REORGANIZATION OF THE NATIONAL HEALTH SYSTEM
PHASE I

(HA-0045)

EXECUTIVE SUMMARY

BORROWER AND GUARANTOR:	The Government of Haiti	
EXECUTING AGENCY:	The Ministry of Public Health and Population	
AMOUNT AND SOURCE:	Full Program:	
	IDB (SF):	US$45.0 million
	Local counterpart funding:	US$ 5.0 million
	Total:	US$50.0 million
	Phase I:	
	IDB (SF):	US$22.5 million
	Local counterpart funding:	US$ 2.5 million
	Total:	US$25.0 million
	Phase II:	
	IDB (SF):	US$22.5 million
	Local counterpart funding:	US$ 2.5 million
	Total:	US$25.0 million
FINANCIAL TERMS AND CONDITIONS:	Amortization period:	40 years
	Disbursement period:	Phase I: 40 months; Phase II: 40 months
	Interest rate:	1% during the 10-year grace period, 2% thereafter
	Inspection and supervision:	1%
	Credit fee:	0.50% annually on undisbursed balance

BACKGROUND: The proposed program, conceptualized as a six-year operation with a total estimated cost of US$50.0 million (Bank financing of $45.0 million), will be implemented in two phases. For programming purposes, each three-year phase will be supported by a separate Bank loan of US$22.5 million. The request for approval of the second phase will be triggered by verification that 50 percent of the resources of Phase I have been committed and that satisfactory progress for the first 24-month period has been made. (See Par. 3.34 and 3.35).

OBJECTIVES: The objective of the program is to support the Government's efforts to improve the health status of

the Haitian population by enhancing the quality, efficiency and equity of health services provided by public and private institutions in the national health system. This will be done by: (i) improving the quality of and access to both public and private health services in a way that is, over the long term, financially and institutionally sustainable; (ii) increasing the efficiency of services at the national level; and (iii) developing innovative models for financing and delivery of basic health services, that are replicable at the national level. (See Annex I, the Logical Framework.)

DESCRIPTION: The program is designed to address a set persistent problems that have limited the sector's ability to improve health conditions. Capitalizing on existing strengths and resources, including the active non-governmental sector and aid community, the program seeks to support establishment of local health networks for delivery of cost-effective health services; strengthen support for these networks at the Departmental and central levels; create a funding channel for domestic and international financiers to contract for health services; and initiate movement toward a financially sustainable system that is responsive to consumers.

The program will provide integrated technical assistance, training, material inputs and targeted recurrent cost support for the provision of a minimum package of services. The program has five components:

1. Development of the UCS Model (Full Program: US$26.2 million; Phase I: US$14.7 million; Phase II: US$11.5 million) will support the implementation of a local health network model of health service delivery in four geographic areas (North, Northwest, Artibonite and Centre Departments) and establish a funding channel for those services. The model is referred to as Communal Health Unit (UCS). It will improve the quality and increase the access of essential health services for approximately 2.0 million Haitians, and increase the total public and private resources devoted to basic health services. Inputs will be technical assistance, clinical and management training, and support for small-scale construction, rehabilitation and basic equipment. Support will also be allocated for recurrent costs for the provision of a cost-effective package of health services, disbursed under contracts and/or performance agreements,

and for health promotion and community participation activities.

2. Institutional Strengthening of the Departmental Directorates (Full Program: US$9.7 million; Phase I: US$3.9 million; Phase II: US$5.8 million) will strengthen the main functions of the Departmental Directorate of the Ministere de Santé Publique et de la Population (MSPP) that are required to support the delivery of essential services under the reorganized delivery and financing model. These functions are planning, management of human, financial and material resources, quality assurance, supervision, logistics and development of health and management information systems. Financing under this component will be used for technical assistance, training, small-scale rehabilitation of offices in the four departments, and the provision of furniture and equipment, including communication equipment.

3. Institutional Strengthening of the Central Directorates (Full Program: US$4.5 million; Phase I: US$2.5 million; Phase II: US$2.0 million) will strengthen the main functions of the Central Directorates in key areas necessary for the national implementation of the new model of delivery and financing. These include policy making, planning, management of human, financial and material resources (including donor coordination), training, operational research, quality assurance, supervision, health communication, financing and regulatory systems, and development of health and management information systems. The component will support technical assistance, training, as well as targeted financing for material, furniture and equipment (including communications equipment) for central offices.

4. Viability and Permanence of the Reorganized System (Full Program: US$4.2 million; Phase I: US$1.3 million; Phase II: US$2.9 million) has the objective of contributing to the financial sustainability of the health system. It will support the use, maintenance and updating of the existing analytic base and generation of new information on which to base a plan for sustainable financing of the health system. It supports the development and implementation of a consolidated financial management system, which will allow for accounting of all sources of health financing. It will also assist in the

identification and implementation of social solidarity efforts, and will finance the establishment and evaluation of pilot revenue generation activities.

5. Evaluation and Administration (Full Program: US$5.4 million; Phase I: US$1.4 million; Phase II: US$4.0 million) will finance activities associated with progressive design of the program, including both process and impact evaluations.

RELATIONSHIP OF PROJECT TO BANK'S COUNTRY AND SECTOR STRATEGY: Support to the health sector, and support to the Government's efforts at decentralization, are priorities within the Bank's strategy for Haiti. In addition, this program moves forward the Bank's agenda in health reform by promoting public-private partnerships and by introducing the mechanism of performance agreements to induce greater efficiency in health service delivery.

ENVIRONMENTAL/ SOCIAL REVIEW: Training of health workers in environmental management for health facilities is foreseen under the program. The small-scale civil works are not expected to have negative environmental impact.

BENEFITS: The health benefits of the program include the prevention of an estimated 12,000 deaths over the full course of the program, assuming moderate reductions in morbidity and mortality associated with expansion and improvement of health services. (Given the structure of the program, somewhat less than half of those health benefits are likely to be realized during the first phase, and more than half during the second phase.) The majority of the beneficiaries are children and reproductive-age women. The economic benefits include greater efficiency in the allocation of the MSPP budget; and more equitable distribution of public spending.

RISKS: Several risks influence the likelihood of successful implementation and sustainability of program benefits. (i) If community participation mechanisms are inadequate, UCS Plans may not successfully identify and respond to local health needs. (ii) Without careful oversight and attention to benchmarks, urgent needs may divert resources from investments that will bring about structural change. (iii) In the face of political swings, the Government may change its policy regarding private-public partnerships in the health sector. (iv) Future economic crises may reduce availability of resources to sustain all the benefits of the program.

It is important to note that very long delays in ratification of the contract in the Parliament may undermine the project's success, as well. Though measures are being taken to maintain the considerable momentum generated by project preparation activities, long delays in project start-up may have a negative impact.

SPECIAL CONTRACTUAL CLAUSES:

Prior to the first disbursement, the Borrower will present evidence to the Bank that: (i) it has created a coordination unit ("cellule de coordination") the Directorate of Planning and External Cooperation (DPCE) for the execution of the project and provided it with the staff requiered for the execution of the project. (Par. 3.10)

(ii) it has delegated authority to the Departmental Directorates in the departments of North, Northwest, Artibonite and Centre to contract services with "Communal Health Units". (Par. 3.22-3.23)

(iii) it has made the necessary provisions for a line-item in the MSPP budget for non-personnel recurrent costs of UCS. (Par. 3.24)

(iv) it has finalized the Operational Manual of the program, which consists of the operational regulations. (Par. 3.13)

(v) the administrative and/or legal instruments to permit the creation of the local health councils exist, to allow for management of funds at the local level. (Par. 3.24)

POVERTY TARGETING AND SOCIAL SECTOR CLASSIFICATION:

The proposed program qualifies as a poverty-targeted investment as set forth in the Eighth Replenishment document (GN-1964-3). The program supports the delivery of basic health services in rural areas, and will thus disproportionately benefit the poor, and particularly reproductive-age women and children. (Par. 4.4)

EXCEPTIONS TO BANK POLICY:

None

PROCUREMENT:

The limit above which international public bidding for the procurement of goods will be done is US$350,000. Small-scale rehabilitation works are anticipated. (Par. 3.16)

I. HEALTH SECTOR BACKGROUND

A. Introduction

1.1 Profound, pervasive and persistent poverty makes the Haitian people vulnerable to preventable disease and premature death. At the same time, unstable political conditions, an overcentralized and financially unsustainable health system, and weak administrative capabilities constrain the Government's ability to finance and deliver public health services, and thus to improve the quality, length and productivity of life in Haiti. In the face of these problems, however, both private and public initiatives have had some success in generating resources for improvement of health services, and the Government has taken the first tentative steps toward establishing leadership in the sector.

1.2 The program described in this document seeks to build on these initiatives--assist in the definition and articulation of public and private efforts, strengthen weak but vital institutions, and set the stage for long-term sustainability of the health sector. In doing so, it directly benefits a significant share of the Haitian population most in need of health services, and indirectly aids the next generation through a sounder system of health service financing and provision.

1. National Context

1.3 With an unemployment rate of 60 percent and a real per capita income of around US$230, Haiti is by far the poorest country in the Western Hemisphere. It is estimated that two-thirds of the Haitian population lives in poverty, with 80 percent of the rural population below the poverty line.

1.4 Political and social instability, manifested during the 1991 *coup d'etat* and in uprisings since that time, have exacerbated the effects of poverty. Since the return of constitutional government in late 1994, the Government of Haiti and the international community have made significant efforts to respond to urgent needs, create a context for peaceful civic participation, and rebuild the economy. Despite some progress, however, the country is characterized by weak institutions, macroeconomic imbalances, political instability deteriorated infrastructure, depleted productive assets and intractable poverty.

1.5 Demographic pressures compound the economic and political constraints. Approximately 42 percent of the Haitian population is younger than 15 years, and the population growth rate is estimated at 2 percent per year (net of outmigration, currently estimated at 0.5 percent annually). Given population momentum and slow declines in fertility rates, the population will continue to grow rapidly into the foreseeable future, placing additional pressures on the country's fragile social infrastructure, and economic and environmental resources.

B. The Health Sector

1.6 Health conditions reflect Haiti's poverty. As shown in Table 1, basic indicators are highly unfavorable relative to other countries in Latin America and the Caribbean, and are more similar to low income countries in other parts of the world. They show a pattern consistent with high prevalence of communicable and other preventable diseases.

Table 1. Basic Health Indicators by Residence

Indicator	Rural	Metro	Total	LAC Ave
Life Expectancy at Birth (years)	N/A	N/A	57	70
Infant Mortality Rate (per 1,000 live births)	89	85	87	44
Child Mortality Rate (ages 1-4, per 1,000)	61	50	59	60
Maternal Mortality Rate (per 100,000 live births)	N/A	N/A	460	167
Total Fertility Rate (per woman, 15-49 years)	5.9	3.0	4.8	2.6
Malnutrition (% of children under 5)	35	20	31	N/A

1. Summary of Major Constraints

1.7 As evidenced by poor health indicators, the Haitian health system has had limited success in combating the spread of major infectious diseases--the main causes of death--or in providing treatment for acute ailments. Severe underfunding in the public sector and recent economic and political crises have clearly contributed to the difficulties. However, given the long-term structural constraints, more than additional funds and political stability are needed to improve quality of and access to health services. The interconnected structural constraints are summarized below, and analyzed in more detail in subsequent paragraphs:

(a) Lack of systematic integration of private providers in sector planning, coordination and implementation

1.8 Non-governmental organizations (NGOs) historically have played a significant role in the provision of health services, particularly in rural areas. 1/ That influence has increased in the last decade. However, NGO activities have largely taken place outside of the sectoral planning process; the Government's efforts to work with NGOs have been insufficient to take best advantage of their

1/ In this context, NGOs are defined as private agencies, usually operating on a not-for-profit basis, affiliated with community organizations, religious entities, or international charitable and/or aid organizations, such as CARE, Save the Children and others.

presence. In addition, the Government has not been in a position to fulfill its regulatory role, and to ensure that private services meet minimum quality standards.

