



# Project Completion Report

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## PCR

***Project Name: Improving Child Survival and Building Blocks for Social Safety Nets***

***Country: Haiti***

***Sector/Subsector: Social Protection and Health***

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***Project Number: HA-L1042 /HA-T1116***

***Loan Number (s), TC(s): 2257/GR-HA ET ATN/OC-11982-HA***

***CRG Date:***

***Final Approval Date of PCR:***

***PCR Team: Principal Author and Members: Meri Helleranta (SPH/CNI), Anna Perez-Exposito (SCL/SPH) and Susan Kolodin (SCL/SPH).***

## Acronyms and Abbreviations

AISE	<i>Activités Intensives pour la Santé de l'Enfant</i>
CHW	Child Health Weeks
EA	Executing Agency
EMMUS	<i>Enquête Mortalité, Morbidité et Utilisation des Services</i>
GOH	Government of Haiti
IDP	Internally Displaced Peoples
IHSI	Institute Haitien de Statistiques et Informatique
MR	Measles-Rubella
MSPP	Ministere de la Santé Publique et de la Population
NGO	Non-Governmental Organization
NTD	Neglected Tropical Disease
PCR	Project Completion Report
PTI	Poverty Targeted Investment
SEQ	Social Equity
STH	Soil Transmitted Helminthes

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## I. Basic Information

BASIC DATA (AMOUNTS IN US\$)							
<b>PROJECT NO:</b> HA-L1042  <b>Borrower:</b> Republic of Haiti <b>Executing Agency (EA):</b> Ministry of Public Health a  <b>Loan(s):</b> 2257/GR-HA – ATN/OC-11982-HA <b>Sector:</b> Social Protection and Health  <b>Lending Instrument:</b> GRN - IDB Grant Facility & FOD - Food Price Crisis Response IDB Fund	<b>TITLE:</b> Improved Child Survival and Building Blocks for Social Safety Nets  <b>Date of Board Approval:</b> Dec 02, 2009 <b>Date of Loan Contract Effectiveness:</b> Dec 23, 2009 <b>Date of Eligibility for First Disbursement:</b> Jun 30, 2010  <b>Months in Execution</b> * from Approval: 51 * from Contract Effectiveness: 51  <b>Disbursement Periods</b> <b>Original Date of Final Disbursement:</b> Dec 23, 2013 <b>Current Date of Final Disbursement:</b> Mar 30, 2014 <b>Cumulative Extension (Months):</b> 3 <b>Special Extensions (Months):</b> 0  <b>Loan Amount(s)</b> * Original Amount: 5,500,000.00 * Current Amount: 5,500,000.00 * Pari Passu (if applicable): 100 %  <b>Disbursements</b> * Amount to date: 100 (%)  <b>Total Project Cost (Original Estimate):</b>  <b>Redirectioning</b> <b>Has this Project?</b> Received funds from another Project [ NO ] Sent funds to another Project [ NO ] N/A [ ]  <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 30%;">To/From Project Number</th> <th style="width: 30%;">From Sub-Loan Number</th> <th style="width: 40%;">Amount</th> </tr> </thead> <tbody> <tr> <td> </td> <td> </td> <td> </td> </tr> </tbody> </table> * Current amount (adjusted for redirectioning):  <b>On Alert Status</b> <b>Is project currently designated "on alert" by PAIS:</b> No <b>If yes then why is the project on alert (DO , IP Ratings and/or relevant PAIS indicators):</b>  <b>Comments on relevance of "on alert" status for this project (if applicable):</b>	To/From Project Number	From Sub-Loan Number	Amount			
To/From Project Number	From Sub-Loan Number	Amount					
<b>Poverty Targeted Investment (PTI):</b> Yes <b>Social Equity (SEQ):</b> Yes <b>Environmental Classification:</b>							

Summary Performance Classifications				
DO	<input type="checkbox"/> Highly Probable (HP)	<input checked="" type="checkbox"/> Probable (P)	<input type="checkbox"/> Low Probability (LP)	<input type="checkbox"/> Improbable (I)
IP	<input type="checkbox"/> Highly Satisfactory (HS)	<input checked="" type="checkbox"/> Satisfactory (S)	<input type="checkbox"/> Unsatisfactory (US)	<input type="checkbox"/> Very Unsatisfactory (VU)
SU	<input type="checkbox"/> Highly Probable (HP)	<input type="checkbox"/> Probable (P)	<input checked="" type="checkbox"/> Low Probability (LP)	<input type="checkbox"/> Improbable (I)

## II. The Project

### a. Project Context

The project was designed to enhance child survival in Haiti via basic interventions that improve children's resistance against disease. Haiti continues to present the highest rate of child mortality in the Americas at 76 per 1000 live births<sup>1</sup>. Malnutrition and inadequate vaccinal coverage are considered as key factors that weaken children's immunity against disease such as acute respiratory infections and diarrheal disease, the most common causes of child mortality in Haiti.

At the time of project approval, it was expected that a series of successive crises would have increased the prevalence of malnutrition in children in relation to the results of the 2005-6 EMMUS IV (Enquête Mortalité, Morbidité et Utilisation des Services) household survey. Less than two years earlier, in 2008, the country had been hit hard by the global fuel and food price crises and four devastating hurricanes, which led to large-scale destruction, internal human displacement, and violent riots. In March 2009 as many as three million people, or one third of the total population, were classified as food insecure.

