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HAITI

REFORMULATION PROPOSAL OF

TRANSPORT AND DEPARTMENTAL CONNECTIVITY PROGRAM (4618/GR-HA) AND SUSTAINABLE COASTAL TOURISM PROGRAM (3383/GR-HA)

FOR THE FINANCING OF

THE IMMEDIATE PUBLIC HEALTH RESPONSE TO CONTAIN AND CONTROL THE CORONAVIRUS AND MITIGATE ITS IMPACT ON SERVICE DELIVERY IN HAITI (IPHR-HA)

REFORMULATION PROPOSAL

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ABBREVIATIONS	
ASCP	Multi-Skilled Community Health Workers (*Agents de Santé Communautaires Polyvalents)*
CBA	Cost-Benefit Analysis
COVID-19	Coronavirus-2019 Disease
CMGP	Multisector Commission to Manage the Pandemic
EA	Executing Agency
ESF	Family Health Team
ESMP	Environmental and Social Management Plan
ESMR	Environmental and Social Management Report
IDB	Interamerican Development Bank
LAC	Latin America and the Caribbean
LDD	Last Disbursement Date
MSPP	Ministry of Health and Population
MT	Ministry of Tourism
MTPTC	Ministry of Public Works, Transport and Communications
PAHO	Pan-American Health Organization
PIH	Partners in Health
PMR	Progress Monitoring Report
POI	Integrated Operational Plan
PPE	Personal Protective Equipment
RN8	National Road 8
SPRP	COVID-19 Strategic Preparedness and Response Plan
UC	Contract Unit
UEP	Investigation and Programing Unit
UGP	Project Management Unit
UNOPS	United Nations Office for Project Services
WB	World Bank
WHO	World Health Organization

I. PROGRAM BACKGROUND AND PROGRESS

A. Purpose and beneficiary request for the reformulation of two programs: "Transport and Departmental Connectivity Program (4618/GR-HA)" and "Sustainable Coastal Tourism Program (3383/GR-HA)".

1.1. The purpose of this document is to request the approval of the Board of Executive Directors of the Bank for the reformulation of the programs 4618/GR-HA and 3383/GR-HA, and use the available resources to finance the Immediate Public Health Response to Contain and Control the Coronavirus and Mitigate its Impact on Service Delivery in Haiti (IPHR-HA).

1.2. **Beneficiary request.** After declaring the emergency due to the pandemic on March 19th, the Government of Haiti (GoH) has requested to the Bank to reassign US$27 million from the two programs identified in Table 1.1, to finance the IPHR-HA, through the letter and signed memorandum presented as OEL#1. The GoH and the Bank conducted an exercise to assess the relevance of interventions in the active portfolio in light of the rapidly evolving COVID-19 crisis, based on which, it was agreed to reformulate US$15 million from the program 4618/GR-HA (see OEL#3, ¶2.4) and US$12 million from program 3383/GR-HA (see OEL#4, ¶2.6). An additional criterion was that the reformulation should not jeopardize achieving each program's general objective.

1.3. **Description of proposed change.** Table 1.1 summarizes the amount to be reoriented. The original expected outputs, proposed changes, their relation to the exercise mentioned in ¶1.2, as well as other derived alterations are presented in the following section and detailed in OEL#3 and OEL#4.

Table 1.1 Proposed amounts by program to be redirected to IPHR-HA (US$)

Name of Program	Agreement No.	Approved (original) Amount	Proposed Redirected amount
Transport and Departmental Connectivity Program	4618/GR-HA	283,180,000[1]	15,000,000
Sustainable Coastal Tourism Program	3383/GR-HA	36,000,000	12,000,000
Total			**27,000,000**

B. Program background, progress, and proposed changes for 4618/GR-HA and 3383/GR-HA.

1.4. The reformulation of both programs entails: (i) changes in program activities; (ii) changes in outcomes and outputs indicators in the Results Matrix; (iii) the addition of the Ministry of Public Health and Population (MSPP) as a new co-executing agency to execute the IPHR-HA; and (iv) new expected outputs and

[1] US$225 million are funded with resources from the IDB Grant Facility.

outcomes from the resources redirected to the IPHR-HA. Modifications (iii) and (iv) affect the Grant Agreement.

1.5. **Background and Progress of Transport and Departmental Connectivity Program - 4618/GR-HA.** The objective of this Multiple Works Program is to improve the quality, accessibility, and safety conditions of Haiti's transport infrastructure through an increase in paved road coverage and the rehabilitation and upgrading of transport infrastructure and departmental roads connecting production centers to local markets. The program also promotes efficiency improvements in the sector by incorporating the works into road maintenance management systems and by building capacity at the Ministry of Public Works, Transport and Communications (MTPTC).

1.6. The program has four components, yet only the first is affected by the reformulation. Component 1. National transport infrastructure interventions, finances: (i) rehabilitation and improvement of national road network segments; (ii) air transport infrastructure; (iii) social and environmental remediation and road safety measures; (iv) a maintenance contract program to be initiated with a pilot for national roads previously rehabilitated with IDB financing; and (v) supervision of civil works. The total budget for this component is US$150 million, US$144 million from IDB´s grant facility and US$6 million as local counterpart.

1.7. The Board of Executive Directors approved the program on September 18th, 2018 (Resolution DE-60/18) for US$283.18 million with four sources as shown in Table 1.2. It is executed by the MTPTC. It reached eligibility on December 3rd, 2019, and current disbursement expiration date is January 2024. To date, the program has disbursed US$2.5 million from the IDB grant. With six months of implementation MTPTC is focused on procurement with two contracts signed for a commitment of US$6.2 million and tenders underway that would commit an additional US$44.5 million.

Table 1.2 4618/GR-HA Program Financing (US$ Million)

Source	IDB (GRF) 4618/GR-HA	EIB Co-Financing	EU Co-Financing	Local Counterpart	Total
Amount	225.00	28.99	23.19	6.00	283.18

1.8. **Proposed changes.** To support the IPHR-HA, US$15 million of the IDBs grant and Component 1 will be used, representing 6.7% of the original budget from the IDB Grant Facility financing. The redirecting of these resources entails a marginal modification to the end of project goal of one output and is also justified given the low level of committed resources achieved. The sections to be funded as part of the road rehabilitation works originally included: (i) National Road (*Route Nationale*-RN) 5, from Pont Pendu to Port-de-Paix (31.6km); (ii) RN1, section 2B (6.2 km), between Ennery and Plaisance; and (iii) RN8 between Fond Parisien and Malpasse (7.5 km). The MTPTC prioritizes the sections located in the North– which presents lower road-coverage, limited access to basic services and higher poverty rate - and has therefore indicated that this program will no longer finance the rehabilitation of the RN8, estimated at US$15 million. Only output 1.3 "National

Road Build or Upgraded" will be modified, reducing its end of project target from 45.3 km down to 37.8 km. There is no change in the associated outcome (OEL#3).