(b) Inefficient allocation of resources within the public sector, due to lack of clarity regarding public sector roles

1.9 In addition to being responsible for policy making, planning, regulatory and related functions, the Central Ministry of Public Health and Population (MSPP) also finances and manages a wide range of health facilities across the country. Partially as a result of adopting a broad mandate, the MSPP is unable to perform any of its functions well. It is unable to efficiently direct its resources toward cost-effective health services that are either public goods or that confer high positive externalities. In the absence of user fees and/or insurance mechanisms, resources are now pulled strongly toward high-cost (hospital) services in urban areas. These tend to benefit higher income populations and have little positive impact on the country's health conditions. Overcentralized management and inflexible staffing further reduce the ability of the Government to deliver services in a cost-effective manner.

(c) Lack of sustainable financing mechanisms

1.10 The health system in Haiti is precariously dependent on external sources. With close to half of the public health budget--and even more of the private resources--coming from external aid, Haiti is vulnerable to geopolitical influences, and subject to high levels of funding insecurity and limited ability to plan. Inappropriate incentives often associated with external funding are manifested in wasteful use of funds, and excessive attention to construction and rehabilitation rather than to sound management, quality control and maintenance.

2. The Supply of Health Services

1.11 The Haitian health sector can be characterized as pluralistic, with services being provided and financed both publicly and privately in a variety of arrangements. These arrangements--generated more by political, economic and social upheaval than by systematic planning--include publicly-financed services, privately-financed services, and mixed services that are partially supported by the public sector (often in the form of secondment of staff).

1.12 The MSPP operates about one-third of the estimated 650 health facilities in the country, 2/ as well as the distribution network for essential drugs. It is responsible for policy making,

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2/ Public funds are disproportionately allocated to the more costly types of facilities. The MSPP operates about 40 percent of the hospitals, 50 percent of the health centers with beds, and 25 percent of the health centers without beds.

norm-setting, overall supervision of the sector, and coordination of external aid. In addition to Central Directorates responsible for functions such as financial control, management of health services, planning, and others, the MSPP operates Directorates at the Departmental level. The Departmental Directorates--typically staffed with only a few people--are responsible for local-level supervision of health services, as well as for epidemiologic surveillance.

1.13 Fulfilling a broad mandate has proven to be a formidable challenge to the MSPP. Limited revenue sources, centralized command, and administrative and technical constraints that are shared with many public health ministries have hampered the MSPP's ability to respond to the full range of public health needs (see Table 2).

Table 2. Characteristics of the MSPP

Agents/Elements	Current Characteristics of the Public Sector
Finance	
Sources	General Revenue (national), External Aid
Allocation Mechanisms	Installed Capacity
Providers	
Decision-making Unit	Hierarchical Administration
Ownership	Central Government
Labor Regime	Civil Service
Complementary Inputs	Central Purchasing
Ensuring Quality	Structured Control
Consumers	
Role of Consumers	Excluded

1.14 In addition, the Ministry has been profoundly affected by recent economic and political crises. In the 1980s, political instability caused large numbers of experienced technicians and administrators to leave public administration. Severe economic constraints resulted in underfunding of vital inputs, while at the same time demand for health services increased. The public sector has only begun in the past three years to reestablish functioning dispensaries, health centers and hospitals. Critical functions such as policy making and regulatory oversight continue to be significantly compromised by lack of resources and clear direction.

1.15 While the public sector has weakened under a growing burden and shrinking or stagnant resource base, private sector entities--primarily NGOs--have expanded their role in service delivery. Currently, about 40 percent of health facilities are privately operated and financed--30 percent by NGOs and 10 percent by for-

profit entities. Another 30 percent are privately operated and receive some portion of their resources from the public sector.

1.16 While the NGO sector, and particularly religious affiliates, have always had a place in the Haitian health sector, many of the NGO facilities now providing services were established only during the past few years, as a response to the deterioration in the public system. The proliferation of NGO health providers has been facilitated by their integration into a variety of community organizing activities, the return of a cadre of trained Haitian health professionals from overseas, and the eagerness of external donors to support humanitarian aid through NGOs when the Government was in crisis. NGO facilities tend to be concentrated in rural areas, and at the lower levels of the service delivery pyramid.

1.17 As might be expected, the NGO sector in Haiti is extraordinarily diverse. According to a recent study, in a sample of 24 NGOs active in health and population activities, the organizations ranged in size from 8 to 402 employees. While their human resources varied, most had professional staff with relatively high levels of training. Funding sources ranged from international charities to international bilateral aid agencies to local charities with religious affiliations (World Bank NGO study, background for 1997 *Poverty Assessment*).

1.18 Despite the activities of both NGOs and the public sector, access to services is low. Only about 60 percent of the population is said to have access to *any* primary health services, compared with an average of 74 percent for Latin American countries. A small minority of the population has access to a reasonable range of preventive and curative services. In the rural areas, access to health facilities is the most limited. For example, an estimated 45 percent of rural households are at least 15 kilometers from the nearest hospital; about 26 percent are at least 15 kilometers from the nearest health center. Some 71 percent of rural households report that it takes more than one hour to travel to the nearest hospital, and about 59 percent say that it takes more than one hour to travel to the nearest health center (EMMUS, 1996). Lack of qualified personnel, drug shortages and disrepair of facilities limits the availability of services even more.

3. <u>The Demand for Health Services</u>

1.19 While information on utilization is dated, it is likely that the situation has not changed dramatically and perhaps even worsened. According to the 1986 World Bank *Public Expenditure Review*, occupancy was typically below 50 percent in public inpatient facilities. Low utilization rates are related to shortages of supplies, equipment and staff, in addition to the high opportunity cost of travel in rural areas.

1.20 There is considerable evidence that demand for (and thus utilization of) private services exceeds that for public services.

In 1978, for example, the average number of patient contacts in a public dispensary was found to be 9 per day, in comparison with 26 in private dispensaries. Overall, it is now estimated that at least half of the health services in Haiti are delivered through private--and predominantly NGO--facilities. This figure is estimated to be as high as 70 percent in rural areas.

4. Financing of Health Services 3/

1.21 Historically, per capita health expenditures in Haiti have been relatively high in comparison to countries at similar income levels. In 1986, the World Bank estimated that total annual public and private health expenditures (recurrent and investment) during the 1980s was about US$16-23 per capita, with individuals accounting for about 40 percent of health spending, private voluntary organizations providing roughly 20 percent of sector spending, and the remaining 40 percent coming from the public sector (of which half was externally financed).

1.22 The recent political and economic crisis severely compromised financing of the health sector. High levels of inflation and lower than expected revenue levels led to a dramatic drop in overall public spending, with public health expenditures dipping by 1993-94 to only 56 percent of the 1989-90 levels in real terms. When taking into account demographic pressures, there was a 50 percent plunge in per capita public health expenditures.

1.23 Part of the recent decline in public expenditures was offset by a rise in private expenditures. According to one study, NGOs have been able to mobilize close to US$40 million annually, approximately three-quarters of that from external assistance.

1.24 Despite private spending and external aid, Haiti now suffers from very low funding levels in the health sector. Currently, total public and private health spending is estimated at about 3 billion gourdes, or US$27 per capita. This compares unfavorably with the Latin America and Caribbean average of about US$202 per capita annual spending on health. This level of spending represents 7-10 percent of per capita income.

1.25 Strictly speaking, the Government currently is responsible for only a small share of total spending in the health sector. About 15 percent of total spending is Government expenditures from tax revenues. This level of public spending--about $4 per capita--is comparable to that seen in South Asia and sub-Saharan Africa. Another 28 percent is external aid, which is channeled through both

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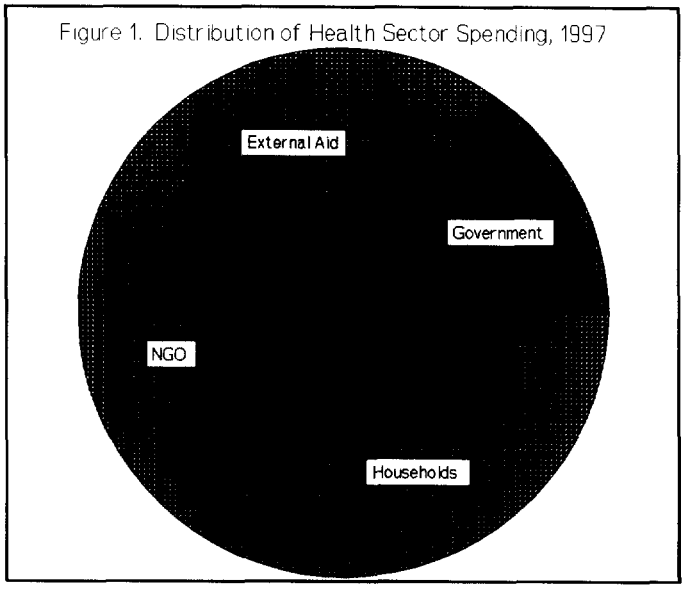
3/ All information on public and private health spending in Haiti should be interpreted carefully, given the severe data limitations and variations from one data source to another. In particular, estimates of private out-of-pocket spending are based as much on educated guesses as on empirical data. However, the general picture of a sector in which the vast majority of funds are from external and private sources is consistent across all sources of information.

the public sector and NGOs. The remainder--57 percent--represents private spending by households and NGOs out of their own resources (see Figure 1).

1.26 While spending is low in the sector as whole, it is particularly low for health services reaching rural households. Using the distribution of hospital beds as a proxy measure for resource allocation, it is reasonable to estimate that less than US$6 worth of public or private services annually reaches a Haitian citizen living in a rural area, including all administrative and other overhead expenses. At this level of spending, even under the most efficient conditions it is extremely difficult for either the Government or private providers to deliver a minimum package of care designed to address priority health problems. 4/



1.27 Given the inefficiencies inherent to the current system--the lack of complementarity among personnel and other inputs, and the poor match between service mix and health needs--the impact of the available funds is reduced even further. Despite shortages of human resources in some key areas, personnel costs crowd out complementary inputs. It is estimated that up to 90 percent of the health budget is allocated to personnel, with little remaining for urgently needed drugs, supplies and maintenance. In addition, scarce public resources are disproportionately allocated to health services that are unlikely to have a significant positive impact on the overall health status of the Haitian population.

4/ Estimates of the cost of a basic package of essential services vary quite markedly. PAHO estimates the annual cost of a minimum package of health services, exclusive of administrative costs, at US$5.30 per capita in Haiti. The World Bank, taking into consideration administrative costs and limited rehabilitation of infrastructure, estimates the cost at US$13.50 per capita (Turbat and Pierre-Louis 1996). A background study commissioned for the preparation of this project estimated that a package of primary care interventions would cost US$11.45 per capita. A more modest--yet effective and more financially feasible--package of services would cost between $4.50 and $7.00 per capita (Consortium Santé Canado-Haitien, Vol II, 1997).

5. Current Policy Context

1.28 Recognizing many of the problems identified above, the MSPP has defined the principles of its health policy for the years to come:

a) decentralization of decision making and execution toward the Departmental and local level; 5/

b) restructuring of the health system around local health systems called Unité Communale de Santé, or UCS 6/ (see Box 1); and

c) guaranteed access to a minimum package of basic services, including maternal and child care, other reproductive health care, care of sick children, care of medical and surgical emergencies, communicable disease control, provision of essential drugs, participatory health education, and basic dental care.