Evidence from 2008 suggested that the level of chronic malnutrition, at the time of project design was around 30% and acute malnutrition above 10% in children under five years of age.<sup>2</sup> Vitamin A supplementation was only reaching 14.5% of 12–59 month old children which was regarded as alarming as Vitamin A deficiency is among the most critical forms of malnutrition due to its impact on the immune system and subsequently to child survival. The evidence from the 2002 prevalence survey on soil-transmitted helminthes (STH) further demonstrated that intestinal worms are likely to be a very common contributor to the high levels of child malnutrition. While the study concluded that at the national level 34% of all school children were infected with STH, in departments such as the Grand Anse up to 70% of school children were shown to carry some type of STH in their intestine<sup>3</sup>.

Delivery of public health services in Haiti continues to be very challenging due to many factors, including poor economic and sociopolitical conditions of the rural population (47% of total population<sup>4</sup>) which is dispersed over a rugged topography and hence poorly served by communication and transportation networks. It is estimated that overall 40% of the population in Haiti have no access to any health care services, creating the need to carry out campaign style public health interventions with an effective outreach component. For instance, the Expanded Program on Immunizations has yet to achieve full coverage in the country and just two years before project approval in 2007 only 33% of Haitian children had completed their vaccination schedule<sup>5</sup> before their first birthday. In particular, the low level of measles vaccine coverage (43% of 12-23 month old children) prompted the urgency of organizing a national campaign in 2007-8 (two years before project approval) which reached 4,7 million people between 1-19 years of age and a national coverage of over 80% (in children 1-4 years).<sup>6</sup>

In this context the Ministry of Public Health (MSPP) was interested in scaling-up a strategy called the Child Health Week (CHW), which would complement the routine services with a regular campaign-style intervention. This strategy was aimed in part to improve predictability, and to avoid the costs and reduced sustainability of large scale ad-hoc campaigns. The CHW

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<sup>1</sup> WHO/PAHO statistics 2012.

<sup>2</sup> Basset et al. Promoting Nutrition Security in Haiti: An Assessment of Pre- and Post-Earthquake Conditions and Recommendations for the Way Forward, World Bank 2008. Article combines prevalence results from different surveys.

<sup>3</sup> Champetier de Ribes et al. Intestinal helminthiases in school children in Haiti in 2002. Bull Soc Pathol Exot 2005;98 (127-32).

<sup>4</sup> Indexmundo.com

<sup>5</sup> In 2007 the vaccination schedule consisted of one dose of BCG (Bacillus Calmette–Guérin) against tuberculosis, the measles vaccine, and three doses of diphtheria, tetanus and pertussis.

<sup>6</sup> Lacapere et al. The use of rapid coverage monitoring in the national rubella vaccination campaign, Haiti 2007-8. JID 2011;204 (Suppl 2).

intervention had been piloted by a USAID micronutrient Program (MOST)<sup>7</sup> in 2005 and was regarded as a viable strategy to deliver both Vitamin A and de-worming to all children under five years of age, and to also offer catch-up immunizations to those who had not been reached by routine immunizations program. It also was recognized that with MSPP taking the lead in executing the intervention, the project would be able to integrate the campaign-style intervention as part of the routine services offered by the public sector. Using the existing health service network meant also that the project's budget would be sufficient to sustain up to six rounds of Child Health Weeks over 3 years, which would have the potential to generate important improvements in child survival at the national level.

The project was approved by the IDB board of directors on December 2, 2009, just 5 weeks prior to the devastating earth quake that occurred on January 12, 2012. The large scale destruction and human suffering in the capital and nearby cities left an estimated 90,000 to 220,000 people dead and as many as 300,000 wounded. The government and the many donor agencies operating in Haiti were then set on an emergency mode which was further exacerbated by the cholera epidemic, which began nine months later.

The MSPP estimated to have lost over 200 of their own personnel in the earthquake and other ministries, which were all located in the worst hit area of Port-au-Prince, also incurred significant losses. The mental trauma of having lost colleagues and family members, and for witnessing such unbearable suffering, left many in a state of despair, and some officials were unable to resume their regular functions for months. The extreme damage to public infrastructure, including many government offices, roads, bridges, water systems, and others, hampered all logistical operations as transport of goods through and inside the capital area were severely restricted. Most of the population of the metropolitan area of Port-au-Prince (estimated 2.5 million people) from government officials to street vendors slept outside in tents for weeks and had to get by with very little access to water and sanitation, electricity and other basic services. At the same time, there were important internal discussions at the IDB to assure that the project remained relevant and implementable under the changed circumstances. Many public ministries attempted to restore their normal functions gradually over the next three to seven months. This project was meeting eligibility requirements and initiating its first activities in this complex situation.

Despite the initial challenges, delivery of the regular CHW was considered an important priority for the MSPP and hence the project quickly caught-up with the original execution schedule by the end of the first year. The first CHW was organized in November of 2010 reaching 307,800 children after which the intervention was repeated four times (in all 10 departments) in intervals of 6-10 months, reaching on average 770,000 children each time.<sup>8</sup> Overall the project can be considered to have reached its objectives despite of the challenging timing of approval. The strong ownership of the project activities that MSPP demonstrated throughout execution should be recognized as one of the most important success factors.

## **b. Project Description**

### **i. Development Objective**

The project objective was to improve child health and nutrition outcomes and create building blocks for a social safety net.

