the relatively well functioning cholera-specific mechanisms into the general surveillance systems. Another key lesson is that cholera rapid response teams are also expected to expand the scope of diseases they respond to and cover infectious diseases outbreaks in general. This would be done under the long-term phase (2019-2022) of the NPEC and would be supported by the proposed new WB project.

Relationship to CPF

11. The proposed Project is aligned with the Haiti CPF for the Period FY16-19 and the Haiti Performance and Learning Review of the Country Partnership Strategy (Performance and Learning Review - PLR, 2018).⁷ The proposed Project will support the CPF Area of Focus 2 (Human Capital), specifically Objectives 6 (Increase Access to Health Services for Mothers and Children) and 7 (Control Cholera in Priority Communes). In accordance with the PLR, the Project builds on the findings of the 2017 WB HFA and focuses on improving the organization of the health sector and the efficiency of the service delivery system, while increasing access and use of health care services with particular attention to women and children.

12. The proposed Project will contribute to achieving Sustainable Development Goals 3.1, 3.2, 3.3 and 5 (on maternal mortality, child mortality, communicable diseases, and gender equality). It is aligned with the goals of the WB’s Health, Nutrition, and Population Global Practice of achieving universal health service coverage and protecting households from catastrophic health care costs – focusing particularly on women, children, and vulnerable families. The proposed Project is also aligned with the WB’s Twin Goals of ending extreme poverty and boosting shared prosperity; its activities and the selection of the intervention areas are expected to especially benefit the poor and vulnerable. In addition, the expected improvements in basic health outcomes will strengthen human capital, which in turn will contribute to tackling poverty.

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⁴ Under the ongoing World Bank Improving Maternal and Child Health Through Integrated Social Services (PASMISSI) Project.
⁵ The program covers public as well as private, non-profit health facilities.
C. Proposed Development Objective(s)

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

Key Results (From PCN)

13. The following key Project indicators will be monitored throughout the Project.

(i) Percentage of under-five children fully vaccinated in Project intervention areas
(ii) Percentage of institutional deliveries in Project intervention areas
(iii) Contraceptive prevalence rate in Project intervention areas
(iv) Percentage of notifications of suspected cases of cholera for which laboratory results are available to the Health Departmental Directorates (DDSs) within 1 week of collection

D. Concept Description

14. Building upon the gains achieved under the ongoing WB PASMISSI Health Project, the proposed Project will focus on strengthening: (i) Haiti’s primary healthcare system in selected geographical areas (including pilots to test new approaches), and (ii) its surveillance system nationwide. The Project would be financed through an Investment Project Financing (IPF) grant of US$40 million and a US$15 million GFF grant. The proposed Project will continue the successful approach of RBF started under the ongoing project – whose closing date is December 2019 – with complementary activities to tackle some of the deficiencies described in the “Sectoral Context” section.

15. The proposed Project will also provide continued financing for the cholera stream under the current Project which has been successful at containing Haiti’s cholera epidemic. However, following the recommendations of the 2017 WB cholera response assessment, the new Project would support a progressive transition from the current cholera-specific approach to one with more integrated surveillance and response systems, covering prevalent infectious diseases.

16. The Project would have four components:

Component 1: Strengthening Primary Health Care Service Delivery (US$ 36 million). This component will have two sub-components – one financing activities to strengthen the structural conditions for PHC service delivery and the other financing RBF activities. Sub-Component 1.1: Improving the Effectiveness of Health Systems for Primary Care Service Delivery in selected geographical areas; and Sub-Component 1.2: Results-Based Financing and Accountability for Service Delivery. Based on the results of the mapping and facility classification exercises, reconstruction of existing facilities could potentially be included, but no new health care facilities will be constructed. The list of facilities to benefit from rehabilitation will be known after project effectiveness.