1.29 Together with significant reinforcement of the primary roles of the public sector, it is expected that implementation of these policies will diversify and stabilize the financing base, increase the autonomy, efficiency and responsiveness of service providers, and increase consumer voice in the health sector.

1.30 While only the first steps toward implementation have been taken so far, the health policy is widely accepted by Haitian policy makers. 7/ As such, it serves as a sound basis for the development of the current operation.

C. The Bank's Strategy and Lessons

1. Bank Strategy

1.31 The Haiti Country Paper clearly articulates the Bank's emphasis on investment in human capital: "The allocation of Fund for Special Operations resources will emphasize initiatives to improve living conditions, health and nutrition, and education and technical training to improve labor skills. This will require a leadership role by the Bank in working with the authorities to define and implement a comprehensive social sector agenda" (Haiti Country Paper, November 1996, page 28).

5/ The term "decentralization" is used liberally in Ministry documents to refer to a system in which MSPP control and financial authority is gradually deconcentrated to Departmental Directorates in the country's 10 geographic entities (9 departments plus the metropolitan area of Port-au-Prince). In addition, responsibility for the provision of health services is seen as being delegated to the UCS level.

6/ The name "Communal Health Unit" implies neither a specific type of physical structure nor the availability of all levels of health care within each commune. Rather, it refers to a network of basic and secondary service providers which may cover the populations of one or more communes.

7/ Bank resources, under the Technical Cooperation ATN/SF-3404-HA, have been used to initiate implementation. The first steps have included a UCS Consensus Workshop, in which the preliminary "rules of the game" were proposed, discussed and amended; identification of all UCS partner institutions; data collection on utilization and financing of public and private health providers throughout the country; elaboration of the costs of the basic package; and analysis and discussion of financing issues related to the adoption of the UCS model.

Box 1. What is a UCS?

An Unité Communale de Santé, or UCS, is defined in geographic, population, institutional and financial terms. A UCS is a network of public and private health care institutions that has the formal responsibility of providing essential health services to the entire population within a geographically-delimited area. The geographic boundaries are established so that the population covered is approximately 100,000 people, or 20,000 households. The network functions as follows:

- A local health council, which includes representatives of both the community and the partner institutions in the UCS, is established for the local-level management of the network. In the event that the council does not yet have the capacity for planning and financial management, an interim working group may be established and one institution--typically a charitable organization--may be identified as the lead agency. This institution will be the one with the greatest number of facilities, as well as the greatest capacity for financial management. The health council or lead agency must have legal personality, and be able to enter into binding contracts with public and/or private entities. The institutions providing health services within the UCS geographic area and meeting pre-established criteria for service delivery and financing management capacity are identified as partner institutions. (New partner institutions will be added if they meet the criteria.)

- Health services are planned based on the UCS. If, for a given UCS, there are more dispensaries, health centers and hospitals than needed to provide access to the population, public facilities can be phased out. Similarly, if there are too few dispensaries, health centers and hospitals, either NGO/private or public facilities can be created in the area.

- There is a referral relationship among facilities (dispensaries, health centers and one hospital). That is, all basic level facilities in the UCS refer patients with special needs to the one UCS hospital.

- The managers of all partner institutions in the UCS agree to provide services within the established minimum package of services (PMS), following the protocols and other service delivery norms prepared by the MSPP. The minimum package would include services in the following areas: maternal, child and reproductive health care, communicable disease control, emergency services, provision of essential drugs, health education, and basic dental care.

- The managers of all partner institutions in the UCS agree to use a common management and health information system, based on the technical requirements of the MSPP.

- Through the local health council managers of all UCS partner institutions (public and private), along with community representatives, prepare a UCS Plan, which is updated on an annual basis. Each UCS Plan will include information about the population to be covered, the services to be provided, institutional capabilities of the UCS partner institutions, the management technical assistance and training support required, the rehabilitation and basic equipment needed by each of the partner institutions, community participation efforts, and proposal for resource generation.

1.32 The Bank's strategy is to assist the Government with the clarification and subsequent implementation of major features of its health policy, which will ultimately lead to a more efficient, sustainable, responsive and effective health system. The Bank's strategic elements include:

a) Improve quality of and access to basic health services by establishing and strengthening public-private partnerships for service delivery, building on existing resources.

b) Support quality service delivery by increasing the capacity of the Departmental Directorates to create and supervise Department-wide plans, based on the UCS model.

c) Increase efficiency and equity in the use of domestic and external resources by increasing the capacity of the MSPP to

fulfill fundamental aid coordination, policy making, regulatory, normative, budgetary and administrative functions.

d) Initiate long-term process toward financial sustainability by building an analytic base, and developing financially sustainable model(s) of service delivery.

2. Donor Experience

1.33 In 1989 the Bank provided funding through a non-reimbursable technical cooperation for the preparation of prefeasibility and feasibility studies for a regionalization of health services. The prefeasibility study began in 1991 and was interrupted due to the political crisis; ultimately, it was deemed unacceptable by the MSPP. In 1995, the technical cooperation was reactivated, and the Government and the IDB agreed to use the remaining funds to support the preparation and implementation of the recently developed policy through short-term, targeted studies. The feasibility study, therefore, was replaced with a series of short-term studies designed to provide information for the preparation of the investment program described in this document.

1.34 Since 1995, execution of the technical cooperation has been a positive experience. The MSPP selected a suitable team, which has quickly mastered IDB regulations and guidelines. Using short-list procedures, the team has selected and contracted with several consulting teams to conduct studies, and followed through with all commitments made to date.

1.35 Other donors, including the World Bank, USAID, the Pan American Health Organization, and the European Union (EU), have a longer tradition of working in the health sector. The main lessons that can be drawn from most donor experiences are: (i) address structural constraints impeding the delivery of quality health services in general, rather than focusing exclusively on vertical disease control programs; (ii) overcome obstacles to implementation caused by lack of technical and managerial capacity within the MSPP; and (iii) avoid the tensions that arise when executing units outside of the Ministry take on parallel technical functions.

1.36 Currently, all major donors are supporting development of the UCS model and, with it, deconcentration of central Government authority to the Departmental Directorates. To this end, for example, IDB and USAID collaborated with the MSPP in conducting a consensus workshop on the implementation of the UCS strategy; IDB and the World Bank joined together to design studies of UCS financing; and the IDB and MSPP organized a workshop on UCS financing. In addition, major donors are seeking consistency and coherence in policy prescriptions. IDB, the World Bank, USAID and the European Union collaborated in the preparation of a public expenditures review that generated recommendations for reallocation of public spending. Importantly, the European Union has expressed interest in ensuring that the policy conditions on its budget support are consistent with those attached to the current IDB program.

II. THE PROGRAM

A. Objectives

1. Goal

2.1 The goal of the program is to support the Government's efforts to improve the health status of the Haitian population by enhancing the quality, efficiency and equity of health services provided by public and private institutions in the national health system. Over the long term, this program will contribute significantly to the development of an integrated and sustainable health care delivery system, in which both NGO and public providers are working efficiently and in a coordinated manner to maximize coverage and quality of basic health service delivery.

2. Objectives

2.2 Given the severity of the problems in the health sector, as well as the harsh economic realities of the country, only the initial steps toward achievement of the long-term goal will be realized within the context of the proposed program. The specific and more modest objectives of the program are: (i) to improve the quality of and access to both public and private health services in a way that is, over the long term, both financially and institutionally sustainable; 8/ (ii) to increase the efficiency of services at the national level; and (iii) to develop innovative models for financing and delivery of basic health services that are replicable at the national level..

B. Program Overview

2.3 As shown in Table 3, the program is designed to address a set of persistent problems that have limited the sector's ability to improve health conditions. Capitalizing on existing strengths and resources, including the active NGO sector and aid community, the program seeks to support establishment or strengthening of local health networks for delivery of cost-effective health services; strengthen support for these networks at the Departmental and central levels; create a funding channel for domestic and international financiers to contract for health services; and initiate movement toward a financially sustainable system that is responsive to consumers.

8/ Approximately 1 million beneficiaries will be covered during Phase I of the program; another 1.0 million will be covered during Phase II.

Table 3. Correspondence between Sector Problems, Project Strategies nd Project Components

Major Sector Problems/Symptoms	System Strengths and Resources	Project Objectives and Proposed Strategies	Project Components/Subcomponents
* High rates of preventable morbidity and mortality * Poor access to quality health services * Inequitable distribution of benefits of public spending	Active NGO sector, particularly in rural areas	Improve quality of and access to basic health services by establishing and strengthening public-private partnerships for service delivery, building on existing resources.	***Component I: Development of the UCS Model*** -Extension of Basic Care -Management, Rehab and HMIS -Community Participation
* Lack of coordination of public and private sectors	Active community participation at Departmental level	Support quality service delivery by increasing the capacity of the Departmental Directorates to create and supervise department-wide plans.	***Component II: Institutional Strengthening of Departmental Directorates*** -Management, Coordination and Supervision -HMIS
* Lack of effective targeting to populations and health conditions * Inefficient use of external aid * Lack of capacity for policymaking, normative and administrative functions	Active aid community Recognition of benefits of decentralization	Increase efficiency and equity of use of domestic resources by increasing the capacity of the Ministry of Public Health and Population to fulfill fundamental policymaking, normative, budgetary and administrative functions. Increase efficiency and equity of use of external resources by improving coordination and monitoring of aid.	***Component III: Institutional Strengthening of Central Directorates*** -HMIS -Management and Administration -National Health Commission
* Chronic underfunding of health services * Unresponsiveness of public services to demand	Increasing awareness of need for greater financial independence	Initiate long-term process toward financial sustainability by building analytic base, and developing financially sustainable model(s) of service delivery.	***Component IV: Viability and Permanence of the Reorganized System*** -Revenue Generation Demos -Analytic Base -Sustainable Financing Plan

2.4 The program will emphasize and allocate most of its resources to the reorganization, management and supervision of health services at the Departmental and local levels of the health system. 9/ This will reinforce the Government's policy of decentralization, and will target the program's resources to levels closest to the community. It ensures that the program will generate immediate benefits for poor households, as well as longer-term benefits for the system as a whole. The program will provide integrated technical assistance, training, material inputs and targeted recurrent cost support for the provision of a minimum package of services. In some cases, the program will strengthen networks that are already established and functioning (pre-UCS) with the provision of targeted managerial and clinical training and marginal improvements in the physical conditions. The greatest contribution of the program to these existing networks will be the creation of a channel for reliable financing for health services under performance contracts. In most cases, however, the program will assist with the creation of new networks, consisting of existing providers who currently operate with little interinstitutional

9/ Given the overwhelming needs in Haiti, this project has chosen to focus on basic, cost-effective services and on the support functions they require. Therefore, the program supports only those activities at the Departmental and Central levels that directly affect access to and quality of basic health services.

coordination. Fundamental institutional strengthening will be the first contribution of the program. After institutional capacities have been increased, partner institutions in the network will be eligible for financing under performance contracts.

C. Geographic Focus

2.5 The regional focus of the program--that is, where service delivery will be directly supported--will be the North, Northwest, Centre and Artibonite Departments. These areas were chosen because of their needs, lack of other large donor projects and potential to serve as models for the other departments. Together, the coverage of the program in these departments could reach approximately 2.0 million Haitians (or about 28 percent of the total). The majority of the beneficiaries would be poor women and children under 5 years, who currently experience the greatest health risks. Table 4 presents salient features of the departments.

Table 4. Features of the Health Sector in Four Departments

Department	Population ('000s)	Hospitals	Health Centers	Disp.	UCS	MSPP Budget (1996-97) (million Gourdes)
North	727.6	1	20	30	9	45,653
Northwest	399.5	1	11	46	6	15,117
Centre	470.3	2	11	31	6	32,804
Artibonite	963.1	4	27	52	6	16,763
National	6,902.6	49	200	405	58	450,000

Notes: Information on population and health facilities from background study on decentralization, covering both public and private facilities. Number of UCSs from UCS Consensus Workshop, December 1996; MSPP has not officially agreed to list of UCSs, therefore these are provisional figures. MSPP budget data from background study on decentralization.