### **ii. Components**

Project activities supported core early childhood interventions that were recognized as an important entry point towards more holistic social sector policies. Its activities were categories in two main programs (A + B) and seven sub-components as follows:

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<sup>7</sup> The project was managed by the International Science and Technology Institute, Inc (ISTI) under the terms Cooperation Agreement No. HRN-A-00-98-0047-00.

<sup>8</sup> In total CHWs were carried-out five times in each department (5 x 10 department= 50). In addition in November of 2011, five departments provided some of the CHW services such as de-worming (50+5= 55).

**Program A: Child Survival and Public Health Nutrition (US\$7,530,000)**

The objective of this component was to deliver key public health and nutrition interventions to improve under nutrition and child survival. These activities were identified as (i) Delivery of CHW; (ii) promotion of breastfeeding; (iii) treatment of acute malnutrition; (iv) micronutrient fortification of staple foods; and (v) institutional strengthening and improved communication platform.

The project had envisioned to finance the delivery of CHW for up to six times in all 10 departments of the country on a bi-annual basis (June and November) and the package of interventions intended to include the procurement and distribution of Vitamin A supplements, de-worming and iodine oil capsules, oral rehydration salts and zinc supplements. In addition CHW was to promote appropriate breastfeeding practices as well as to deliver other health promotion messages for caregivers.

**Program B: Building Blocks for Social Safety Nets (US\$350,000).**

The objective of this component was to produce key inputs that begin to lay the foundation for qualitative improvements to Haiti’s social safety net over the next three years using maternal and child health as an entry point. In specifically the objective was to (i) Create a Social Information System in 3-4 communities to help plan future safety net pilot programs; and to (ii) Pilot safety net in maternal and child health via community health workers.

**c. Quality -At- Entry Review N/A**

Quality -At- Entry Review			
<input type="checkbox"/> Highly Satisfactory (HS) - 1	<input type="checkbox"/> Fully Satisfactory (S) - 2	<input type="checkbox"/> Less than Satisfactory (LS) - 3	<input type="checkbox"/> Unsatisfactory (U) - 4

### III. Results

#### a. Outcomes

ACHIEVEMENT OF DEVELOPMENT OBJECTIVES (DO)				
Development Objective(s) (Purpose)		Key Outcome Indicators		
1. Child survival improved and immunity enhanced through supporting interventions delivered				
1.1: 6-59 month old children who receive Vitamin A during the Child Health Week <sup>9</sup>				
1.2: 6 month to 12 year old children who receive de-worming drug during the Child Health Weeks integrated with Neglected Tropical Disease (NTD) campaign				
1.3: Children (6-59 months) consumed Vitamin A supplement in the 6 months preceding the survey				
Classification: P				
		<b>Planned Outcomes</b>		<b>Outcomes Achieved</b>
<u>Baseline</u>	<u>Intermediate</u>	<u>End of Project</u>	<u>Intermediate</u>	<u>End of Project</u>
1.1: 200,000 (2006)	1.1: 1,200,000 (2012)	1.1: 800,000 (2013)	1.1: 2,018,435 (2012)	1.1: 617,415 (2013)
1.2: 0 (2010)	1.2: 1,900,000 (2012)	1.2: 500,000 (2013)	1.2: 1,891,719 (2012)	1.2: 1,134,158 (2013)
1.3: 31% (2010)	1.3: 35% (2012)	1.3: 60% (2013)	1.3: N/A (2012)	1.3: 44% (2013)
2. Health safety net extended				
2.1: School health program to reached vulnerable children designed				
Classification: HP				
		<b>Planned Outcomes</b>		<b>Outcomes Achieved</b>
<u>Baseline</u>	<u>End of Project</u>			
2.1: 0 (2010)	2.1: 1 (2013)	2.1: 1 (2013)		
3. Maternal health improved				
3.1: Mothers received Vitamin A postpartum within two months of delivery				
Classification: HP				
		<b>Planned Outcomes</b>		<b>Outcomes Achieved</b>
<u>Baseline</u>	<u>End of Project</u>			
3.1: 29% (2005)	3.1: 40% (2013)	3.1: 46% (2013)		
PPMR Retrofitting: [ X ] N/A				
Summary Development Objective(s) Classification (DO):				
[ ] Highly Probable (HP)      [ X ] Probable (P)      [ ] Low Probability (LP)      [ ] Improbable (I)				
<p><b>Outcome 1:</b> The number of children reached with the CHWs and NTD campaigns far exceeded the set targets<sup>10</sup>. The PMR indicator gives the number of children reached each year but as the CHW was organized twice on some years, those children who were reached via both campaigns, were counted twice in the figure for the yearly total. The <i>end of project</i> value is the number of children reached during the last CHW in June of 2013. The EMMUS V household survey of 2012 showed that while Vitamin A supplementation coverage had improved from 31% in 2005 to 40% in 2012 the project fell short of reaching its target of 60%. It should be noted though that three CHWs took place after the data collection of EMMUS V had taken place hence the <i>end of the project</i> value does not capture the full impact of the project.</p> <p><b>Outcome 2:</b> The school health program was designed as an outreach strategy to reach children in remote areas via mobile clinics. The project contributed to three mobile clinic buses and developed the operational manual for their use.</p> <p><b>Outcome 3:</b> Very significant improvement took place in terms of Vitamin A delivery to postpartum mothers based on the EMMUS V results which showed that the reach had improved from 29% (in 2005) to 46% (in 2012) exceeding the target for the project which had been set for 40%. The project advocated for post-partum Vitamin A during the CHW, repeatedly replenished the Vitamin A stock in the departmental health facilities and delivered Vitamin A to postpartum women during the first two rounds. Despite of this, this documented improvement in the reach of Vitamin A to postpartum women is expected to rather reflect the increase in institutional births; in 2005 26% of births took place in a health facility while by 2012, 36% of the women delivered in a health facility.</p> <p>The prevalence of stunting and acute malnutrition were not selected as project indicators but it is possible that the project contributed to the documented improvements between 2005 (EMMUS IV) and 2012 (EMMUS V). During this time stunting reduced from 24% to 22% and acute malnutrition from 9% to 5%.</p> <p><b>Country Strategy.</b> While the <i>health sector</i> is not included in the current Country Strategy 2011-2015, a primary aim of the strategy is to address the lack of basic services in the country in order to improve the living conditions of the population as whole, and in particular those of the poorest communities. As only 60% of the population has access to health care, it is the poorest communities who lack access to vaccines, Vitamin A supplementation and de-worming medication and hence the project is aligned with this vision set forth in the strategy.</p>				