1.9. Based on implementation progress and studies conducted so far, other adjustments to the results matrix are proposed to better reflect the updated multiple works program implementation planning. An additional outcome indicator (indicator # 6) "*Vehicle operation cost in road section Port-de-Paix – Anse-à-Foleur (RD-501)*" is proposed to enhance the program's vertical logic. Its baseline and target have been defined in the Cost-Benefit analysis performed in November 2019 as a prerequisite for eligibility of this work under this multi-work program.

1.10. **Background, progress of Sustainable Coastal Tourism Program - 3383/GR-HA.** This Specific Investment program was approved on December 11th, 2014 (Resolution DE-194/14), for US$36 million from the IDB Grant Facility, with the objective to increase tourism employment and income for the local population and low-income people on the South Coast. It has two components: (i) enhancement of the tourism product; and (ii) tourism governance and capacity building. It is co-executed by the Ministry of Economy and Finance (MEF) through its executing unit (UTE) - responsible for Component 1 and the audit-- and the Ministry of Tourism (MT)-executing Component 2 and the evaluation of the program.

1.11. Since its eligibility in 2015, program implementation has progressed slowly. Disbursements at the original Last Disbursement Date (LDD) of April 21st, 2020 amounted to US$12.2 million, 33.7% of the approved amount. Only about 20% of the undisbursed balance was committed. Three factors explain the delays: (i) difficulties in operationalizing the design; (ii) internal capacity constraints; and (iii) external shocks. Firstly, the initial aim under Component 1 was to enhance and restore numerous tourist sites in the South. However, feasibility studies were not available at program launch and required international procurement processes to mobilize locally unavailable expertise. To date, only works for one of four outputs are in progress. Secondly, the main difficulty is the lack of coordination between co-executors, and high staff turnover, and lack of program management experience of the MT. Thirdly, 2016 Hurricane Matthew, ongoing civil unrest and increased insecurity since 2018 affecting travelling on roads, have impeded the execution and supervision of activities and also stalled the growth of tourism in general.

1.12. The GoH and the IDB agreed on the priorities for each component defining a plan for the rest of the program, as reflected in the signed aide-memoire of August 2019 (OEL#5). The aide-memoire supports the extension of the program that would be presented in 2020 along with a partial cancellation of funds. The current LDD is April 20th, 2022 and in the context of the COVID-19 crisis it was agreed that the US$12 million that was to be cancelled should support the IPHR-HA.

1.13. **Proposed changes.** US$12 million would be reoriented towards the IPHR-HA, representing 33% of the Program's original budget. The reformulation will not modify the general objective of the program. Most products are maintained but a few are adjusted in scope. Those adjustments and mostly the drastic changes in the operational environment (security issues, COVID crisis), make it necessary to

modify the expected impact and outcomes indicators, also considering internal factors (execution capacities and achieved commitments and disbursements).

1.14. The US$12 million for IPHR-HA (that were to be cancelled) come from the following changes. In component 1: reduction in the number of attractions to be restored, considering studies and the lack of adequate access under the current conditions; and cancelation of an interactive information tool to be achieved through the second component, and of the Investment Plan for Côte de Fer, due to loss of relevance after several private investments were abandoned. In component 2, the strengthening of the local tourism committees will be cancelled for lack of viability in the current situation, and the information system will be achieved at a lower cost, reforming the current system in lieu of creating a new one, freeing resources up to increase the number of Small and Medium Enterprises to be supported (Table 3. of OEL#4).

1.15. **Environmental and social risks due to the reformulation.** Category "B" for both 4618/GR-HA and 3383/GR-HA is confirmed according to the environmental and social risk classification of Directive B.3 of Operational Policy OP-703. During the preparation of reformulation, the review of programs' documentation and consultation with the operations' safeguards specialists and team leaders, confirmed that the operations do not have any environmental or social liabilities. The safeguard supervisions of both operations made in September and December of 2019 showed satisfactory and partially satisfactory compliance (REL#2).

1.16. With regards to 4618/GR-HA, no new risk or liability has been identified due to reformulation considering that the road construction that will no longer be covered by this program was never publicly announced. For the same reason, no new risks or liability arise due to the reformulation of 3383/GR-HA as none of the eliminated outputs had been publicly consulted. However, the main risk identified in 2019 remains in the difficulty of carrying out the work due to the various crises limiting access to the construction sites, so that the agreement to reduce scope and extend the LDD remains valid (OEL#6).

1.17. **Implementing mechanisms and financial terms** and conditions remain unchanged for the original interventions and for both investment grants 4618/GR-HA and 3383/GR-HA; the MSPP will be added as a new co-executing agency to manage the US$27 million to be reoriented towards the IPHR-HA.

II. PROPOSED MODIFICATIONS AND RATIONALE

A. Background, problem to be addressed, and rationale for the use of resources to support the immediate health response

2.1 **Background**. On March 11th, 2020, the World Health Organization (WHO) declared the COVID-19 outbreak a pandemic. COVID-19 is a respiratory disease caused by the 2019 novel coronavirus. As of July 14th, more than 13.1 million cases were reported worldwide, resulting in 573,752 confirmed deaths.[2] The first

[2] WHO novel-coronavirus-2019 information site, accessed 07/15/2020.

cases in Latin America and the Caribbean (LAC) were reported in late February; since then their number has been rising fast, with 3,431,213 confirmed cases of COVID-19 and 146,831 deaths reported as of July 14th.[3] Haiti registered its first COVID-19 cases later than most LAC countries as the Haitian Ministry of Health and Population (MSPP) confirmed the first two cases on March 19th, 2020.[4] The presidency declared a state of emergency on that day,[5] named the COVID-19 Scientific Commission, comprising medical professionals, a week later and appointed the Multisector Commission for the Management of the COVID-19 Pandemic (CMGP) on April 6th, with the mandate of supporting the MSPP in the implementation of the health response.[6] As of July 14th, Haiti had 6,727 confirmed cases and 141 confirmed deaths. Community transmission was first reported on April 5th and is firmly established.[7]

2.2 **Macroeconomic and Social Context.** Haiti has registered a chronically low GDP growth over the last 20 years, averaging 1.2% per year. A series of fuel disruptions and repeated bouts of social unrest (such as the so called 2019 "Peyi Lock") resulted in a collapse of economic activities in FY2019, causing a GDP contraction of 1.8% according to the MEF. The IMF projects that COVID-19 — in addition to new episodes of social unrest at the beginning of the fiscal year — will result in a 4% contraction in FY2020. The main external factors that will affect economic growth are a decrease in remittances (which represent 35% of GDP), expected to contract by 23% in FY2020 and exports, expected to contract by 19%, notably due to a decrease in demand from the United States for textile products. This contraction of the economy will further reduce the fiscal space, expanding the fiscal deficit from -3.6% to -6.2% of GDP.