2.6 The program also will have national impact in several ways. First, it will support Central functions of the MSPP, thereby having positive effects on health service financing, management and delivery throughout the country. Second, the program will support preparation of a plan for long-term financial sustainability of the system. Third, the development, implementation, evaluation and adjustment of the service delivery model has important demonstration effects for all geographic areas.

D. Program Phases

2.7 The program, conceptualized as one six-year operation with a total estimated cost of US$50.0 million (Bank financing of $45.0 million), will be implemented in two three-year phases, each supported by a Bank loan of US$22.5 million. Approval of the second phase will be triggered by verification that 50 percent of the resources of Phase I have been committed and that satisfactory progress for the first 24-month period have been made. (See Chapter III ("Execution") for procedures proposed for Board approval of the second phase.)

E. Components

1. Development of the UCS Model (Amount: Full Program: US$26.2 million; 52.4 Percent of Total Cost; Phase I: US$14.7 million; Phase II: US$11.5 million)

2.8 This component will support the implementation of a local health network (UCS) model of health service delivery in four geographic areas and the establishment of a funding channel for those services. For each of the approximately 27 UCSs, support will be based on a comprehensive UCS Plan initially prepared by a working group ("groupe de pilotage") identified by the corresponding Departmental Directorates.

2.9 Investments under this component will lead to development of UCS Plans, establishment and functioning of UCS councils, strengthened institutional management capacity for improved quality and efficiency of service delivery, and provision of an essential package of health services to a large share of the Haitian population. During Phase I of the program, these activities will be tested in approximately 15 UCS health networks; by the end of the six year program, approximately 27 UCS networks will be functioning.

2.10 Through an integrated package of small-scale construction and rehabilitation, technical assistance, training and financing of recurrent costs for services through performance agreements, the component supports activities in three subcomponents:

(a) Extension of Basic Health Services

2.11 Support for the extension of basic health services has three dimensions: (i) it will allow more, better quality and more cost-effective basic health services to become accessible to poor households in rural areas; (ii) it will stimulate public and private providers to specialize in the provision of essential health services, consistent with the Government's health policy and with international standards; and (iii) it will create a financing mechanism through which the Government and donors can channel resources in a way that rewards efficient provision of good quality services. The first two dimensions are expected to confer immediate health benefits, while the third will contribute to the search for sustainable financing strategies over the long term.

2.12 In this subcomponent, a portion of the proceeds of the loan will be used to finance contracts and/or performance agreements that will subsidize delivery of a basic package of health services to a geographically-defined population. The agreements will be made between the MSPP and approximately 27 health service networks (UCSs) in four departments. The subsidy will range from US$3 to US$6 per capita, as determined through methods described in Chapter III, Section D.

(b) Management, Rehabilitation and Health Management Information Systems

2.13 This subcomponent provides packages of technical assistance, training, small-scale rehabilitation inputs, and equipment to support establishment and strengthening of approximately 27 UCSs and their partner institutions. Given the wide variation in local conditions and existing competencies at the UCS partner institutions, each UCS will be able to draw down program assistance based on its individual UCS Plan and on its management capacity. This will permit non-functioning UCSs to receive the assistance that they need to get started without overwhelming their absorptive capacity. This approach also will allow programs that are already functioning as "pre-UCSs" to quickly develop as development models for other UCS and to serve as sites for operational research. 10/

2.14 Investment program assistance will include technical assistance and training in planning and management, management information systems, financial systems, supplies and logistics and training, environmental control, personnel management and supervision, and continuing medical and nursing education. The provision of small-scale construction and rehabilitation of dispensaries and health centers, and basic equipment for those facilities will also be based on the approved UCS Plans. No infrastructure and equipment inputs will be provided prior to the initiation of technical assistance and/or training to support management strengthening. No significant support to hospital-level services is foreseen.

(c) Community Participation Initiative

2.15 Financing for technical assistance and local workshops will be provided to ensure systematic attention to obtaining community input for preparation of the UCS Plan, creation of local health council for oversight and eventual management of the UCS, and dissemination of information about the activities of the UCS and its partner institutions.

2. Institutional Strengthening of Departmental Directorates (Amount: Full Program: US$9.7 million; 19.4 Percent of Total Cost; Phase I: US$3.9 million; Phase II: US$5.8 million)

2.16 This component will strengthen the capacity of the MSPP Departmental Directorates to support basic service delivery in the four geographic areas under the program using the UCS model. The inputs financed by this component--technical assistance, training, small-scale rehabilitation of offices and basic office and

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10/ Due to the foundation established by other donors' investments, and planning activities financed under the IDB Technical Cooperation ATN/SF-3404-HA, several "pre-UCS," such as Maissade, St. Marc, Cap Haitian and Henche, are nearing completion of their development plans, and are able to assist other UCS that are not as far along.

communications equipment--will facilitate implementation of the Government's decentralization policy.

2.17 It is expected that the results of the investments under this component of the program will be improved supervision, coordination and planning capacity to ensure higher quality, and more accessible health services in four departments. Phase I investments will focus on the building up core capacities, primarily through the provision of technical assistance. Phase II investments will strengthen and expand the health and management information system, as well as the physical infrastructure of the departmental offices.

(a) Management, Coordination and Supervision

2.18 Based on an assessment of needs, this subcomponent provides technical assistance and training to the four Departmental Directorates in planning, management of human, financial and material resources, quality assurance, supervision and logistics. Each of these functions is required to support the new approach to service delivery and financing embodied in the UCS model.

2.19 This subcomponent also provides support for small-scale rehabilitation of the offices of Departmental Directorates to make them functional for the expanded and strengthened roles of the units under a decentralized health system.

(b) Health and Management Information System

2.20 This subcomponent provides technical assistance and equipment necessary for the establishment of a basic health and management information system (HMIS). The HMIS will allow the Departmental Directorates to receive and analyze information from the UCS level. This information system will be used for discussion, trouble shooting and feedback to the UCS management team, as well as reporting to the Central MSPP.

3. Institutional Strengthening of Central Directorates (Amount: Full Program: US$4.5 million; 9.0 Percent of Total Cost; Phase I: US$2.5 million; Phase II: US$2.0 million)

2.21 The objective of this component is to improve the capacity of the Central MSPP in the areas most critical to fulfilling its role in making policy, setting norms, preparing and enforcing regulations, and financing the delivery of services to poor populations using domestic and external resources. Primary inputs are technical assistance and training, with limited funds being set aside for equipment. It is expected that this component will yield improved capacity in key support areas, and improved coordination of external aid. Phase I investments will focus on strengthening the core capacities at the central level, primarily with the provision of technical assistance and limited equipment. Phase II investments will intensify efforts toward sectoral and donor coordination.

(a) Health and Management Information System

2.22 This subcomponent provides technical assistance and equipment necessary for the establishment of a basic health and management information system. The HMIS will allow the Central MSPP to receive and analyze information from Departmental Directorates. This information system will be used for discussion, troubleshooting and feedback to the Departmental management teams, as well as reporting to the Government and partner agencies on health sector operations.

(b) Management and Administration

2.23 Support will be provided for technical assistance and training in planning and management, operations research, quality assurance, training, supervision, health communication, financing and regulatory systems, and human resources management.

(c) National Health Commission and Aid Coordination

2.24 This subcomponent will provide support for the creation and operation of an intersectoral advisory body, which will serve as a forum for exchange of information, coordination across ministries, and representation of the views of private non-profit and for-profit actors in the health system. In addition, this subcomponent will provide support for several aid coordination workshops and follow-up, including dissemination of workshop results, one-on-one meetings with donor agencies, and targeted studies related to aid coordination.

4. Viability and Permanence of the Reorganized System (Amount: Full Program: US$4.2 million; 8.4 Percent of Total Cost; Phase I: US$1.3 million; Phase II: US$2.9 million)

2.25 This component supports the initial steps toward financial sustainability of the health system by using, maintaining and updating an analytic base, developing a consolidated accounting of sources of health finance, evaluating revenue generation experiments, and preparing a workable plan for health system financing. Inputs for this component include technical assistance, training and workshop support. It is expected that a limited number of revenue generation demonstration projects will be initiated during the first phase of the program, and some survey data collection will be conducted; however, most of the activities under this subcomponent will occur during the second program phase.

(a) Revenue Generation Demonstration Projects

2.26 This subcomponent provides technical assistance to UCSs and partner institutions for the design of strategies to raise revenues. These strategies may promote local revenue generation through the provision of health services (e.g., user charges, local health insurance systems, or other mechanisms), or through the provision

of non-health related goods and/or services (e.g., production and sale of handicrafts by NGOs to cross-subsidize health services). The approaches used will depend on local conditions, and will be proposed in the UCS Plan. Assistance will be provided by both the Executing Unit and external technical assistance for development and monitoring of resource generation pilots. In addition, this subcomponent will support the external evaluation of the various revenue generation experiments across UCSs, and provide an analysis of the lessons learned, such as estimates of the proportion of total costs that can reasonably be covered through user fees in rural areas.

(b) Analytic Base

2.27 This subcomponent finances the use of existing data and support for a set of studies related to public and private expenditures, and the costs of service delivery in public and private institutions. The studies would provide, for example, the technical information required for national health accounts and for the preparation of a "vulnerability index" that can be used to weight allocations from the central Government in a way that takes economic and gender equity into account. The studies will provide the analytic underpinning for a sustainable financing plan.

(c) Sustainable Financing Plan

2.28 This subcomponent supports the preparation of a plan for sustainable financing at a national level. Technical assistance and support for workshops will be provided to synthesize information from the two other subcomponents (Revenue Generation and Analytic Base), and to gather input from interested parties. Under this subcomponent, the MSPP will develop a detailed and comprehensive 10-year plan for phasing out of donor support, and phasing in increased domestic (public and private) funding through mechanisms that promote equity, efficiency and responsiveness to consumer choice.

5. Evaluation and Administration (Amount: Full Program: US$5.4 million; 10.8 Percent of Total Cost; Phase I: US$1.4 million; Phase II: US$4.0 million)

2.29 This component supports administrative costs of the program, as well as the considerable investment in evaluation of the process and impact of program activities. Included under this component are all consultancies and workshops required for the progressive design of the program (i.e., assessing progress and obstacles under Phase I, and preparing Phase II workplans).

F. Linkage Among Components

2.30 The components of the program are linked, although they are sufficiently independent so that slow progress in one area will not

significantly impede progress in others. The linkages can be summarized as follows:

(i) All support to the Departmental level in Component 2 is targeted at key functions that help to sustain quality and access improvements at the UCS level in Component 1.

(ii) All support to the Central level in Component 3 is targeted at key functions that help to sustain supervisory, planning and coordination improvements at the Departmental level in Component 2.

(iii) The sustainable financing plan (Subcomponent 4) builds on information generated through implementation of the UCS Plans (Subcomponent 1a).

(iv) The sustainable financing component (Component 4) generates information that will be disseminated and discussed by the National Health Commission (Subcomponent 3c).

(v) Community participation initiatives (Subcomponent 1c) will contribute to the success of revenue generation experiments (Subcomponent 4a), given the need for the providers of services to gain information about and respond to local demand, and to take advantage of local resources.

G. Program Costs and Financing

1. Program Costs

2.31 Total program costs are estimated to be US$50.0 million, of which US$45.0 million will be financed with Bank funds. The breakdown of costs for Phase I is summarized in Table 5. The cost estimates from non-infrastructure and equipment activities are drawn from action plans and corresponding levels of effort prepared for each of the program activities. Estimates of infrastructure and equipment costs are based on an analysis of needs prepared with input from the Departmental Directorates. The cost of financing service delivery is based on estimates of targeted populations in each region and the cost of services to be provided; estimates for these can be found in background documents produced during program preparation (Study on UCS Implementation; Background Study on Decentralization; Background Study of Departmental Investment Priorities). It is important to note that the estimated costs of services and other activities are subject to revision during the Phase I evaluation.