<sup>9</sup> CHW included the following interventions: Vitamin A (6-59 month old children), Albendazole (24-59 month old children), Oral polio vaccine (0-59 month old children), Pentavalent vaccine (1.5-23 month old children), Diphtheria-Tetanus-Pertussis vaccine (24-59 month old children) and zinc and oral de-hydration salts (0-59 month old children with diarrhea). The pentavalent vaccine was added to the Haitian vaccination schedule in 2012. Iodine capsules were provided only on the first two rounds of CHW (0-59 month old children and pregnant women).

<sup>10</sup> The outreach element of the CHW was rather extensive consisting of 5000-6000 delivery posts which were equipped with a team of three health personnel.

## b. Externalities

**Unintended negative externalities:** The first CHW intervention was planned to take place in May of 2010. At that time, some development organizations in the health sector suggested that that the intervention should be delayed in order to not interfere with the ongoing emergency operations following the earthquake and the MSPP agreed to this. A similar discussion took place again eight months later, when the large scale spread of cholera seemed inevitable. Despite these considerations, the MSPP assessed that CHW's potential to mitigate the health risks associated with the rupture in the delivery of routine services outweighed the risk of interference with cholera-related activities. For the first round of CHW organized in November of 2010, the campaign included cholera prevention and treatment messages to its communication plan and distributed oral rehydration salts to all children under five years of age and not just to those with diarrhea, which is part of the regular CHW protocol.

**Unintended positive externalities:** The project can be considered a flagship project as it was the first IDB financed health sector operation to be fully integrated to the MSPP's structure. This setting contributed greatly to the sense of ownership that the MSPP had over the project. Although the project document detailed the composition of a seven member execution team to be hired with project resources, the MSPP decided to use its own personnel to execute the project, who did not receive any additional compensation for these responsibilities in addition to their regular MSPP salary. Throughout execution, the MSPP was eager to use its convening power over other health sector partners to jointly support the delivery of CHW. While the IDB project guaranteed the availability of financing for each round, the contributions from other organizations occasionally exceeded 30% of intervention costs. As a result, the project was able to deliver five rounds of CHWs (in each of the ten departments) instead of the six planned at approval even though the counterpart financing which was expected to cover 36% of the expenses, did not materialize in monetary terms. While MSPP's personnel expenses related to the project can be considered as a contribution towards counterpart financing, the monetary value of this in-kind input has not been estimated. The CHW received very significant support from UNICEF, and important contributions also from other organizations such as Micronutrient Initiative, World/PanAmerican Health Organization, World Food Program, USAID, Centers of Diseases Control and others as technical expertise and in-kind support e.g. with transport and social mobilization.

## c. Outputs

IMPLEMENTATION PROGRESS (IP)	
<b>Components (Outputs):</b>	
<b>1. Sub-program A: Child Survival &amp; Public Health Nutrition</b>	
Total cost of Component 1:	7,530,000 US\$
Counterpart:	2,500,000 US\$
IDB:	5,500,000 US\$
IDB Disbursement:	100%
<u>Classification:</u> HS	
<b>Key Output Indicators<sup>11</sup>:</b>	
<b>1.1:</b> Child Health Weeks conducted in each department <b>1.2:</b> Breast feeding campaigns organized <b>1.3:</b> Children given locally produced ready-to-use-therapeutic food to treat acute malnutrition <b>1.4:</b> Study to improve children's dietary deficiencies with a locally manufactured complimentary food <b>1.5:</b> Capacity building training conducted for institutional strengthening	

<sup>11</sup> In the PMR system, each one of these output indicators corresponds to its own component, hence five indicators for five components. In order to facilitate presentation in this PCR, the indicators are structured under the two subprograms as in the original project document.