Component 2: Strengthening Surveillance and Control for Infectious Diseases (US$ 15 million). This component will aim to maintain the effective nationwide surveillance and response capacity of MSPP in the fight against cholera achieved under the ongoing WB PASMISSI project, while integrating cholera surveillance tools into the general surveillance system.
Given the sharp decline in resources available to finance cholera response activities and in the overall health sector, this component will continue to ensure the financing of critical surveillance and control activities for cholera and scale up the system to include other prevalent infectious diseases, complementing the support of the U.S. Centers for Disease Control and Prevention (CDC) to MSPP’s surveillance capacity.

**Component 3: Strengthening the Management Capacity of MSPP (US$ 4 million).** This component will finance: a) activities to strengthen the capacity of the central MSPP units and Departmental health authorities to support activities related to primary health services delivery and to the surveillance and control of infectious diseases (i.e. the activities under Components 1 and 2); b) Project monitoring and evaluation activities; c) activities related to financial management, procurement and safeguards for the Project, including the Project audit.

**Component 4: Contingency and Emergency Response Capacity (CERC) (US$ 0 million).** This component will facilitate the immediate availability of funds for immediate and emerging risks, such as natural and man-made disasters, conflicts, epidemics and economic shocks.

**SAFEGUARDS**

**A. Project location and salient physical characteristics relevant to the safeguard analysis (if known)**

The Project will strengthen the primary health care system in selected geographical areas and will strengthen the surveillance system in all the national territory. Small scale rehabilitation and civil works will take place for existing health facilities only (component 1). The infrastructure to be rehabilitated is of small size consisting mostly of fixing walls, windows, doors, minor electrical and water systems repairs, and facility fences. The size of the target structure for rehabilitation could include both small size health clinics as well as small-size community referral hospitals. Reconstruction of existing facilities could potentially be included, but no new health care facilities will be constructed. The exact list of sites will be known after project effectiveness. The project will not intervene on wastewater management facilities since they are not managed by the Ministry of Health. Small incinerators will likely be rehabilitated in selected health facilities and where possible, more environmentally friendly technology will be considered.

**B. Borrower’s Institutional Capacity for Safeguard Policies**

The proposed project will be implemented by the MSPP. Implementation arrangements will be similar to structures already in place for the implementation of the ongoing health project. These arrangements have proven to be robust and have helped produce good performance with the RBF and the cholera activities, which account for the bulk of the project’s funds. All safeguards responsibilities for the proposed project will be assigned to an existing PIU (Unité de Gestion de Projet or UGP) at the MSPP, which has been managing the ongoing Bank supported health project. The PIU would be headed by a Coordinator (appointed by the Minister of Health and subject to approval by the Bank) and would also include dedicated environment and social specialists to ensure adequate monitoring of safeguards policies. UGP (which is part of MSPP) will remain responsible for safeguards implementation and will keep working closely with MSPP’s Directorate for Health Promotion and Protection of the Environment (DPSPE) on both environmental and social safeguards since DPSPE is the main entity of the Ministry responsible for environmental aspects and community health interventions. Under the current project, DPSPE and the PIU safeguards specialists have developed a robust capacity to
manage safeguards and are expected to continue strengthening their capacity under the new project.

C. Environmental and Social Safeguards Specialists on the Team

Nyaneba E. Nkrumah, Environmental Specialist
Asli Gurkan, Social Specialist

D. Policies that might apply

<table>
<thead>
<tr>
<th>Safeguard Policies</th>
<th>Triggered?</th>
<th>Explanation (Optional)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Environmental Assessment OP/BP 4.01</td>
<td>Yes</td>
<td>Activities likely to trigger safeguard policies are mainly associated with the delivery of health and essential social services, the management of healthcare and medical waste, accidental wastewater/sewage discharge from health facilities, and Environmental Health and Safety (EHS) during construction. OP 4.01 Environmental Assessment is triggered due to the risks associated with the inappropriate management, disposal and elimination of medical and healthcare waste. The ESMF prepared for the ongoing Project (P123706) includes 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 toxic healthcare waste and the inadequate management of disposal sites and will be updated during Project preparation. The WBG Guidelines for Health Care Facilities will be considered during the preparation of the updated ESMF.</td>
</tr>
</tbody>
</table>