2. Financing Plan

2.32 US$45.0 million equivalent represents 90 percent of total program costs. Correspondingly, the Bank-financed portions of the Phase I and Phase II loans represent 90 percent of sub-program costs. The Government will finance US$5.0 million equivalent, or 10 percent of

total program costs, divided into the two phases. Given that this is considered a Poverty Targeted Investment, the matrix is 90/10. The total execution period for each phase will be 36 months, with a disbursement period of 40 months.

TABLE 5
PROGRAM COSTS AND FINANCING PLAN FOR PHASE I
(US$ thousands)

CATEGORIES	IDB	GOH	TOTAL	% OF TOTAL
Development of the UCS Model				
Subtotal	12439	2300	14739	59.0%
Consultancies	16		16	0.06%
Training	1277		1277	5.1%
Equipment	860		860	3.4%
Civil Works	3836		3836	15.3%
Recurrent Costs	6450	2300	8750	35.0%
Institutional Strengthening of the Departmental Directorates				
Subtotal	3929		3929	15.7%
Consultancies	1554		1554	6.2%
Training	762		762	3.0%
Equipment	1373		1373	5.4%
Civil Works	150		150	0.6%
Institutional Strengthening of the Central Directorates				
Subtotal	2486		2486	9.9%
Consultancies	1085		1085	4.3%
Training	837		837	3.5%
Equipment	414		414	1.7%
Civil Works	150		150	0.6%

CATEGORIES	IDB	GOH	TOTAL	% OF TOTAL
Viability and Permanence of the Reorganized System				
Subtotal	1349		1349	5.4%
Consultancies	705		705	2.8%
Training	280		280	1.1%
Equipment	4		4	0.02%
Civil Works	360		360	1.4%
Evaluation and Administration				
Subtotal	1447		1447	5.8%
Consultancies	1178		1178	4.7%
Training	21		21	0.1%
Equipment	198		198	0.8%
Civil Works	50		50	0.2%
Financial Costs				
Subtotal	850	200	1050	4.2%
Inspection Fees	250		250	1.0%
Interest	600		600	2.4%
Credit Commission		200	200	0.8%
GRAND TOTAL	22500	2500	25000	100.0%
SHARE OF TOTAL	90.0%	10.0%	100.0%	

III. EXECUTION

A. Design Principles

3.1 Several principles underlie the design of the program:

1. Incorporate learning and flexibility

3.2 The program is designed to allow for systematic evaluation and adjustment at key stages in implementation. By utilizing a "progressive design" in two phases, both the Bank and the Government are able to articulate clearly the program's objectives, scale and scope. At the same time, the parties are able to respond quickly to lessons from experience and to new needs as they emerge. For example, during the first two years of the program it is anticipated that a variety of UCS organizational structures will be tested; at an interim evaluation, positive and negative experiences will be reviewed, and the lessons inferred will inform later decisions about the organizational structures that will be supported.

2. Allocate resources on the basis of demand and absorption capacity

3.3 Each UCS (or Departmental or Central Directorate) will "draw down" program assistance based on individual action plans rather than on a central plan that "pushes down" activities and assistance. The merits of this approach are as follows: (i) It emphasizes decentralized planning and avoids over-centralization of program activities at the national level. This also helps create program ownership and a participatory approach at the peripheral level to drive the program. (ii) It allows existing "pre-UCSs" to access resources quickly and to serve as development models for other UCS. At the same time it permits non-functioning UCSs to receive the assistance to get started without overwhelming their absorptive capacity. 11/ (iii) It simplifies planning and budgeting for the Coordination Unit ("cellule de coordination", or CC). The CC plan/budget will anticipate the demand for each type of assistance, e.g., "rehabilitate 50 dispensaries during 1998," without having to specify the location of the 50 dispensaries ahead of time. (iv) It can create a positive competition between UCSs (or Directorates).

3. Anticipate and avoid bottlenecks

3.4 Implementation of several parts of the program will benefit from strategies that seek to eliminate potential bottlenecks to decision making. For example, in the implementation of Component 1 (UCS Model), UCS Plans are submitted to be approved by Departmental

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11/ A five-level ranking system has been prepared to classify UCSs according to their readiness and absorptive capacity. The system ranks the UCSs on the basis of functioning infrastructure, community organization, and coordination among partner institutions.

Directorates. This system is designed to reinforce the newly decentralized functions of the MSPP, but it has the potential to impede program implementation if turn-around time at the Departmental level is long. Therefore, the UCS Plan can be submitted directly to the program executing unit if the Departmental Director does not respond within 10 working days.

4. Plan for transfer of responsibilities as capacity grows

3.5 Current weaknesses of the MSPP imply that it is unlikely that a program of this size could be effectively executed in a timely manner without the establishment of a coordination unit. While the CC will not have a cadre of technical personnel, which would duplicate the work of the Ministry itself, it will have responsibility for the program's planning, administrative and evaluation functions. However, as program activities strengthen the capabilities at both Central and Departmental levels, some CC functions can be integrated into the daily work of the two Ministerial levels.

B. Organizational Structure for Program Implementation

3.6 The executing agency will be the MSPP, which will establish acoordination unit ("cellule de coordination") for the implementation of the program. Within the organizational structure of the MSPP, the CC will be under the Directorate of Planning and External Cooperation and, after approval of action plans, will be delegated the authority to coordinate program activities and approve disbursements to all other relevant units of the Ministry, including Central and Departmental Directorates, and participating UCS lead institutions.

1. Coordination Unit Mission and Functions

3.7 The mission of the CC will be to coordinate the realization of all program activities. The functions of the CC are to: (i) prepare plans of operation for each component of the program, in coordination with the relevant MSPP units (the plans of operations are summaries of the detailed workplans for each subcomponent); (ii) prepare all relevant documentation related to the satisfaction of contractual conditions; (iii) contract and supervise firms and individuals for provision of goods and services; (iv) participate with relevant units of the MSPP in the elaboration of terms of reference for training and technical assistance; (v) ensure compliance with the program schedule of activities; (vi) develop and maintain a technical and financial information system for program activities; (vii) disseminate information about the program; (viii) prepare requests to the Bank for disbursement, with the required supporting documentation; (ix) establish an accounting system that permits adequate control over the utilization of program resources (both Bank and counterpart funds); (x) prepare periodic technical and financial reports using standard formats; (xi) provide technical assistance to other units of the Ministry;

(xii) comply with contractual conditions established in the loan contract; and (xii) coordinate the conduct of periodic evaluations and phase design exercises.

2. Coordination Unit Structure and Composition

3.8 At the start of the program, the CC will be composed of five to eight professionals in the following specialty areas, as shown in Table 6. All members of the CC will be contracted to the unit for two-year periods. Contract renewals will be based on performance evaluations that are incorporated into periodic evaluations. The key positions that must be filled prior to first disbursement are: Coordinator (i), Technical Specialist(s) (1-3) (3), and Financial Specialist (1).

Table 6. Staffing of the Coordination Unit

Position	Responsibilities	Transfer of Responsibility by Phase II
Coordinator (1)	Oversee progress of all project activities and compliance of procedures with Bank requirements	
Technical Specialist(s) (1-3) UCSs and Depts. North, Northwest UCSs and Depts. Centre, Artibonite Central and sustainable financing	Prepare plans of operation for the activities under their domain; ensure timely implementation of activities; provide technical assistance to departments	These functions will be transferred to the corresponding MSPP Departmental Directorates and the Planning Directorate at the central level
Financial Specialists (2)	Provide financial and administrative support for all project activities, including maintenance of accounting records, processing disbursements, maintaining administrative records, contracts and the carrying out of related activities; review all contracts and make payments for activities approved by the technical coordinators	These functions will be transferred to the MSPP Financial Directorate
Administrator (1)	Provide support within the CC	
Information Specialist (1)	Establish and maintain one or more databases for the storage and manipulation of information about project activities, and about Ministry activities related to areas of project interest	These functions will be transferred to the MSPP Planning Directorate

3.9 During at least the first six months of the program, the CC will require external technical assistance, particularly in the areas of preparation of Plans of Operation, and creation of the information and accounting systems. In view of the importance of adequate dissemination of information about program activities, the consultants will also be required to organize workshops with relevant Ministry units.

3.10 *As a condition prior to first disbursement of the financing, the Borrower will present evidence to the Bank that it has created under the Directorate of Planning and External Cooperation (DPCE) a coordination unit ("cellule de coordination") for project execution and has staffed it with professionals meeting the qualifications outlined above.*

C. General Operational Guidelines

1. Workplans

3.11 All program activities will be conducted based on the preparation of workplans. Separate workplans will be used for each of the phases and for each of the subcomponents (i.e., there is a workplan for Phase I, Component 3). The technical inputs for these workplans are available in the background documents developed during program preparation.

2. Operational Regulations

3.12 All functions, activities, and procedures of the CC as well as for each of the components will follow Operational Regulations. The Operational Regulations will be elaborated to form the Operational Manual for the program, and may be revised as needed, subject to Bank approval.

3.13 *Prior to first disbursement, the Borrowerwill present the final version of the Operational Manual of the program, which consists of the operational regulations. The Operational Manual will describe all of the functions, activities and procedures of the coordination uni ("cellule de coordination"), as well as each of the program components.*

3. Recognition of Prior Expenditures

3.14 The Bank may reimburse the Borrower for eligible expenses incurred after loan approval and prior to loan effectiveness. All such expenditures will conform with accepted Bank procedures.

3.15 If as a result of the systematic reviews referred to in Section F or of other reviews in which the Bank participates, the Bank determines that counterpart resources for the Program have not been provided on a timely basis by the Government, the Government and the Bank shall withhold authorization of all new activities and of all new calls for bidding, price competitions, and any other form of contracting for the procurement of goods or services to be financed with resources of the loan, until the Government has taken adequate measures, to the Bank's satisfaction, to fulfill its counterpart obligations and to ensure that future counterpart resources for the program will be provided on a timely basis.

4. Procurement

3.16 Procurement of goods and services will be done according to Bank guidelines, as set forth in Annex B of the loan contract, and will be handled by the CC. Public international bidding will be required for the procurement of goods over US$350,000 and

construction contracts over US$1.0 million. 12/ In the operational annexes, guidelines and procedures pertaining to acquisitions under these amounts are presented. All contracting of consulting services will be done in accordance with Bank policies for the selection and contracting of consultants.

5. Procurement of Information Technology.

3.17 Prior to the acquisition of computer equipment for program support, the Borrower must present to the satisfaction of the Bank documentation on system design, that electrical and cabling requirements are completed, and that personnel required are available and trained in software applications to be utilized.

D. Phase I Execution of Components

1. Development of the UCS Model

3.18 At the start of the program, when it is not expected that the local health councils will yet be fully functional, the Departmental Directorates in the four departments of the program will identify members of a working group for each UCS. Working group members will include representatives from the commune (commune doctor or local authorities), the community, selected health facilities, and NGOs working within the UCS geographic area. The working groups will prepare UCS Plans, following a standard format. Each UCS Plan will include information about the population to be covered, services to be provided, institutional capabilities of the UCS partner institutions, management technical assistance and training support required, rehabilitation and basic equipment needed by each of the partner institutions, community participation efforts and proposed resource generation experiments. (The contents and format for a UCS Plan are available in the technical files.) In addition, the UCS Plan will identify the lead UCS institution and provide detailed information about its financial management capabilities. (This institution ultimately will be responsible for managing the funds providing under Subcomponent 1 in cases where the local health council does not have sufficient management capacity.) At the discretion of the CC, technical assistance may be contracted to assist the with the preparation of UCS Plans.