2.3 Haiti ranks 169th out of 189 countries in the 2019 United Nations Human Development Index. The Haitian population faces a series of structural socioeconomic vulnerabilities, including a national poverty rate of 59%, an extreme poverty rate of 24%[8] and a life expectancy of 63.7 years, compared to 76 years in LAC. Food security has also deteriorated: the National Coordination on Food Security, projected in October 2019 that, due to worsening economic conditions brought by the 2019 social unrest, the number of people facing acute food insecurity would increase from 3.7 to 4.1 million (40% of the population) between March and June 2020, including an estimated 1.2 million people at emergency levels.

2.4 **Health Sector and Policies.** The MSPP has developed policies largely aligned with best practice since the 2010 earthquake, however their implementation is limited, due to the lack of a stable public budget and challenges in coordinating a system highly dependent on many external actors. These policies emphasize

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3 PAHO consolidated table of COVID-19 cases in the Americas, accessed 07/15/2020.
4 DELR-MSPP Situation épidémiologique du COVID-19, accessed 05/24/2020.
5 Dispositions de l'arrêté déclarant l'état d'urgence , accessed 05/24/2020.
6 Jovenel Moïse crée une Commission multisectorielle de gestion du Covid-19, accessed 05/22/2020. The Commission's mandate was renewed on July 4th through October 4th.
7 MSPP, COVID-19 dashboard, accessed 07/15/2020 Bulletin de Surveillance du nouveau Coronavirus, 5 avril 2020.
8 United Nations Depelopment Programme, Haiti Country Profile. PAHO Health Information Platform accessed 06/17/2020.

community-based health to expand access, and establish an integrated network based on primary health care.[9] Service delivery is structured conforming micro-networks in the 42 Districts of the 10 Departments, and managed based on a deconcentrated, public health approach addressing health determinants at the local level through a dedicated structure consisting in the District Units for Health (UAS) under the Health Departmental Directorates (DDS). For community outreach the UAS deploy the Family Health Teams (ESF, one doctor and two nurses) to provide the first contact with the population. The ESF expand their reach by coordinating the work of the Multi-skilled Community Health Workers (ASCP), community resources formally hired and trained by MSPP to support health in their community.

2.5 The capacity to provide the basic hospital and specialized care that COVID-19 patients presenting moderate and severe symptoms require – typically, up to 20% of confirmed cases,[10] was already limited pre-crisis. The system's 1,033 health facilities are concentrated in low-resolution units; only 16% and 13% of facilities respectively are health centers with beds and hospitals.[11] In 2016, there were 23,344 health professionals with an uneven distribution across the country's departments, resulting in a density of health professionals well below recommended standards.[12] The availability of hospital beds pre-crisis was less than 7,600, with a density of 6.7 beds per 10,000 people[13], less than half that of the neighboring Dominican Republic-DR (16) and one third that of Panama (23). As for intensive care, only 124 beds were available according to a 2019 assessment, which also documented that the capacity to mechanically ventilate was limited to 62 possible patients, and that only one third of the staff treating critical patients was formally trained in intensive care.[14]

2.6 The system is fragmented, and service provision relies heavily on non-governmental support as 17% of facilities correspond to not-for-profit providers and 19% to mixed governmental-not-for-profit[15]. While some non-state actors have been present in Haiti for decades, others have entered following the 2010 earthquake. Partners in Health (PIH) has been active in Haiti since 1987 and operates a network of 12 facilities (hospitals and health centers) in the Plateau Central and lower Artibonite through its sister organization Zanmi Lasanté. The facilities are part of the public network, though PIH assumes all aspects of their operation (including funding) under a mixed status agreement. The low level of public health expenditures is a main factor underlying the country's low capacity of health care as per-capita, on-budget health expenditures (from Government and

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9 MSPP, Politique Nationale de Santé, 2012, Plan directeur de santé 2012-2022.
10 WHO Q&A on Coronaviruses (COVID-19).
11 MSPP, Institut Haitien de l'Enfance (IHE), ICF-International Health Service Provision Assessment II (EPSS-2017-18), 2019.
12 PAHO, Haiti Country Report, 2017. Accessed 05/25/2020.
13 WHO formerly recommended no less than 10 beds per 10,000 inhabitants.
14 Losonczy LI, Barnes SL, Liu S, Williams SR, *et al.* (2019) Critical care capacity in Haiti: A nationwide cross-sectional survey. PLoS ONE.
15 Ibid: MSPP, IHE, ICF 2019.

donor sources) was around US$32 in 2015, when the estimated cost of an essential package of services in Low Income Countries is US$86.[16]

2.7 **Problem to be addressed.** Community transmission is installed and producing a rapid increase in the number of COVID-19 cases. This is putting more pressure on the already limited capacity of the Haitian healthcare system, which will require significant, immediate external assistance. This includes setting up capacity to manage COVID-19 patients and to also maintain essential care to attend other pre-existing and on-going health needs. The April 2020 updated assessment by the WHO of countries preparedness to handle COVID-19[17], classifies Haiti on a 5-level scale (where 1=low and 5=high), as level 2 (low capacity), with gaps impacting the entire pandemic management cycle.

2.8 COVID-19 can spread from person to person through respiratory secretions[18] and direct contact, making social distancing and isolation essential measures of the public health response to reduce the number of healthy people whom a patient can infect (known as the reproduction number), to a value below 1. These measures slow the spread of COVID-19, to delay and minimize a sudden spike of cases that would overwhelm the healthcare system.[19,20,21,22]. Specialized care is necessary for coronavirus patients, hence complementary interventions to increase the capacity of the system to treat COVID-19 patients while maintaining basic healthcare services to vulnerable populations are indispensable.