<u>Planned Outputs</u>		<u>Outputs Achieved</u>
<u>Baseline</u>	<u>End of Project</u>	
1.1: 0 (2010)	1.1: 55 (2013)	1.1: 55 (2013)
1.2: 0 (2010)	1.2: 9 (2013)	1.2: 5 (2013)
1.3: 0 (2010)	1.3: 80 (2013)	1.3: 4771 (2013)
1.4: 0 (2010)	1.4: 1 (2013)	1.4: 1 (2013)
1.5: 0 (2010)	1.5: 1 (2013)	1.5: 1 (2013)
<p>Briefly explain differences between planned and actual outputs (if applicable).</p> <p><b>Output 1.1:</b> All ten departments delivered CHW five times. In addition in the fall of 2011 five departments that were supported by IDB water and sanitation projects (HA-X1014 and HA-L1039) were able to deliver some CHW related activities such as de-worming.</p> <p><b>Output 1.2:</b> The project financed breastfeeding advocacy (flyers, pamphlets) and campaign activities around the certification and re-certification of five hospitals (see footnote 10). As opposed to stand-alone campaigns, advocacy activities related to certification process have shown to provide long-term improvements in breastfeeding practices.</p> <p><b>Output 1.3:</b> MSPP has collaborated with UNICEF to qualify both public and private facilities on the treatment of acute malnutrition. This project managed to treat over four thousand children more than initially planned because it only financed the actual product (Medicamamba<sup>12</sup>) used for the treatment and did not invest in training and supervision of the facilities like initially planned.</p> <p><b>Output 1.4:</b> The financed study evaluated acceptance of a lipid based complimentary food and its impact on breastfeeding practices in order to give insight to practices to prevent both acute and chronic malnutrition.<sup>13</sup></p> <p>The original project document included twelve other output indicators of which eleven<sup>14</sup> were listed under <i>milestones</i> in the PMR system because unlike initially planned, project funds were not used to finance them even though all but one (Ratification of International Code of Marketing of breast milk substitutes) were accomplished.<sup>15</sup></p>		
<b>Restructuring</b>		
[ X ] N/A		
<b>2. Sub-program B: Building blocks for Social Safety Net</b>		
Total cost of Component 2: 350,000 US\$		
Counterpart: 0 US\$		
IDB: 350,000 US\$		
IDB Disbursement: % 100%		
<u>Classification:</u> S		
<b>Key Output Indicators:</b>		
<b>2.2: Building blocks for social safety nets: Multi-partner maternal and child health insurance mission designed and piloted</b>		
<b>2.3: Mobile clinic targeting vulnerable school children in remote regions piloted</b>		
<u>Planned Outputs</u>		<u>Outputs Achieved</u>
<u>Baseline</u>	<u>End of Project</u>	<u>End of Project</u>
2.1: 0 (2010)	2.1: 1 (2013)	2.1: 1 (2013)
2.2: 0 (2010)	2.2: 1 (2013)	2.2: 1 (2013)

<sup>12</sup> This is a Ready-to-Use-Therapeutic-Food (equivalent to the Plumpinut by Nutriset) manufactured by a Haitian NGO (Meds and Food for Kids) in Cap Haitian.

<sup>13</sup> Lesorogol et al. Preventative lipid-based nutrient supplements (LNS) and young child feeding practices: findings from qualitative research in Haiti. *Matern Child Nutr* (May) 2014.

<sup>14</sup> The 12<sup>th</sup> output indicator not listed in the PMR system is *Number of Baby Friendly Hospitals certified/re-certified*. By May 2014 the MSPP had re-certified four hospitals and certified a fifth with technical support from UNICEF (HHF Jeremy; HCH Port-au-Prince; HAS Gonaive; HUP Cap Haitian and HAM Gromone) but this project only supported financially the production of advocacy and campaign materials related to this process.

<sup>15</sup> Milestones in the PMR system are: (1) National nutrition policy updated; MSPP *Politique nationale de nutrition, Jan 2012 and MSPP Plan Strategique de Nutrition 2013-2018*; (2) Social mobilization strategy for breastfeeding promotion delivered; (3) Assessment on hospitals' progress towards Baby Friendly Hospitals (IDBDOCS#38812235); (4) Study conducted on complementary foods (Iannotti et al. *Am J Clin Nutr* 2014); (5) Strategy designed to mainstream national treatment protocol; (6) Health personnel trained on treatment protocol for acute malnutrition; (7) Pilot on community based trial to prevent/treat acute malnutrition; (8) Multi-sectoral taskforce on fortification created; *WPF-UNICEF-WHO-USAID-WB-IDB*; (9) Action plan developed to advance food fortification policies (IDBdocs 38812446); and (10) Multi-partner mission conducted to identify micronutrient fortification opportunities.

Briefly explain differences between planned and actual outputs (if applicable).

**Output 2.1:** The joint mission for social protection in health was organized in February of 2012 with WHO/PAHO, World Bank, USAID, Agricultural Cooperative Development International and Government of France to explore the possibilities of harnessing the service delivery capacity of the occupational health network for maternal and child health.

**Output 2.2:** MSPP has converted three buses into mobile clinics which are equipped with dental chairs, refrigerators for drugs and vaccines, solar panels and a water system. MSPP has been assigned a team consisting of a doctor, three nurses and a guard/driver for each vehicle and the pilot testing of their operation has begun.

The original project document listed two output indicators for this component: (i) Home visit model of community health workers piloted; and (ii) Social information system database created. The Government of Haiti (GOH) is in the process of defining their policies in terms of social safety nets and hence the originally envisioned specific interventions measured by these indicators could not be carried-out. These indicators were replaced with the above (2.1 and 2.2) in the PMR system in order to reflect the activities supported by the project which were aligned with project objectives and MSPP's priorities.