3.19 Each working group will submit its UCS Plan to the corresponding Departmental Directorate, which will review and approve the plan (or return it to the working group for revisions). The Departmental Directorate will pass the approved plan to the appropriate Technical Specialist at the CC.

3.20 The UCS Plan, once submitted to and approved by the Departmental Directorate, provides the basic information for resource

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12/ It is not anticipated that any contracts of this magnitude will be financed under the project.

allocation. It indicates the types of services provided by each partner institution, as well as the level of utilization. Based on utilization information, estimates are made of the population served, and a total subsidy is estimated for the UCS. For example, the total subsidy could be the sum of US$3 x number of individuals for public facilities and US$6 x number of individuals for private facilities. 13/

3.21 A performance contract or agreement is made between the UCS lead agency and the MSPP Departmental Directorate. The contract or agreement, in effect for a one-year period, establishes the set of services to be provided, the total population to be covered, the total amount of funds to be transferred, financial management standards to be met, monitoring and evaluation criteria, and penalties for non-compliance and/or malfeasance. Upon signature by both parties, the specified funds are transferred by check from the CC to the UCS lead agency or in cases where it has sufficient management capacity, the local health council. The lead agency or local health council is then responsible for forming subagreements and/or subcontracts with the partner institutions for the delivery of services. (Note that according to a legal opinion these subagreements and/or subcontracts are outside the scope of the program and need not be approved by the Bank or the MSPP, or follow a standard format.)

3.22 To execute this subcomponent, the CC will assist the Departmental Directorate or take responsibility for: (i) preparation of contracts and/or agreements with the UCS for the delivery of health services; (ii) contracting for technical assistance and training services; (iii) contracting for rehabilitation (the small works will not be scheduled to begin until after the initiation of technical assistance to the UCS); (iv) procuring equipment; (v) entering all monitoring and evaluation information presented in the UCS Plan into the program database; (vi) disbursing an advance payment for health services to the lead UCS institution, which will manage the funds. All civil works must conform to the technical and economic criteria established in the Operational Regulations.

3.23 *Prior to first disbursement, the Borrower will present evidence to the Bank that it has delegated authority to the Departmental Directorates in the departments of North, Northwest, Artibonite and Centre to contract for services with "Communal Health Units". The UCS is the fundamental element of the decentralized national health system, and must meet criteria established in the Operational Regulations.*

13/ At the inception of the project, the subsidy rate will vary between US$3 and US$6, to be calculated based on the following factors: share of personnel paid by the public sector (ranging from 0-100, with a higher subsidy given for UCS that have a smaller proportion of public sector personnel); and types of services provided (full or partial package of services). Later in the project, the subsidy rates will be weighted with a "vulnerability index" to achieve economic and gender equity objectives; they will also be changed to reflect increases in community and household contributions through user fees and other mechanisms.

3.24 *Prior to first disbursement, the Borrower will present evidence to the Bank that it has made the necessary provisions for a line-item in the MSPP budget for non-personnel recurrent costs of UCS.*

2. Institutional Strengthening of Departmental Directorates

3.25 During the first 12 months of the program, each of the Departmental Directorates will develop a Plan for Departmental-level strengthening, based on a standard format. Technical assistance will be provided by the CC and/or individual consultants to support development of the Plan. Based on technical information included in the background study on decentralization, the Plan will include information about the geographic boundaries, and environmental and health conditions within the Department, the overall Departmental strategy, the management technical assistance and training support required, the rehabilitation and basic equipment needed, plans for creation of a health council in each of the UCS, and a list of all partner institutions in each of the UCS. In addition, the Departmental Plan will provide detailed information about the Directorate's financial management capabilities. It is anticipated that all four Departmental plans will be developed during the first six months of the program.

3.26 The Departmental Plans will be submitted to the CC and reviewed by the DPCE for approval by the Director General. Once a Department's Plan is approved, the CC will: (i) prepare requisitions for technical assistance and training services; (ii) prepare requisitions for rehabilitation (the rehabilitation will not be scheduled to begin until after the initiation of technical assistance to the Departmental Directorate); (iii) procure equipment; (iv) enter all monitoring and evaluation information presented in the UCS plan into the program database. All civil works must conform to the technical and economic criteria established in the Operational Regulations.

3. Institutional Strengthening of Central Directorates

3.27 During the first 12 months of the program, workplans will be developed in each of the following areas: governance, planning, financial management, information systems, human resource management, regulation, and quality assurance. The workplans will be prepared by working groups comprised of designated individuals from the relevant central directorates (e.g., for planning, the Planning Directorate; for financial management, the Financial Directorate). Technical assistance for development of the workplans will be provided by the CC and, and the CC's discretion, external consultants. Based on the analytic work developed during program preparation (see Institutional Evaluation of MSPP, and Training Needs Study), the workplans will include information about the Directorates' role under a decentralized system, a timetable and budget for activities, the management technical assistance and training support required, and basic equipment needed. It is

anticipated that workplans for all of the relevant areas listed above will be developed during the first 6 months of the program.

3.28 The workplans will be discussed with the CC and submitted jointly by the CC and the Directorate to the General Director approval. Once a workplan is approved, the CC will assist the Central Directorates or take responsibility for: (i) preparing requisitions for technical assistance and training services; (ii) procuring equipment; and (iii) entering all monitoring and evaluation information presented in the UCS plan into the program database.

4. Viability and Permanence of the Reorganized System

3.29 Two types of activities will occur under this subcomponent: (i) Technical assistance will be contracted by the CC to design and execute studies to build the analytic base for sustainable financing. These include a household demand study, a private sector cost study, a public sector cost study and a national health accounts study. Study results will be disseminated through workshops; and (ii) Based on approved UCS Plans, funds will be disbursed to UCS lead institutions to conduct and evaluate revenue generation experiments.

5. Evaluation and Administration

3.30 In addition to routine administration of the program, the CC will contract consultants to conduct evaluation of Phase I and design of Phase II activities and disbursement targets.

E. Supervision and Evaluations

1. External Audit

3.31 The Borrower, through the Executing Agency, will present annually the workplans and the financial statement of the program certified through formal external audits acceptable to the Bank.

2. Annual Reports

3.32 During the execution of the program, the CC will present progress reports on both physical and financial achievements, which will include: status of fulfillment of contractual obligations; progress on each workplan with impact indicators for all subcomponents; and indicators of progress as shown in the Logical Framework (see Annex 1). These reports should also include statements on activities programmed for the subsequent review period, with terms of reference for studies and consultants.

3. Program Supervision

3.33 The Country Office will be responsible for the supervision of program execution. The Bank will carry out a series of missions to review the general advance of the program, workplans, and will seek

immediate solutions for bottlenecks or other problems that arise during implementation.

4. Phase I Evaluation and Design of Phase II

3.34 Twenty-four months after approval, a formal evaluation will be conducted by consultants contracted using the proceeds of the loan (under Component 5), working with Bank staff and Ministry counterparts. The evaluation will critically assess the progress to date toward the program's overall objectives, strategies to accomplish these objectives, and benchmarks (see Table 7). The evaluation team will also analyze changes in conditions that might have transpired. The evaluation team will work with the CC to prepare a plan for the subsequent phase, laying out in detail the activities, allocation of resources, changes in procedures or staffing, and evaluation indicators. (Relevant evaluation indicators, such as those related to community participation, training output, and service utilization and other health indicators, will be disaggregated by gender.)

Table 7. Priority Benchmarks for Project Evaluation for Phase I

Categories	Verifiable Indicators	By 24 months
Health Status	Access to minimum package of services (% of households in 4 departments)	50
Component 1. Implementation of the UCS Model		
Planning and Management	UCS have development plans (number of UCS in 4 departments)	15
Infrastructure and Equipment	Health facilities have adequate equipment to provide minimum package of services (% of facilities in 4 departments)	50
Financial System and Management	Health facilities are using minimum financial and management package (% of facilities in 4 departments)	50
Component 2. Institutional Strengthening of Departmental Directorates		
Planning and Management	Departmental Directorates have annual and four-year plans (number of directorates)	4
Financial Management	Departmental Directorates use a financial system and modern management	4
Component 3. Institutional Strengthening of Central Level Directorates		
Planning and Management	Central Directorates have an operational manual and five-year plan (% of Central Directorates)	100
National Health Information System	Health facilities in the country use common data collection forms (%)	70
Component 4. Sustainable Financing		
Planning of the Financial System	Progressive and global draft plan of financing the health system prepared	Yes

3.35 It is expected that RE2/SO2 will return to the IDB Board of Directors with a request for approval of Phase II of this program after the following conditions have been met: (i) At least 50 percent of the resources for Phase I have been committed; and (ii) Satisfactory progress for the first 24 months of program execution has been made.

5. Disbursement Schedule

Disbursement Schedule (US$ Millions)					
Component	**Year 1**	**Year 2**	**Year 3**	**Total**	**%**
UCS Model	2.4	4.0	6.0	12.4	62
Departmental Directorates	1.0	1.4	1.5	3.9	19
Central Directorates	0.7	1.3	0.5	2.5	12
Financial Sustainability	0.4	0.4	0.5	1.3	6
Total	4.5	7.1	8.5	20.1	
%	22	35	42	100	

IV. BENEFITS AND RISKS

A. Benefits

4.1 Program investments will have direct benefits for the Haitian population through two central mechanisms: (i) increasing the cost-effectiveness of the package of health care services; and (ii) increasing population coverage of health services. Using relatively conservative assumptions about these two factors, the effect of the program on health status can be quantified. Relevant indicators include the pre- and post-program number of disability-adjusted life years lost, or DALYs (taking into consideration both morbidity and mortality), and the number of deaths averted due to program interventions. The analysis covered benefits of the full program, rather than Phase I. (Details of this analysis can be found in the Economic and Financial Analysis, in the technical files.) 14/

4.2 The total burden of disease without the program is estimated to be 1,425,000 DALYs lost per year. This figure is net of the burden avoided--112,500 DALYs--from consumption of health services available in the absence of the program. With the program's more cost-effective package of health services, there is projected to be a net reduction in the burden of disease, equal to 104,215 DALYs in Year 1, a figure that drops to 94,333 by Year 6. The reduction in the burden of disease attributable to the program is therefore 6.7 percent in Year 1, and 5.6 percent by Year 6. The present value of the disease burden avoided from the program over six years, with a 5 percent annual discount rate, is 496,417 DALYs, or 5.8 percent of the present value of the burden of disease without the program. The cost-effectiveness of program funds is estimated at US$35.85 per DALY saved, while the number of lives saved with the program is estimated at 12,410.

1. Sensitivity Analysis

4.3 This estimate is relatively robust to varying assumptions of out-of-pocket spending and price elasticity. If current per capita out-of-pocket spending on health care were US$6.00 instead of US$4.50 (as assumed in the base scenario reported above), program impact would be greater: more beneficiaries would be covered by the program (almost 3.0 million people by Year 6), the reduction in the burden of disease would be 6.1 percent, and the number of lives saved by the program would increase to 14,000 people. If current per capita spending were only US$3.00, or well below the cost of the basic package of US$4.50, the program beneficiary population would remain rather stagnant at 2.0 million people; the burden of

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14/ Indirect benefits will be generated by project activities that improve aid coordination, enhance health service supervision, and develop health and management information systems. These benefits, though real, are difficult to quantify, and therefore are excluded from this analysis.

disease would drop by only 5.4 percent, and the number of deaths averted would only be 9,000. Finally, if current out-of-pocket spending were US$4.50, as in the base scenario, but demand price elasticity were only -0.25, then program impact would be milder. This is so because people would respond more moderately to the subsidy offered by the program.