2.9 Haiti has a very young population: only 6% is 65 years or older— an advantage since older age has been documented to put COVID-19 patients at greater risk of displaying more severe manifestations of the disease, including a higher lethality.[23] On the other hand, there is a high prevalence of underlying conditions, also known to significantly increase those same risks. Haiti has the highest incidence of tuberculosis in LAC;[24] in some marginal urban communities, hypertension has been documented to affect as much as 49% of women and 38% of men,[25] while 14% of women and 8% of men[26] in the 35-65 years age group are diabetic. Finally, crowded living conditions and persistent food insecurity affecting large portions of the population are further social determinants of poor health specifically relevant to assess the risk of transmission and lethality of the disease. In this

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16 World Bank, Better Spending for Better Care: a Look at Haiti's Health Financing, 2017

17 WHO Updated Country Preparedness and Response Status. Capacity was evaluated based on the International Health Regulations (IHR 2005).

18 WHO Q&A on Coronaviruses.

19 Hellewell, J., S. Abbott, A. Gimma, et al. Feasibility of controlling COVID-19 outbreaks by isolation of cases and contacts. Lancet 2020; 8(4): 488–496.

20 Day. T., A. Park, N. Madras, et al. When is quarantine a useful control strategy for emerging infectious diseases? American Journal of Epidemiology 2006; 163(5): 479–485.

21 Ferguson, N., D. Cummings, C. Fraser, et al. Strategies for mitigating an influenza pandemic. Nature 2006; 442: 448–452.

22 Dénes, A., A. Gumel. Modeling the impact of quarantine during an outbreak of Ebola virus disease. Infectious Disease Modelling 2019; 4:12–27.

23 i.e., the ratio of deaths to cases. WHO Who is at Risk of Developing Severe Disease?.

24 WHO COVID-19 Dashboard, accessed 05/22/2020.

25 Tymejczyk O, McNairy ML, Petion JS, et al.,Hypertension prevalence and risk factors among residents of four slum communities: population-representative findings from Port-au-Prince, Haiti, Journal of Hypertension Vol. 37 Issue 4, 2019.

26 MPSS, IHE 2019, Mortality, Morbidity and Use of Services Survey-2016-2017 EMMUS VI.

context, initial estimates for the number of deaths directly related to COVID-19 range between 5,700, with successful mitigating measures, and 200,000 with no intervention.[27]

2.10 **Challenges and progress.** Haiti faces multiple challenges in the implementation of an effective public health response to COVID-19.

2.11 **Balancing COVID and non-COVID interventions.** MSPP reports that the number of malaria cases and maternal deaths had already increased by 15% and 20% respectively in the first quarter of 2020 compared to the same period in 2019, likely due to the socio-economic context described above. The onset of community transmission and the restriction of movement under the state of emergency further reduce access to services, also because supply chains are disrupted. There is anecdotal evidence of lower demand for health services due to loss of income and to the perceived risk of contagion in health facilities. As a result, COVID-19 will also likely have an indirect effect on general mortality due to maternal mortality, vaccine-preventable diseases, malaria, HIV/AIDS, tuberculosis, and chronic diseases.[28] Using the predictive model Lives Saved Tool (LiST), researchers at the Global Funding Facility project a drop in coverage of 19% for oral antibiotics for pneumonia in children, 33% for diphtheria, pertussis and tetanus immunization, 19% in births attended in an institutional setting and 15% in the use of family planning services.[29] Infant mortality is expected to increase by 10% and maternal mortality by 15% due to those indirect effects of the pandemic in the next 12 months. The previous analysis advocates for including robust interventions aimed at sustaining coverage of essential services while also attending COVID-19 patients.

2.12 **Expanding capacity within a limited fiscal space**. Compounding low initial funding, the economic context is one of limited fiscal space. To mitigate this situation, as of May 29th, 2020, the MEF had disbursed approximately US$36 million for COVID-19 response to cover for health interventions and cash or in-kind transfers to the vulnerable population.[30] Moreover, the World Bank (WB) has approved a US$20 million COVID-19 operation to be executed by the MSPP. Contracting has started to support the purchase of personal protective equipment (PPE, such as masks, gloves, surgical gowns, etc.), specialized equipment and the implementation of communication and awareness campaigns (OEL#5). However, the resources mobilized so far remain insufficient to implement the National COVID-19 Response Plan, with an estimated cost of US$71 million. (OEL#7 and OEL#8), according to the July updated budget.

2.13 To expand the capacity to provide care, the GoH has mobilized the support of specialized agencies, such as the Panamerican Health Organization (PAHO) and not-for-profit organizations such as PIH. PAHO, the World Health Organization

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27 Pape JW, *Vision du Plan National de lutte contre l'épidémie COVID-19 en Haïti*, CMGP public presentation, April 2020.

28 Roberton, T et al., Early Estimates of the Indirect Effects of the Coronavirus Pandemic on Maternal and Child Mortality in Low- and Middle-Income Countries (The Lancet, pre-print version), Global Financing Facility - Haiti, Préserver les soins de santé essentiels pendant la pandémie de COVID-19, 2020.

29 Ibid. Global Financing Facility – Haiti 2020.

30 http://www.mef.gouv.ht/upload/doc/rapport-decaissements-covid19-29-mai-2020.pdf, accessed 06/03/2020.

regional office for the Americas, is providing technical assistance in planning and implementing the response. With financing from the WB, it has deployed a large-scale training program to build capacity in managing COVID-19 cases. PAHO is maintaining its pre-crisis support to the continuity of essential services at the local level, bolstering the community health model and integrated health network described in ¶2.4. Meanwhile PIH activated the first facility to treat COVID-19 patients in late March at the Mirebalais Hospital, and, in coordination with the MSPP, has added three COVID-19 sites in separated wards of other facilities including the Hospitals in Belladere, at the border with the DR. Finally, the United Nations Office of Project Services (UNOPS) is also supporting MSPP through the WB operation with the procurement of equipment for COVID-19 sites. Funding from this operation will enable PIH, PAHO and UNOPS to expand their support (OEL#5).

2.14 **Overcoming the shortage of specialized services and risks of invasive ventilation in a low capacity setting.** The shortage of professionals trained to provide specialized, especially intensive care, increases the inherent risks of such care. On the one hand, to mitigate the general shortage of staff, the MSPP appealed to healthcare and non-healthcare personnel outside of the system and willing to join the COVID-19 response, to apply to new positions.[31] On the other hand, with available resources geared towards basic, not specialized care, the CMGP has proposed to focus on minimizing the need and use of intensive care. The National Plan prioritizes: (i) informing and educating the population about COVID-19 and the importance of preventing transmission and take early measures; (ii) attracting and retaining healthcare personnel by improving work conditions with hazard pay, food, and the provision of PPE, etc.; and (iii) offering early, systematic non-invasive oxygenation, along with detection and treatment of co-morbidities, as the case management strategy.