N/A

**Restructuring**

N/A

**Summary Implementation Progress Classification:**

Highly Satisfactory (HS)     Satisfactory (S)     Unsatisfactory(U)     Very Unsatisfactory (VU)

### d. Project Costs

Sub program	Categories	Total Project Cost - Planned (US\$000)			Total Project Cost - Executed (US\$000)			% Difference
		IDB Grant Facility	IDB Food Price Crisis fund	Total	IDB Grant Facility	IDB Food Price Crisis fund	Total	
A	Child Survival & Public Health Nutrition	2,030.00	3,000.00	5,030.00	1,998.94	2,731.30	4,730.24	-6%
A.1	Child Health Weeks	1,220.00	2,680.00	3,900.00	1,965.60	2,244.80	4,210.40	+8%
A.2	Promotion of breastfeeding	30.00	0	30.00	33.34	-	33.34	+11%
A.3	Treatment of severe acute malnutrition	0	320.00	320.00	-	486.50	486.50	+52%
A.4	Micronutrient fortification	200.00	0	200.00	-	-	-	-100%
A5	Institutional strengthening	580.00	0	580.00	-	-	-	100%
B	Building Blocks for Social Safety Nets	350.00	0	350.00	323.00	25.00	348.00	-1%
B.1	Creation of Social Information System	250.00	0	250.00	-	-	-	-100%
B.2	Pilot Safety Net in maternal & child health	100.00	0	100.00	323.00	25.00	348.00	+248%
	<b>Evaluation &amp; Audits</b>	<b>120.00</b>	<b>0</b>	<b>120.00</b>	<b>40.00</b>	<b>-</b>	<b>40.00</b>	<b>67%</b>
	<b>TOTAL</b>	<b>2,500.00</b>	<b>3,000.00</b>	<b>5,500.00</b>	<b>2,361.94</b>	<b>2,756.30</b>	<b>5,118.24</b>	<b>7%</b>

## IV. Project Implementation

### a. Analysis of Critical Factors

The project execution spanned over turbulent years in Haiti which included the aftermath of the earthquake, cholera epidemic and the change of government after presidential elections. At this time, the government prioritized the education sector, which could have contributed to the lack of counterpart financing towards this health sector project. As a consequence, the overall budget to

execute the planned activities was 36% less than originally planned and hence without close collaboration with other development partners, the objectives of the project, most likely, would have fallen short of key deliverables.

MSPP's decision not to hire the seven member execution team also had its downside, because the technical personnel in charge of project execution had many other parallel responsibilities and could not fully devote to the activities related to the project. Often times this also meant that the workload of a few devoted staff members of the MSPP was very heavy and they were not compensated for the extra hours. As an example, the project assigned personnel for financial management at the Directorate for Administration and Budget (DAB)<sup>16</sup> were somewhat overwhelmed after each round of CHW when confronted with the task of consolidating the individual financial justifications which came in by the thousands.

The reoccurring emergencies, all with critical health implications, had a profoundly overwhelming impact on MSPP; and some planned reforms like the organizational restructuring of the directorates of the MSPP were delayed. The envisioned new structure would have placed the Unit for Nutrition<sup>17</sup> under the Directorate of Family Health; and to anticipate this change, the minister assigned personnel from both directorates to manage project execution. Originally, the project was designed to build capacity in child nutrition particularly under the Unit for Nutrition yet as CHW was moved under the Family Health Directorate, the project supported capacity building in both units. The focal points at the departments assigned to the CHW were however not affected by this shift.

Another challenge was that while the country experienced a significant increase in donor financing after the earthquake<sup>18</sup>, many of the projects had been designed as purely humanitarian, and therefore did not consider elements of sustainability. Collaboration among partner organizations in the health sector was also hampered due to the very high staff turnaround. UNICEF who managed the stock for Vitamin A for MSPP had their designated person change five times during the first year of project execution.

### **b. Borrower/Executing Agency Performance**

The MSPP can be commended for their unflinching persistence in maintaining the delivery pace of the project activities under difficult and constantly changing circumstances. While having the envisioned team of consultants support the execution would have significantly facilitated project management, the higher management of MSPP (Dirección Superior) remained open to take corrective actions, assigning highly motivated and capable people to advance project activities. It is also important to recognize the sound financial practices in place at the DAB which played an important part in execution.

<b>Borrower/Executing Agency</b>			
<input type="checkbox"/> Highly Satisfactory (HS)	<input checked="" type="checkbox"/> Satisfactory (S)	<input type="checkbox"/> Unsatisfactory (U)	<input type="checkbox"/> Very Unsatisfactory (VU)

### **c. Bank Performance<sup>19</sup>**

MSPP: *“During the preparation of the project, the IDB involved many key partners in the dialogue and a significant effort was made to avoid duplication and to collaborate with organizations that were already delivering similar services. A priority of the MSPP was that it would be assigned all execution responsibilities and this vision was incorporated to project design. Based on these*

<sup>16</sup> La Direction de l'Administration et du Budget (DAB)

<sup>17</sup> L'Unité de Coordination Nationale du Programme de Nutrition

<sup>18</sup> Ramachandran et al. The Guardian Jan 2013/ UN Office of the special envoy to Haiti: Haiti received an unprecedented amount of support after the earth quake: More than \$9bn (£5.6bn) in public and private donations, of which official bilateral and multilateral donors pledged \$13bn.

<sup>19</sup> See annex II for the full borrower's evaluation.