2. Benefits to Women

4.4 As with most basic health projects, women and their children are expected to be the primary direct beneficiaries of program investments. It is estimated that approximately 840,000 women will benefit from better and more accessible health services during and after program implementation. (Among this population are nearly 700,000 women living below the poverty line.) The types of health services provided, including enhanced maternal care, will disproportionately benefit reproductive-age women who currently experience high rates of morbidity and mortality related to childbearing.

4.5 The mechanisms developed under this program for community participation in the management and financing of health care are anticipated to have positive effects on women. It is expected that local-level decision making will be more responsive to women's health needs, and social and financial constraints.

4.6 Women will also benefit from training, in proportion to their representation as health workers. In addition, funds will be provided under the program for a set of special studies to examine the gender-specific impact of changes in the health system (see Box 2); results will influence the development of the country's financing and other reform plans.

Box 2. Operations Research Issues Related to Gender Differentials

Given the lack of data on health financing and health seeking behaviors in Haiti, and the general lack of understanding of gender-specific impacts of health reforms, support will be provided under the project to conduct operational studies that address the following questions:

(1) How does the implementation of changes in management and staffing of health services affect women's opportunities for employment in the health sector?

(2) For differential weighing of resources between geographic areas, what is the optimal index to ensure sensitivity to social vulnerability?

(3) How can community-based structures best integrate the participation of all health service users, and particularly women?

(4) What process and outcome indicators are most appropriate for monitoring the impact of changes on the health of women and on gender-based inequalities?

Note: These and other research priorities are described in Standing, 1997.

4.7 All evaluation indicators related to utilization of health services, expenditures on health services, and employment of health workers will be disaggregated by gender.

3. Environmental and Social Viability

4.8 Training of health workers in environmental management for health facilities is foreseen under the program. The small-scale civil works are not expected to have negative environmental impact.

B. Program Risks

4.9 Two types of risks affect the potential impact of the program: (i) constraints to successful implementation; and (ii) constraints to long-term sustainability of program benefits.

1. Constraints to Implementation

4.10 Aside from standard risks associated with political instability and institutional weakness, implementation may not yield the anticipated benefits if the plans developed under the program--and particularly the UCS Plans--fail to adequately identify and respond to local health needs. This may occur if the working groups established emphasize the financial or political interests of the UCS partner institutions over the health needs (and demands) of the community. While several safeguards are in place, including the establishment of local health councils, this risk is inherent to a demand-driven approach to allocation of program resources that supports decentralized decision making.

4.11 A second possible constraint to implementation is the potential for urgent needs to divert resources from investments that will bring about structural improvements in health service delivery. This could occur, for example, if the Government of Haiti could find no other sources of funds for its essential drugs program, and sought to reallocate a share of the proceeds of the IDB loan to procure and distribute medicine. To some extent, this risk is mitigated through the establishment of benchmarks for each phase.

2. Constraints to Sustainability

4.12 Institutional and financial factors also influence the long-term sustainability of the program. Institutional sustainability--that is, the continued existence of and support for a mechanism to channel public funds to NGO providers--depends on continuing interest of the Government to form partnerships with the private sector, and on continuing (and growing) capacity of NGO providers to deliver services through performance contracts. The greatest risk to institutional sustainability, therefore, is the potential for a dramatic shift of course within the Haitian Government resulting from a backlash against private-public partnerships.

4.13 Financial sustainability--a central objective of the program as a whole--is dependent on the ability (and willingness) of the Government and private entities to generate additional revenues for health services, and to finance the recurrent costs associated with investments under the program. There are two types of recurrent

costs to consider, although one is far more significant than the other: (i) There will be a negligible increase in operational expenditures associated with capital improvements under the program. The small scale of the civil works and the minimal equipment purchases are not expected to increase the maintenance or other costs to the MSPP. (ii) To continue to cover the beneficiary population by contracting for health services through the UCS model will imply an increase in the MSPP's recurrent cost obligations. Applying assumptions regarding beneficiary contributions mobilized during and after implementation, it is estimated that the recurrent cost burden on the Government will be approximately US$3 million per year. This represents about a 10 percent increase over the current recurrent budget, exclusive of external aid. 15/ Whether or not this level of additional spending is sustainable remains a question that cannot be answered with certainty, given existing knowledge of political and economic conditions. However, the program seeks to establish the funding channel, planning capacity, revenue generation and aid coordination mechanisms that will contribute to the likelihood that additional expenditures on health services can be achieved and used efficiently.

15/ In absolute terms, this implies about a US$1 per capita increase in expenditures for the population in the four departments.

LOGICAL FRAMEWORK FOR THE MSPP/IDB INVESTMENT PROGRAM

CONCEPTUAL APPROACH: Strengthen the support components of the health system, especially at the Community Health Unit (UCS) and departmen levels, to establish and sustain a Minimum Package of Services (PMS) at the community and health center levels.
see attachment: A Conceptual Framework for an Integrated Health System of Haiti

Goal and Purpose	Verifiable Indicators 1/	Important Conditions
GOAL: Improve the health status of the Haitian population	Investment program activities in four departments will contribute to a national: 1. Decrease in the infant mortality rate from 74/1000 to 50/1000 2. Decrease in the childhood mortality rate from 131/1000 to 110/1000 3. Decrease in the fertility rate from 4.6 to 4	The creation of a functional Coordination Unit with the capacity to coordinate technical and financial assistance targeted by the project. The utilization of project resources for targeted activities.
PURPOSE: Improve the quality, efficiency and equity of health service provision by strengthening the support components of an integrated and sustainable health care system, in which both NGO and public providers are working in an efficient and coordinated manner.	1.1 80% of the population has access to a minimum package of sustainable health services (PMS) 2/within 5 kms and two hours walk from home. 1.2 The percentage of the national health budget directed at UCS reaches 50%. 1.3 80% of UCSs attain at least a functional level of 4 3/ as replicable and acceptable models of management, supervision, financing and health service delivery. 1.4 The coverage rates (utilization by the population) increases by at least 10% for each component of the minimum package of services (PMS)	

1/ All indicators are for five years in the four departments assisted by the investment program except if otherwise indicated.
2/ PMS includes comprehensive child health; maternal health; reproductive health; control of transmissible diseases; medical-surgic emergencies; water and sanitation; essential medicines; health education; and basic dental care.
3/ Level 4 means that four basic services are available and functional on a continuous basis, but certain elements of the health servic are missing; community organization is active for the health program; population is covered by the institutional and communi network, but not throughout the entire UCS.

1. Development of the UCS Model in Four Departments

Program Components	Verifiable Indicators	Means of Verification	Important Conditions	Activities
1.1. **Planning and Management:** Achieve an acceptable management of UCS based on advanced and appropriate planning	90% of UCS have a development plan that fixes the geographic limits of the UCS and its objectives and implantation strategies (particularly a strategy for effective participation of the population) 90% of UCS are headed by a Community Health Council having a technical capacity in the areas of general administration, finances, personnel, stock management, and supervision of institutional policies	UCS Plan Reports of the councils Evaluation Supervision reports	Establishing a contract between the Department and UCS Work Group for the preparation of the UCS development plan The financing of the UCS development plan Legal status of councils Available resources for the training of councils	Signing of the contract with the UCS work grou Elaboration of the UCS development plans Dissemination of management tools including thos concerning the management of the communal resources of UCSs Implementation of local health councils
1.2 **Infrastructure and Equipment:** Increase the capacity of UCSs to provide the minimum package of health services for their level of complexity	90% of health facilities of the UCS have the necessary equipment and the capacity to provide the minimum package of services at their level of complexity. 90% of UCS have established a health map corresponding to norms 90% of institutions have the minimum infrastructure necessary for their category	Evaluation Supervision reports	Existence of equipment list by level Existence of norms for infrastructure and equipment	Acquisition and distribution of equipment Rehabilitation of infrastructures Construction of infrastructure Implementation of maintenance system
1.3. **Supply Line and Logistics:** Establish a intra-UCS system of essential medicine distribution that decreases stock-outs of essential medicine.	100% of UCS health facilities sanitary of the UCS have a reliable stock of essential drugs.	Evaluation Reports	Functional departmental procurement system Revision of acquisition procedures Existence of an essential medicine list by level Availability of personnel	Establish decentralized depots Establishment of management committees Dissemination of tools for stock management Training in stock management for depot personne Workshop

Program Components	Verifiable Indicators	Means of Verification	Important Conditions	Activities
1.4 **Health Information System (HIS):** To achieve a functional HIS that is useful for making decisions on the improvement of services	90% of institutions complete a monthly HIS 90% of institutions are using a supervision system of key indicators and that make evident the utilization of data to make operational decisions	Monthly reports	Implementation of the national Health Information System	Putting in place a HIS at the level of institutions according to their level of complexity Dissemination of data collection instruments
1.5 **Financial System and Management:** To make possible the application of an efficient and transparent minimum management package (PMG) that is and based on a consolidated budget and Generally Acceptable Management Procedures	75% of institutions put into practice a minimum management package according to their level of complexity 70% of UCS prepare a consolidated budget	Report Evaluation Audit	Definition of a minimum management package Development of a model for a consolidated budget	Put in place accounting systems and adequate management procedures at each institutional leve Elaboration of consolidated budgets for UCSs Put in place financial control mechanisms
1.6 **Community Participation:** To obtain effective participation of the population in the planning, management and the financing of health care.	The population participates in management of 50% of UCS health facilities 25% of the functioning budget of the UCS is supported by the population	Evaluation Audit Budget plan for the UCS	The departmental plan takes into account community participation.	Identification of community communication channels Research into alternative financing mechanisms Realization of community participation workshops Financial support for community initiatives Community mobilization and use of community resources Evaluation of the satisfaction with health services
1.7 Training and Supervision: Make available the trained human resources at the level of the health institutions and assure that norms are followed for the essential package of services by each level of provider	90% of health institutions apply a program of continuing training and have in place a mechanism to ensure competence 90% of identified training needs of personnel are satisfied 90% of institutions benefit from at least 3 supervision visits by immediate supervisors 50% of the problems identified at the health center level are treated appropriately	Evaluation Reports	The Departmental Directorates develop a plan for continuing training, supervision and quality control	Identification of training needs Implementation of a program of supervision and continuing training at the level of the institution Standardization of supervision procedures Dissemination of supervision and quality control tools Implementation of mechanisms to measure and follow competencies at the level of the institutions

Program Components	Verifiable Indicators	Means of Verification	Important Conditions	Activities
1.8 **Education and Information for Health:** Put in place a local system of information, education and communication by using local channels	100% of UCS plans take into account IEC 90% of health facilities have a calendar of activities for IEC, and possess and utilize IEC materials 70% of the programmed IEC activities are executed	Supervision reports UCS plan	Resources are available for IEC	Dissemination of IEC materials Training of leaders and community groups in IEC Use of traditional/local channels of communicatio Interventions by mass media and other channels Training of institutional workers in IEC
1.9 **Quality Assurance and Operational Research:** Create a local mechanism to study and solve problems and to supervise the application of minimum package of services	90% of health facilities satisfy the norms of infrastructure and personnel, i.e., they are accredited by the departmental level 1000% of reference hospitals benefit from a system of quality assurance (Circle of Quality) 25% of UCS utilize the Operational Research to seek solutions for local problems	Accreditation Report Supervision Research Protocols Reports	Health institutions are accredited at the level of department Elaboration of a guide to evaluate the satisfaction of health system users	Create a system to supervise institutions Dissemination of norms and training of sanitary personnel concerning matters of and in principles of Operational Research Establishing a quality circle at the level of reference hospitals National Conference of UCSs to share experiences, lessons learned and OR results