2.15 **Enhancing surveillance in a highly mobile population**. While the measures to reduce contagion include suspension of all flights and closing the border with the DR, there may exist up to 200 informal border crossings used to travel to and from the neighboring country for formal and informal work and trade, severely limiting the capacity to implement border surveillance and identify and isolate suspected cases. The International Organization of Migration (IOM) reports that more than 30,000 Haitians have returned to Haiti since March 29th across the four official border checkpoints and another 46 unofficial crossings and expects the flow to continue. The proposed intervention will reinforce border surveillance, case investigation, quarantine, and isolation activities, and address the health needs of people re-entering Haiti (¶2.30).

2.16 **Fostering acceptance of public health measures including social distancing when livelihood depends on close contacts**. To contain transmission the President first decreed a series of measures such as border closure, movement restrictions and curfew, closure of schools and factories and the prohibition of groups of more than 10 people; the use of face masks is now mandatory in public.

[31] MSPP, Registre d'inscription pour la lutte contre Covid-19, accessed 06/03/2020.

However, 74% of the population lives in slums[32] and 88% of the non-agricultural employment in Haiti is informal, in occupations that rely on social interactions for day-to-day income. Enforcing physical distance is a challenge and, as during past cholera outbreaks, social peace may deteriorate with violent episodes towards healthcare centers and people suspected of being infected, as well as further Gender Based Violence (GBV). The MSPP, in cooperation with Civil Protection, has launched a nationwide campaign which contemplates public health as well as violence prevention messages, crucial for the viability of most other interventions. It uses a large body public messages previously developed with stakeholders to ensure cultural pertinence and effectiveness and incorporates specific information on COVID-19.

2.17 **Rationale.** As the number of cases of COVID-19 increases, Haiti will need more investments to close gaps in the response capacity. WHO has prepared guidelines for drafting a COVID-19 Strategic Preparedness and Response Plan (SPRP),[33] which consist of eight pillars: (i) coordination, planning, and monitoring; (ii) risk communication and community engagement; (iii) surveillance, rapid-response teams, and case investigation; (iv) points of entry; (v) national laboratories; (vi) infection prevention and control; (vii) case management; and (viii) operational support and logistics. There is evidence of the effectiveness of the proposed interventions (OEL#12). PAHO has been supporting the MSPP and the CMGP in developing Haiti's SPRP (OEL#8).[34] This evolving plan is aligned with WHO guidelines.

2.18 **Bank's experience and lessons learned.** In line with the WHO Guidelines, the main lessons learned from the IDB 2011 operations, 2503/GR-HA and GRT/WS-12619-HA, to contain the Cholera epidemic, are that: (i) MSPP needs strengthening to manage and centrally coordinate the multifaceted response to an epidemic; and (ii) it is necessary to rapidly and comprehensively expand the capacity in all areas of the response: first and foremost, communication of risks and for behavior change; then deployment of sites for quarantine, isolation and case management-through temporary structures attached to existing facilities; hiring of incremental personnel, training, supplies, and mechanisms to ensure logistics; transportation of patients; activities related to biosecurity and the general administration of the response. Both lessons have been incorporated in this operation with the support in Component 1 to the operation of the COVID-19 situation room, and through the integrated design of the program. With limited financial resources, support aims to cover prioritized territories and facilities with all the components. Prioritizing facilities will ensure effective care by documenting that inputs are integrated into actual services; it also provides a practical criterion for coordinating with other donors' support. Finally, in order to rapidly deploy services, most of the interventions will be consolidated under just three contracts with a not-for-profit (PIH) and two specialized agencies (PAHO and UNOPS) that offer extensive health emergency-response capacity, and will act as implementing partners, as they would be contracted to assume much of the coordinating,

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32 World Bank, World Data, accessed 06/03/2020 and IHSI, Rapport Provisoire de l'Enquête sur les Conditions de Vie des Ménages Après le Séisme (ECVMAS), 2014.

33 WHO, COVID-19 SPRP, OPERATIONAL PLANNING GUIDELINES, accessed 04/13/2020.

34 MSPP, *Plan de Préparation et de Réponse du MSPP au Coronavirus, mars 2020*.

operational and logistics responsibilities, as well as technical ones (see ¶2.19, ¶2.25, ¶2.33, y ¶2.35).

2.19 **Coordination with other multilateral and/or donor agencies.** The CMGP, which is co-chaired by the MSPP's General Director, has constituted a Crisis Room, staffed mostly by MSPP personnel, as the main coordinating mechanism for the multiple actors willing to contribute to the national plan, and has proposed simplified formats to share plans and progress reports on a monthly and quarterly basis, informing specific contributions to the National Plan. The IDB has been in close communication with the CMGP, WB, PAHO, UNOPS, and other UN agencies, directly or through PAHO, to ensure that this IPHR-HA operation complements other donor resources to maximize support to the national plan. So far only the WB operation has been approved. In coordination with the MSPP, the IDB and WB teams are documenting the complementarity of their funding as reflected in OEL#5. MSPP is the executing agency (EA) of both operations. The implementation partners it is expected to contract using either bank's financing, will include in their progress reports the final destination of all goods and services financed— e.g., the health facility where incremental personnel is assigned or where a shipment of PPE is delivered, as well as the information requested by the CMGP. (¶2.53).

2.20 **Bank's response**. The Bank is supporting the GoH response to Covid-19 with its current and new portfolio. Approximately US$10 million have been redirected for specific support, mostly from the Water and Sanitation, Social Protection, Education and Tourism sectors. In addition, HA-L1145 was approved (under Grant Agreement 5068/GR-HA) for US$60 million to contribute to ensuring minimum levels of quality of life for vulnerable persons amid the crisis caused by COVID-19. See OEL#2 for an overview of all IDB-funded support to Haiti's COVID-19 response.

2.21 **Strategic alignment.** The operation is consistent with the Second Update to the Institutional Strategy (AB-3190-2) and aligned with the Social Inclusion and Equality development challenge by focusing on strengthening health care service delivery to suspected or confirmed COVID-19 patients and ensuring the provision of other essential health services for priority health groups. The intervention is also aligned with the crosscutting areas of Gender Equality and Diversity, by developing social marketing campaigns and disseminating protocols to care for GBV in health facilities. In addition, the program will contribute to the Corporate Results Framework 2020-2023 (GN-2727-12) through the indicator on beneficiaries receiving health services. Furthermore, it is consistent with the Health and Nutrition Sector Framework Document (GN-2735-7) by: (i) strengthening communication to foster behavioral change; (ii) strengthening service delivery, including providing the necessary medical equipment and supplies and training health care providers; and (iii) strengthening cross-sector coordination to achieve the expected outcomes. This program is consistent with the Proposal for the IDB Group's Governance Response to the COVID-19 Pandemic Outbreak (document GN-2996).