*arguments, the Bank's performance during project preparation can be considered as satisfactory. The IDB also provided important guidance and support throughout the implementation and these efforts can be regarded as one of the success factors of the project. Specific points with regards to the IDB's support to the Ministry during execution include the following: (i) Technical assistance in the training of the personnel who executed the project, especially with regards to the Child Health Weeks; (ii) Regular supervision visits to improve interventions in the field; (iii) Support to the technical and financial planning of the activities; and (iv) Training and knowledge sharing on administrative and fiduciary procedures."*

Bank Performance			
<input type="checkbox"/> Highly Satisfactory (HS)	<input checked="" type="checkbox"/> Satisfactory (S)	<input type="checkbox"/> Unsatisfactory (U)	<input type="checkbox"/> Very Unsatisfactory (VU)

## V. Sustainability

### a. Analysis of Critical Factors

The CHW was always intended as a temporary strategy to reach children with vital interventions, while the MSPP worked to scale-up their capacity to deliver routine services and achieve national coverage. As per MSPP's medium-term vision, the CHW would gradually become redundant as the coverage of routine services would increase from 60% closer to universal access. The expectation was also that over the four year execution period, GOH would gradually increase their financing of the operational expenses of the CHW from the assigned counterpart financing. Due to the competing priorities in the country context however, as mentioned earlier, counterpart financing did not materialize in monetary terms. Nevertheless, the in-kind contribution of the MSPP can be considered significant. Even though CHW is now fully integrated to the MSPP's functions and implemented mostly by their own personnel, the lack of external resources can jeopardize the sustainability of the intervention unless the government or another donor will provide the necessary funds. In November 2013, this risk materialized when IDB project financing for CHW had been depleted; and for the first time in four years CHW were not organized by any department. Unfortunately, sustained improvements in the levels of routine vaccination coverage have not been documented during the life course of the operation<sup>20</sup> to justify a dismantling of the routine CHW schedule .

With IDB's support to anthelmintic campaigns of the MSPP via the education (HA-L1066) and water and sanitation (HA-L1039, HA-X1014) projects, MSPP will be able to treat over 500,000 school children for intestinal parasites six months for the next two years. This essentially means that MSPP will sustain the treatment coverage gained with the CHW for pre-school age children (3-5 years), as this age group coincides with the target groups for school health.

### b. Potential Risks

Government's share of national health expenditure has reduced significantly from 24% (1995) to 10% (2011)<sup>21</sup> while total spending on health is at its all-time high at 8% of GDP. It is estimated that the health system receives 38% of its total expenditure via external donors (176M US\$/year) which pays for service delivery both in private NGO clinics as well as in public facilities. Both the decline of government financing to health and high dependency on external donors can be considered as destabilizing factors for the sector as a whole and put at risk the sustainability of the gains achieved by the project.

<sup>20</sup> According to EMMUS results 41% of children (12-23 months) were fully immunized in 2005, and the immunization coverage had increased to 45% in 2012.

<sup>21</sup> Health expenditure report, The World Bank 2011. Public health expenditure consists of recurrent and capital spending from government (central and local) budgets, external borrowings and grants (including donations from international agencies and nongovernmental organizations), and social (or compulsory) health insurance funds.

### c. Institutional Capacity

The MSPP and its personnel managed all aspects of the project supported activities from technical design of the interventions to their evaluation and fiduciary management. On average the project financed an estimated 640 hours of training to MSPP personnel, and it is estimated that in total 134 staff members and 15,000 campaign workers benefited from the capacity building<sup>22</sup>. All of these design aspects that created capacity within the MSPP can be considered to add to the potential sustainability of project interventions. On the other hand, the health system as whole continues to be challenged with insufficient financing for medical as well as other supplies, and is largely dependent on external financing e.g. for propane gas to maintain the cold chain for vaccines. Such harsh realities are very challenging for the health personnel, whose technical capacity is greatly undermined by these circumstances.

#### Sustainability Classification.

[ ] Highly Probable (HP)      [ ] Probable (P)      [ X ] Low Probability (LP)      [ ] Improbable (I)

## VI. Monitoring and Evaluation

### a. Information on Results

Information on intervention coverage was based on MSPP's monitoring data collected by tally sheets which record number and age of children and the drug dose administered. These data are first collected at the departmental or district level and then compiled for national results. The population estimates for the target age group were obtained from the *Institute Haitien de Statistiques et Informatique* (IHSI).<sup>23</sup> To monitor the number of children treated for acute malnutrition, the project relayed on service delivery reports compiled by UNICEF. The EMMUS V household survey was conducted in January of 2012 and these results were used to report progress for several outcome indicators as it was expected to be the only the household survey to be carried-out during the lifetime of the project.<sup>24</sup>

The project also financed two surveys: (i) to verify the intervention coverage of the Activités Intensives pour la Santé de l'Enfant (AISE) campaign and (ii) to assess the prevalence of STH infection in school children as follows:

- (i) **AISE rapid coverage monitoring:** Between April and June of 2012 a significant consortium of donors provided support to assist MSPP to conduct a large vaccination campaign in conjunction with CHW to target all children under 9 years of age in order to prevent a potential future spread of three diseases (measles, rubella and polio) all of which had been thought to be eradicated from the Americas by 2000, including from Haiti. A rapid house-to-house monitoring of vaccination coverage was conducted following the campaign to provide authorities the necessary assurance that sufficient coverage had been achieved. Communes in which 95% or more of those included in rapid monitoring assessments had been vaccinated (documented or verbal report) were considered to have successfully completed vaccination activities.<sup>25</sup>
- (ii) **National STH prevalence study:** In November of 2013 the MSPP conducted a nationally representative study on STH prevalence in school children in order to monitor potential progress from the 2003 prevalence figures. For the study 253 schools were randomly selected from each department and stool samples were gathered from 6,600

<sup>22</sup> Prior to each one of the five CHW, each of the ten departments received an eight hour capacity building training.