The infrastructure to be rehabilitated is of small size consisting mostly of fixing walls, windows, doors, minor electrical and water systems repairs, and facility fences. The size of the target structure for rehabilitation could include both small size health clinics as well as small-size community referral hospitals. Reconstruction of existing facilities could potentially be included, but no new health care facilities will be constructed. The exact list of sites will be known after the project becomes effective. The project will not intervene on wastewater management facilities since they are not managed by the Ministry of Health. Small incinerators will likely be rehabilitated in selected health facilities and where possible, more
Moreover, the Project will include mechanisms to enhance positive impacts, address grievances and improve environmental management. The ESMF and the RPF will be updated in consultation with stakeholders. The results of the consultation will be integrated in the final documents, which will be disclosed in country and at the World Bank’s website. Site-specific ESMPs will be prepared, following completion of the screening form, if necessary. Alternatively, for small-scale, less adverse rehabilitation civil works, the project will implement simple mitigation measures, following the checklist annexed to the updated ESMF. For any given project site, no civil works shall commence prior to the preparation, approval and disclosure of its specific ESMP or the determination of simple environmental mitigation measures, whichever is appropriate, as determined by the completion of the screening form.

Social risks and impacts: On the social side, no major safeguards risks are expected. Potential risks may include conflicts/tensions between beneficiaries and non-beneficiaries of the project if the selection of activities is not properly communicated in the targeted localities.

In accordance with the Bank’s Guidance: Contingent Emergency Response Components, the ESMF will include a specific CERC section describing the potential emergencies and the types of activities likely to be financed, and provide a preliminary evaluation of potential risks and mitigation measures associated with them.

<table>
<thead>
<tr>
<th>Performance Standards for Private Sector Activities OP/BP 4.03</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Nature Habitats OP/BP 4.04</td>
<td>No</td>
</tr>
<tr>
<td>Project activities will not involve the conversion or degradation of critical natural habitats. No major civil works will be supported by the Project. Thus, no land or water where native plants and animal species predominate will be affected. Therefore, this policy will not be triggered as defined by the Bank Operational Policies.</td>
<td></td>
</tr>
<tr>
<td>OP/BP</td>
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</tr>
<tr>
<td>--------</td>
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<tr>
<td><strong>Forests OP/BP 4.36</strong></td>
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<td><strong>Pest Management OP 4.09</strong></td>
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<td><strong>Physical Cultural Resources OP/BP 4.11</strong></td>
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<td><strong>Indigenous Peoples OP/BP 4.10</strong></td>
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<td><strong>Involuntary Resettlement OP/BP 4.12</strong></td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Safety of Dams OP/BP 4.37</strong></td>
<td>No</td>
</tr>
</tbody>
</table>
### Projects on International Waterways

**OP/BP 7.50**

| No | The Project will not include activities related to international waterways as defined by the WB policy. |

### Projects in Disputed Areas

**OP/BP 7.60**

| No | The Project will not include activities related to disputed areas as defined by the WB policy. |

## E. Safeguard Preparation Plan

Tentative target date for preparing the Appraisal Stage PID/ISDS

**Nov 15, 2018**

Time frame for launching and completing the safeguard-related studies that may be needed. The specific studies and their timing should be specified in the Appraisal Stage PID/ISDS

The ESMF and RPF are expected to be completed by November 2018.

## CONTACT POINT

### World Bank

Andrew Sunil Rajkumar  
Sr Economist (Health)

### Borrower/Client/Recipient

Ministère de l’Economie et des Finances  
Ronald Grey  Decembre  
Minister of Finance  
ronaldg.decembre@mef.gouv.ht

### Implementing Agencies

Ministère de la Santé Publique et de la Population  
Marie Greta Roy Clément  
Ministre de la Santé Publique et de la Population  
laministre@mspp.gouv.ht