B. Objectives and components

2.22 **Objectives.** The overall objective of the program is to contribute to the reduction of mortality and morbidity from COVID-19 and to mitigate the indirect impacts of the pandemic on health. There are four specific objectives: (i) strengthen the response coordination at the country level; (ii) improve detection and monitoring of cases; (iii) support efforts to interrupt the chain of transmission of the disease; and (iv) improve the capacity of provision of care. The OEL#5 presents the breakdown of outputs by implementation partner, geographic area, and the complementarity with other donors' support. The operation is structured along four components.

2.23 **Component 1. Response leadership at the country level (US$675,000).** This component will fund activities for the Ministry of Public Health and Population (MSPP) for the implementation of cross-sector emergency management mechanisms, including: (i) strengthening and operating mechanisms established by the CMGP such as the Crisis Room; (ii) establishing and deploying information sharing mechanisms for management of the epidemic- including reporting mechanisms from the ground up- with differentiated approaches for urban, slum, rural and border areas; and (iii) detailing and periodically updating specific plans under the national SPRP: plans to expand and deploy the capacity to implement the activities of Components 2, 3 and 4, detailing environmental and social management measures. PAHO and UNOPS will provide technical assistance under this component, related to epidemiological and clinical information management (PAHO), and to the specific plans to deploy the capacity for COVID-19 case management (UNOPS).

2.24 **Component 2. Case detection and monitoring (US$1,596,600).**

2.25 **Subcomponent 2.1. Surveillance, rapid-response teams, and case investigation. (US$660,000)** This subcomponent will finance: (i) deploying a rapid response to seek and early-detect cases (including diagnostic testing), to support and follow up on patients in isolation, tracing and follow up of contacts; and (ii) producing studies and other analysis at the national level to monitor the dissemination of the virus, transmission intensity, illness trends, virologic characteristics, and assess the impact on healthcare system capacity. Surveillance and detection will be organized under the MSPP community-health model, mobilizing, training and giving technical assistance to the ASCP and ESF in rural, slum and border areas involving both already active and additional staff.[35] That personnel will be trained to communicate expected symptoms, screen for suspected cases, promote testing, collect samples, and disseminate and monitor measures for quarantine and isolation, expecting to cover the catchment area of 169 primary care facilities in the prioritized areas. Two implementation partners will support MSPP under this subcomponent, PAHO and PIH. The distribution of responsibilities between them is indicated on map 2.1, and applies to all their interventions under components 2, 3 and 4. All materials required at the

[35] IDB Funding for personnel will be eligible for: the full cost associated with new (incremental), temporary positions, and the supplemental portion of cost for pre-existing positions consisting in hazard pay, insurance, or mobilization costs.

operational level will be available in French and Creole. Personnel costs[36], training and operational support such as per diems for personnel travel, may be financed under all components.

2.26 **Subcomponent 2.2. Laboratory network. (US$936,600).** This subcomponent will support expanding diagnostic capacity, procuring the equipment, staff training, test kits and all other inputs necessary for three regional labs to be able to perform polymerase chain reaction (PCR) testing. WB funding covers further equipment, staff training and strengthening of the National MSPP Laboratory. The availability of inputs for diagnostic testing will be covered, and also expenses for the recollection and treatment of tests by the implementing partners (¶2.25) in the prioritized departments including border points of entry (¶2.30). Finally, the operation will support, through PAHO, the expansion and operation of the info line (call center) put in place by the MSPP to assist the public, help locate suspected cases and dispatch personnel for testing.

2.27 **Component 3. Interruption of the chain of transmission (US$3,048,118).** This component will finance interventions to contain transmission through three subcomponents.

2.28 **Subcomponent 3.1. Communication with the public. (US$330,000)** This subcomponent will finance the implementation in the prioritized territories of the communication strategy contemplated in the national plan. It will disseminate knowledge, and raise public awareness about COVID-19, and includes violence prevention such as avoiding patient stigmatization as well as GBV. The strategy also aims at disseminating actions taken and available services and explain prevention and treatment measures. New messages will be validated with stakeholders from different priority groups, to ensure cultural pertinence and effectiveness. The resources of this subcomponent channeled through PAHO and PIH will emphasize communication activities at the local level (namely, the quarantine and treatment sites) - using a variety of media channels (radio, TV, on-line and printed media), and will complement nation-wide activities and in other territories prioritized under the WB funded operation.

2.29 **Subcomponent 3.2. Protocols. (US$1,897,970)** This subcomponent will finance support to MSPP by PAHO in the preparation, updating and dissemination of health care guidelines that aim at decreasing and interrupting the COVID-19 chain of transmission, based on existing MSPP and WHO/PAHO guidelines and will take into account the context of different priority groups: migrants, slum dwellers, rural population, among others, to tailor measures to those contexts and validate them with stakeholders whenever feasible.

2.30 **Subcomponent 3.3. Points of entry. (US$820,148)** This subcomponent is critical under Haiti ‘s SPRP given the flow of returning migrants at the Dominican border. The official border points of *Ouanaminthes* (Northeast), *Belladère* (Center), and *Anse-à-Pitres* (Southeast), will be covered, organizing activities to inform travelers about COVID-19 and its symptoms, preventive measures, and how and where to seek medical care; to separate and screen travelers, detect COVID-19 cases and

[36] Idem 35.

provide isolation, treatment, to organize quarantine in the border areas and nearby *communes*. This includes sample collection and transportation of lab tests, the safe transportation of patients and close contacts to designated isolation or health care centers, hygiene kits and food packages to foster adherence by quarantined and isolated patients and all other necessary support services. Activities will entail setting up or expanding and adapting existing health facilities at the border or in nearby sites, including interventions such as electricity provision and the installation of temporary structures adjacent to those facilities. PIH will cover all aspects of the intervention for the *Belladère* point and surrounding area in the Center department, while, for the *Ouanaminthes* and *Anse-à-Pitres* areas, UNOPS will procure and install the equipment needed, distribute oxygen; and manage payroll;[37] while PAHO will assume all clinical and other operational aspects of the intervention.

2.31 **Component 4. Improvement of the capacity for service delivery (US$20,629,058).** This component will support the provision of care, in priority departments for COVID-19 patients and to ensure the continuity of essential health care services during the emergency.