2. Institutional Strengthening of Departmental Directorates in four departments

Program Components	Verifiable Indicators	Means of Verification	Important Conditions	Activities
2.1 **Planning and Management:** Achieve decentralized management of the health department based on annual and four year departmental plans which include the development and coordination of UCSs	All Departmental Directions have an annual plan taking into account the following components: the geographic delimitation of UCSs, the formation of CCSs, the development and the financing of UCSs, and community participation.	Evaluation Supervision reports	Existence of a framework and tool for planning Definition of a planning cycle Legal statute for health councils	Development of an annual plan and a plan for four years Supervision of the elaboration of plans of UCSs Installation of health councils Periodic evaluation of annual plans Training in planning and management for th Staff of the Departmental Direction
2.2. **Infrastructure, Equipment and Human Resources** To make Departmental Directions more capable for their functions of planning, control and coordination	All departmental directions have the infrastructure, equipment and necessary human resources for their functioning	Reports Supervision Organigram of Departmental Directorate	Existence of qualified personnel at departmental level	Creation of a capacity for maintenance of small equipment Evaluation of needs of the D.D. in human resources, equipment and in infrastructure Endowment in human resources Acquisition of equipment Rehabilitation or construction of infrastructure
2.3 **Supply System:** Implement a plan and a functional departmental mechanism for the distribution of essential medicines	All departmental depots do not record stock-outs lasting more than 3 days for the 5 most essential medicines	Reports Supervision	Central depots are functioning adequately Norms for depots exist	Create and/or reinforce departmental depots Reinforcement of management capacity (tool for stocks management,training in stock management)

Program Components	Verifiable Indicators	Means of Verification	Important Conditions	Activities
2.4. Health Information System (HIS) Establishment of a functional departmental health information system (HIS) that produces epidemiological and management data that can help decision-making.	All Departments participate in health information system (HIS) All departments use data generated by the health information system (HIS) to make decisions	HIS Reports Supervision	Existence of qualified personnel (epidemiologist and statistician)	Implementation of the HIS at the departmental level Dissemination of tools for data collection Management of health information with feedback Strengthening of departmental staff in HIS (training, recruitment)
2.5. **Financial management system** Establish a financial system and a system for an efficient and transparent allocation of resources	All Departmental Directions use a financial system and modern management procedures	Evaluation Audit	Modernization of the accounting and financing system Existence of qualified personnel (accountant, manager)	Implement an acceptable financial and accounting system Implement mechanisms for financial control and allocation of appropriate resources Strengthening of departmental in accounting
2.6. Community Participation Achieve the application of a decentralization policy that strengthens the capacities of participation by the population	All departmental plans have a component of community participation	Departmental Plan Evaluation	Institutionalization of the community participation Elaborate of the MSPP decentralization policy	Creation of Councils Awareness increasing campaigns Implementation of multisectoral departmental councils
2.7. Training, Supervision and Logistics Create a mechanism for in-service training and supervision of competence of health personnel and strengthen the supervision capacity of the Departmental Direction	All departments have an in-service training program and mechanisms for supervision of competence All departments have a monthly supervision schedule 50% of problems identified at the UCS level are resolved appropriately	Departmental plan Supervision reports Evaluation	Choice of strategy for in-service training	Elaboration and implementation of in-service training at the departmental Elaboration of a departmental supervision plan Organization of supervision visits Strengthening of supervision mechanisms (dissemination of instruments, training)

Program Components	Verifiable Indicators	Means of Verification	Important Conditions	Activities
2.8 Education and Information for Health: Implement a departmental plan for information, education and communication (IEC) by using local systems of communication	All Departmental UCS plans take into account IEC 50% of programmed activities are executed	IEC Plan	Resources are available for IEC	Dissemination of IEC materials Interventions for media Strengthen Departmental and UCS capacity for IEC
2.9 Quality Assurance and Operational Research: Create a local mechanism to study and solve problems and to supervise the application of PMS and management *norms*	75% of Departmental Directions use Operational Research to seek solutions for local problems 50% of Departmental Directions benefit from a system of quality control (Circle of Quality)	*Reports* Supervision		*Training of personnel in the principles of* Quality Assurance and Operational Research National Conference of UCSs to share experiences, lessons learned and OR results

3. Institutional Strengthening of theCentral Directorates

Program Components	Verifiable Indicators	Means of Verification	Important conditions	Activities
3.1 Planning and management: Establish decentralized management of the health system based on annual and five year planning and on appropriate support mechanisms	All Central Directions have an operational annual plan based on the five year MSPP plan 70% of programmed activities in annual plan are executed 100% of budget for annual plan is disbursed	Plan Evaluation	Formal assignment of personnel to update the five year MSPP plan Knowledge of available budgetary resources	Diagnostic inventory and evaluation of potentials for central and departmental directions.
				Creation of five year plan by the MSPP Diagnostic inventory and evaluation of potentials for central and departmental directorates Development and dissemination of planning tools Support to departmental directorates for elaboration of annual plan Support for the elaboration of departmental plans Development of an organizational and legal cadre for the local health councils Support for work on a National Health Commission Support for development of health economics capabilities Functioning structure of the Central Support Committee for UCS Strengthening of the central staff in management (training, additional staff)

Program Components	Verifiable Indicators	Means of Verification	Important conditions	Activities
3.2 Health Information System (HIS) Establish a functional Health Information System (HIS) by supporting the CASIS (Support Committee for the Health Information System)	90% of departments submit a quarterly complete report 90% of institutions in the country use the same data collect forms	Reports Supervision Evaluation	Le CASIS designs the HIS	Creation of a national unit for information technology to establish a functional information network between the central units and departmental directions Implementation of HIS on a national scale Development of management procedures for the HIS Production of baseline database documents Equip infrastructures (departmental and central level) in material and computer equipment that use alternative energy sources

Program Components	Verifiable Indicators	Means of Verification	Important Conditions	Activities
3.3. Financial System and Regulation Develop and adopt a progressive and adapted global plan to modernize the financial management system	75% of departments and UCS which are examined successfully complete an audit 50% of UCS benefit from technical support	Evaluation Audit		Modernization of the accounting system and management procedures Definition of a minimum management package (PMG) with tools, norms and procedures Implementation of a general inspection unit Support for the preparation of a consolidate budget *Creation of a data base with financial* information
3.4 Training Increase competence of the personnel at the UCS, departmental and central levels to implement the national health policy	Number of persons trained by level and by type of training	National training plan		Elaboration of a national policy for training and supervision Elaboration of a curriculum conforming to th needs of the system Evaluation of training needs Elaboration of an inservice training program and program for training of new personnel for the UCS Training of trainers at the central, departmental and UCS levels Data base on training at the national level, maintained by the Directorate of Human Resources Production and diffusion of training materials

Program Components	Verifiable Indicators	Means of Verification	Important Conditions	Activities
3.5 **Human Resources** Have available qualified health personnel	90% of personnel are recruited according to established norms 90% of personnel are evaluated according to established norms	Reports Analysis of data base		Revision and implementation of recruitment norms Dissemination and use of recruitment norms *Elaboration of a career plan* Implementation of software for management of personnel and salaries Develop mechanism for control and accreditation of personnel Establish norms for personnel evaluation *Modernize personnel management*
3.6 Supervision Increase the support capacity and supervision by the Central Directions	All Central Directions have supervision plans At least two supervision trips per department are conducted 50% of the problems identified at the department level are resolved appropriately	Supervision reports	Simplification of procedures for accessing resources for supervision	Elaboration of norms and guidelines/checklist for supervision of personnel and health facilities. Elaboration of an integrated supervision plan Operational research on plans *Obtain logistical materials to so as to* strengthen the supervision capacity of the central level Training and TA for developing the norms and guidelines

Program Components	Verifiable Indicators	Means of Verification	Important Conditions	Activities
3.7 Education and Information for Health: Increase population access to health information	80% of institutions use a minimum package of IEC	Reports Supervision		Develop operational and strategic plans of communication Finalize the selection of IEC materials The production and distribution of IEC materials Creation of a central documentation center and depot for materials Support for operational research and evaluation of IEC Support to the D.D. for the elaboration and implementation of the departmental IEC pla
3.8 Quality Assurance and Operational Research: Put into application updated and improved norms in all areas of work	100% of the PMS components are regulated by updated norms 75% of departmental and UCS teams are trained in the principles of Quality Assurance or Operational Research	Norms Training modules Training reports		Inventory of existing norms and need for updated norms Implementation of ethics committee Elaboration and/or updating of norms for th different components of the PMS and the different support components for PMS Workshop on the methodology of the formulation of norms, Quality Assurance (Circle of Quality) and Operational Research Distribution and promotion of PMS norms and the principles encircles quality and Operational Research

4. Viability and Permanence of the Reorganized System

Program Components	Verifiable Indicators	Means of Verification	Important Conditions	Activities
4.1 Planning of the Financial System: Ensure a progressive financial independence form donor funding	All the UCS in 4 departments are able to cover at least 25% of their recurrent costs within 6 years A progressive increase in the percentage of the national budget allocated to peripheral structures, to reach 50%	Plan UCS budgets; Annual UCS reports. *Evaluation* Consolidated Budget MSPP Budget	Development by the MSPP of a budgeting by program, according to needs and in accordance with equity rather than a budget *under based on previous funding (on routine)*	Diversifification and stabilization sources of financing of the health sector. Development information on public and private health expenditures Improvement of the performance in the distribution of the public health budget by developing the information and the analytic capacity to the support decision-making. *Identify new alternatives for sustainable* financing including operational research on the financing of the system Develop a system or a formula for distribution of national subsidies which is equitable
4.2 Income Generation: Increase gradually local financing for the functioning of the UCS	25% of UCS utilize Operational Research to develop and test local income generation strategies e.g., systems of mutualization and insurance.	Protocols Reports		Operational research for the implementation of altenative financing mechanisms Implementation of pilot experiences in revenue generation at the local level *Exchange of results from operational* research on revenue generation

REORGANIZATION OF THE NATIONAL HEALTH SYSTEM
PHASE I

TENTATIVE PROCUREMENT PLAN

Principal Program Procurement	Financing (%)		Method	Prequalification	Approximate Publication Date in AEA (semester/year)
	IDB	Local			
A. Procurement of Goods					
Computing Equipment and Software	100		International Competitive Bidding	Yes	1/99
Vehicles	100		Local Competitive Bidding	Yes	
Photocopy Machine	100		Local Competitive Bidding	Yes	
Network Equipment	100		International Competitive Bidding	Yes	3/99
Office Furniture	100		Local Competitive Bidding	No	
Office Equipment	100		Local Competitive Bidding	No	
Basic Medical Equipment	100		International Competitive Bidding	Yes	6/99
B. Procurement of Services					
Cosmetic Repairs	100		Local Shopping	No	
Rehabilitation	100		Local Competitive Bidding	Yes	
Consultancies (Firm)	100		International Competitive Bidding	Yes	3/99
Consultancies (Individuals)	90	10	N/A	No	
Other Services	100		N/A	N/A	

RGII-HA100P
Original: English

PROPOSED RESOLUTION

HAITI. LOAN ____/SF-HA TO THE REPUBLIQUE D'HAITI
(Program for the Reorganization of the Health Sector, Phase I)

The Board of Executive Directors

RESOLVES:

That the President of the Bank, or such representative as he shall designate, is authorized, in the name and on behalf of the Bank, to enter into such contract or contracts as may be necessary with the République d'Haïti, as Borrower, for the purpose of granting it a financing to cooperate in the execution Program for the Reorganization of the Health Sector, Phase 1. Such financing will be for the amount of up to US$22,500,000, or its equivalent in other currencies, except that of Haïti, which are part of the resources of the Fund for Special Operations, and will be subject to the "Special Contractual Conditions" and the "Terms and Financial Conditions" of the Executive Summary of the Loan Proposal.