<sup>23</sup> Some departments adjusted the IHSI figures to those used by the immunization program in order to receive sufficient amount of supplies for the second round because the most recent population census dates back to 1995. This means that results presented as coverage which use the estimated target population as a denominator, do not provide reliable estimates of campaign reach. Because of this, it was decided that the PMR indicator would monitor the number of children reached instead.

<sup>24</sup> [Household survey EMMUS V 2012](#)

<sup>25</sup> [Results report for AISE and CHW \(MSPP 2012\)](#)

students across the country<sup>26</sup>. The results proved that that in the last ten years (2000-2013) the STH prevalence in school children had reduced from 46% to 18%, which presents a favorable trend and speaks to the effectiveness and reach of the STH interventions.

#### **b. Future Monitoring and Ex-Post Evaluation**

Future IDB support via the education sector to de-worming programs could facilitate a prevalence study measuring e.g. STH infection in five years from now and also Vitamin A and iodine deficiency in school children to determine if mass-distribution via campaigns continues to be warranted. Nonetheless, no ex-post evaluation has been planned for the project.

### **VII. Lessons Learned**

- This project piloted an integrated model for project execution and demonstrated that intervention delivery via the public health sector in Haiti is a viable strategy and can produce significant results in terms of intervention coverage with relatively modest investment. If a similar execution mechanism would be replicated in future projects, the workload assumed by MSPP personnel should be carefully analyzed and measures adopted to ensure efficiency in execution. As an example the lengthy process of consolidating individual financial justifications from each department after every CHW repeatedly created delays with the subsequent intervention.
- Natural disaster or a wide spread epidemic can have serious long term consequences particularly in countries where external donor financing constitutes a significant share of the sector's financing. Often times donor funds are programmed shortly after the onset of a disaster, yet due to the delay in initiating interventions, the emergency mode in project delivery may continue longer than deemed necessary which further delays the reinitiating of routine services. Because of this, even projects designed as a response to an emergency should assign provisions to re-initiate routine services when surrounding circumstances allow for this. Otherwise external aid provided for the emergency will have very limited possibilities to strengthen institutional capacity of the government.
- Collaboration and alignment with other donors and development agencies can facilitate project execution especially in low-capacity environments. This project benefited from cross-fertilization and development of synergies with other health sector partners which also helped to rationalize the use of scattered resources from different donors. Such alliances with likeminded partners can have high-returns when changing circumstances on the ground require continuous readjustment of the course of implementation, and support from other organizations is needed.
- Campaign style health interventions are considered by many as the *last resort* activities due to their prohibitive cost. The GOH was also concerned that the campaign style interventions would monopolize health care personnel at the expense of routine immunization. In this project, to address both concerns a package of interventions (vaccines, Vitamin A, de-worming and iodine) was provided to maximize the benefit that a hard-to-reach beneficiary would receive. Another positive element with the CHW was that these campaigns were not a response to a disease outbreak but rather a carefully planned preventive strategy repeated every six months. This enabled the MSPP to improve their delivery each time and for the project to benefit from economies of scale in terms of supplies.
- An important lesson learned during the AISE campaign focusing particularly on eradicating measles is that door-to-door vaccination is necessary to reach the target coverage. In Haiti, in 2011, only 59% of children younger than 1 year of age had received

<sup>26</sup> [Protocol for the prevalence study on intestinal helminthes \(MSPP 2013\)](#)

measles-rubella vaccine and yet a vaccination rate above 90% is necessary to ensure that a country's population is protected from the spread of measles or rubella viruses. Failure to reach this target via the mass vaccination could have compromised elimination efforts in the neighboring Dominican Republic and rest of the Americas as well. While the AISE campaign (in conjunction with June CHW in 2012) boosted the rate to 91%, unfortunately only half of the children received the two doses required for full immunity.

- Activities that would benefit from external expertise for their implementation are difficult to manage if there are no resources allocated to specialized short-term human resources during execution. As a result, some activities foreseen at design (such as *baby-friendly hospital certification*) were eventually supported financially mostly by other donors who were able to provide a team of experts (rather than direct financing) to strengthen the MSPP's team.
- The dependence on campaign style interventions will continue in Haiti until the failures of the primary health care system are addressed. For example, missed opportunities to vaccinate and provide Vitamin A to children when they visit health centers for other reasons, lack of stock, poor maintenance of the cold chain equipment resulting in vaccine waste or worse and administration of non-potent vaccine are all areas that need urgent attention. Sustained improvements in primary health care will require a substantial increase of public financing to the sector and capacity building within the MSPP for them to assume their mandate for surveillance, sanitary regulation, quality assurance and gain access to accredited teaching hospitals and other facilities also presented in the MSPP strategic national plan for 2012-2022.

#### **Annexes:**

1. [Minutes from the Exit Workshop](#)
2. [Borrower's Evaluation](#)