2.32 **Subcomponent 4.1. Delivery of health care for COVID-19 patients. (US$14,327,543)** For the provision of care to COVID-19 patients, financing will cover expenses to: outfit physical spaces, procure and install diagnostic and treatment equipment; hire incremental staff and/or offer economic incentives of hazard pay and insurance to current staff; adjust protocols if needed and train personnel in their implementation; procure all necessary inputs; and cover logistics expenses such as transportation of patients, personnel and supplies. Existing facilities in the prioritized departments have been identified by the MSPP and will undergo minor and temporary refurbishments to expand their capacity and organize separate flows for potentially infectious patients, including for triage and isolation. The outfitting may include the installation of a power source, temporary and modular structures that can be rapidly erected and removed, and the installation of equipment for the proper on-site handling of solid and liquid biological waste.

2.33 The distribution of responsibilities between implementation partners follows technical and geographic criteria (Map 2.1). MSPP will supervise directly the four facilites of the West Department, with adminitrative support from UNOPS; UNOPS and PAHO will intervene covering public facilities in the South-East, North and North-East Departments, while the third partner, PIH, will cover public facilities in the Departments of Artibonite and Center. The technical breakdown between the two UN agencies for this subcomponent is as follows: (i) UNOPS will procure and install the equipment needed (i.e., hospital beds and equipment for noninvasive oxygenation therapy); the distribution of oxygen; and will manage payroll;[38] while (ii) PAHO will assume all clinical and other operational aspects of the intervention: staff training and clinical supervision, the procurement and distribution of medical supplies including PPE and medicines; and (iii) PIH will implement the entire intervention cycle in its geographic area of responsibility, from outfitting facilities to

[37] Idem 35.
[38] Idem 35.

personnel training and patient care. Finally, and with a nationwide scope, UNOPS will strengthen the National Ambulance Center (CAN) with logistics support and will manage staff supplemental remuneration (previously existing posts) for this entity.

2.34 **Subcomponent 4.2. Continuity of essential care. (US$5,552,515)** This subcomponent will finance interventions to ensure the continuity of essential care to susceptible populations: (i) delivery of modern family planning methods to women of child-bearing age (or their partner); (ii) ante-natal care and institutional birth care; (iii) nutrition, growth and development monitoring for children under five; (iv) vaccine compliance under the expanded immunization program for the same group; (v) follow up on hypertensive and diabetic patients including the provision of treatment; (vi) as well as for TB patients and people living with HIV; and finally the (vii) detection, diagnosis and treatment of malaria patients. Eligible expenses will include all needed supplies- medical and nonmedical, operational costs for supply logistics and patients' transportation, and basic and portable equipment to organize care in health facilities, in community settings and through mobile teams. The same concepts of costs related to personnel will apply, covering the full cost of incremental staff as needed to ensure continuity, and over-cost for pre-existing staff.

2.35 Implementation partners will follow the same breakdown of responsibility indicated for subcomponent 4.1. The work of PAHO and PIH under this subcomponent is an expansion of the support they have been providing to MSPP to implement the community-based essential and integrated care model. Hence, care will rely on and expand the existing network of primary care staff and community health workers, under the organization of the health services network coordinated by the DDS.

2.36 **Subcomponent 4.3. Portable/temporary solutions for water supply, waste management, and operation of basic sanitation services. (US$749,000).** This subcomponent will finance interventions to support the temporary supply of water, the procurement, transportation, and delivery of portable solutions, in line with recommended hygiene measures and handwashing. It will also finance waste management and sanitation activities: (i) supporting operations and maintenance to finance operating expenses (personnel and equipment), waste collection and disposal systems or services (trucks and containers), and site development for final waste disposal; (ii) managing waste in health facilities, for instance, by procuring and operating hospital and health facility waste sterilizers or compactors; (iii) implementing emergency plans during the upcoming months to address the increase in conventional solid waste to collect from households and hospitals and cleaning of container systems. This subcomponent will also reinforce bodies disposal intervention including, if need be, alternatives such as mass graves and crematoriums. The activities of this subcomponent will be implemented by UNOPS in four departments as indicated on Map 2.1, where it will coordinate with the MSPP, local authorities and PAHO to strengthen local capacity for medical waste collection, management, and disposal. PIH will assume the management of medical waste in the sites it helps operate. Finally, UNOPS will coordinate all aspects related to proper and culturally accepted body disposal, in all six priority

departments, considering the MSPP protocols being developed with support from specialized agencies and civil society.

2.37 **Administration (US$1,049,824).** This budget category will finance staff and operating expenses (e.g. staff per diem) to strengthen three MSPP Directions indicated in ¶2.46 and ¶2.52 in order fulfill their coordinating (Investigation and Programing Unit - UEP), operational and fiduciary role (Project Management Unit - UGP and Contract Unit - UC) within the MSPP. It will also cover operational costs for the implementation partners[39], the financial audits, evaluations and contingencies.

Map 2.1 Prioritized departments and Implementing partner breakdown for IPHR-HA

2.38 **Prioritization.** The interventions described in Components 2 to 4 will prioritize the departments shown on map 2.1, including all along the Haitian-Dominican border (including South-East), the West and North which comprise the two main urban areas of Haiti estimated to account, jointly, for approximately 3 million people--high density areas are particularly exposed to the risk of higher transmission; and finally, the Artibonite and Centre departments, which have the better developed network of health facilities around the public University Hospital of Mirebalais, on which to anchor the expansion of the country's case management capacity. This prioritization will help ensure the complementarity of funding for the COVID-19 response, as reflected in OEL#5.

2.39 **Beneficiaries.** The program will benefit the population of Haiti through prevention actions that will be communicated at large, particularly the population of the prioritized departments with approximately 80% of the total population or about

[39] Although contracts are not finalized, the implementing partners would also charge an overhead fee of no more than 7% which has been prorated in the estimated costs of their interventions in components 1 through 4.

8,990,920 people. It will benefit specifically people suspected of having COVID-19 and those diagnosed and needing care. An additional 775,000 women of child-bearing age, 370,000 children under five years, close to 50,000 chronic patients, and 3,500 TB patients in the targeted area[40] are expected to benefit from the interventions to sustain essential health services.

C. Key results indicators

2.40 **Expected outcomes.** The main outcomes will be to increase the percentage of laboratories with capacity to diagnose COVID-19, percentage of points of entry with epidemiological surveillance based on national standards, percentage of health facilities able to do triage, and the percentage of people with confirmed cases receiving treatment based on national protocols.

2.41 **Economic viability.** A cost-benefit analysis was prepared for the measures recommended under WHO guidelines. It considered their impact on COVID-19 mortality and morbidity rates under a treatment scenario (implementing the measures), versus a counterfactual scenario with no countermeasures. Scenarios were simulated using a basic SIR model (Susceptible - Infectious - Recovered), with evidence-based, conservative parameters and assumptions available in published articles on COVID-19 or similar epidemics. The costs associated with the interventions are those estimated by WHO in its COVID-19 SPRP. Under the base case scenario for treatment, the cost-benefit analysis showed positive Net Present Value reaching US$16.9 million and a benefit-cost ratio of 1.68, suggesting that the proposed series of interventions are economically beneficial. Based on the analysis, the earlier the reproduction number is reduced, the higher the benefit-cost ratio— because the costs of containing the outbreak are higher over time if transmission continues and the benefits in terms of lives and worktime saved are lower (OEL#11).

D. Costs

2.42 IPHR-HA program cost amounts to US$27 million, from the IDB Grant Facility reoriented from 4618/GR-HA (US$15 million) and 3383/GR-HA (US$12 million).

Table 2.1. Estimated program costs (US$)

Components	IDB Total	%
Component 1. Response leadership at the country level	**675,000**	**2.51**
Component 2. Case detection and monitoring	**1,596,600**	**5.91**
Subcomponent 2.1. Surveillance, rapid-response teams, and case investigation	660,000	2.44
Subcomponent 2.2. Laboratory network	936,600	3.47
Component 3. Interruption of the chain of transmission	**3,048,118**	**11.29**
Subcomponent 3.1. Communication with the public	330,000	1.22
Subcomponent 3.2. Protocols	1,897,970	7.03
Subcomponent 3.3. Points of entry	820,148	3.04

[40] Estimates: PAHO, Haiti Office, Project Proposal to support MSPP and CMGP in the fight against the COVID-19 pandemic, May 2020.

Components	IDB Total	%
Component 4. Improvement of the capacity for service delivery	**20,629,058**	**76.40**
Subcomponent 4.1. Delivery of health care for COVID-19 patients	14,327,543	53.06
Subcomponent 4.2. Continuity of essential care	5,552,515	20.56
Subcomponent 4.3. Portable/temporary solutions for water supply, waste management, and operation of basic sanitation services	749,000	2.77
Administration	**1,049,824**	**3.89**
Total US$	**27,000,000**	**100.00**

2.43 It is expected that the resources of this program will be disbursed in a period of 12 months, with an additional three months for audit and financial closure. Disbursements are likely to be agile since a significant portion of funding is channeled through the implementing partners and up to one fifth would cover reimbursement of incurred expenses.

Table 2.2. Projected disbursements (US$ million)

	2020	2021	Total
IDB - GRF	19.50	7.50	**27.00**
%	72.22	27.78	**100.00**

E. Environmental and Social Risks

2.44 The activities financed by IPHR-HA will generate minimal negative environmental and social impacts, classifying as “C”. Therefore, it is not necessary to conduct an environmental and social assessment. These risks and impacts are associated with medical and laboratory waste management, low scale temporary housing operation, COVID-19 corpse management, communication with the population of the communities, the disaster risks due to Haiti’s geographic location, and contamination risk due to health personnel being exposed to COVID-19 patients (see ¶1.15 and REL#2).

2.45 As good practice, an Environmental and Social Management Plan (ESMP) is being prepared to include sub-plans to mitigate each type of impact mentioned above: (i) medical waste management plan, especially those resulting from the care of patients from COVID-19 and laboratories - including measures from generation, transportation, temporary storage, and final disposal, consistent with the Guidelines of the WHO for this type of waste; (ii) COVID-19 corpse management; (iii) communication plan; (iv) Occupational health and safety Plan, including safety protocols for medical personnel exposed to COVID-19 patients (aligned to those of the WHO); and (v) emergency response plan, specifically to threats in Haiti (flood, earthquakes, and hurricanes). Likewise, as good practice, the ESMP will be published on the IDB Website before the program is submitted to the Board of Executive Directors.

F. Fiduciary risk

2.46 The risk has been identified as high. The Project Management Unit (UGP) of MSPP, as the executing agency (EA) of recent WB programs (¶2.52), has experienced delays in preparing financial reports and presenting justification of funds for that donor, and limitations in inventory management, all due to increased workload, weak institutional and coordination capacity across different technical and administrative units of the MSPP, combined with high program's flow of funds and the country context. To mitigate these risks, the implementation scheme consolidates operational and technical responsibilities under three main implementation partners: PAHO, PIH and UNOPS, taking advantage of their existing capacity and experience in the field. This will contain the volume of transactions for MSPP to a manageable level (see ¶2.58). Moreover, financial management and procurement will be strengthened by recruiting: (i) a financial specialist for the daily recording of transactions, compilation of financial reports and submission of disbursement requests; (ii) two financial controllers to support the EA with the preparation of justification reports and the review of supporting documents; and (iii) an inventory manager to document the distribution of equipment. Ongoing financial management support will be provided by the project team to UGP-MPSS and other units of MSPP as indicated below (¶2.52) in the rendering of accounts, including specific training and supervision on technical, implementation and coordination issues, specifically aligning reporting requirements to document the final destination of goods and services by health facilities across funding sources and sharing progress reports on both operations with the two banks' teams. Finally, given the need to coordinate between multiple actors, the IDB will facilitate bi-monthly meetings with the MSPP and implementing partners to document progress, identify potential bottlenecks and their resolution.

G. Other key risks and issues

2.47 **Development risks.** Three development risks were identified and classified as high. Firstly, high worldwide demand has created shortages and price increases for key items needed to respond to the pandemic (e.g. PPE, equipment for oxygenation therapy, diagnostic kits), and second, border closings and disruption of global air transportation, could both impact delivery times and costs of supplies to be procured under the program. For mitigation, the threshold for direct contracting was raised to accelerate processes. Moreover, procurement of supplies and equipment is included and channeled through the three implementation partners who are coordinating and consolidating procurement with other sources of funding, have well established networks of suppliers and initiated procurement early in the crisis. They will have access to the consolidated list of available suppliers, with a special focus on domestic suppliers and/or those located in LAC consolidated by the Bank in collaboration with PAHO and the WB (OEL#9 and OEL#10), and to the Global Pandemic Supply Chain Network for the World Economic Forum, through its COVID Action Platform.

2.48 Thirdly, the surge in patients needing care and high contagion among front-line staff at hospitals could produce shortages of health care providers. To mitigate this

risk, the MSPP has called on unemployed and retired professionals to apply for positions through temporary contracting, and is offering hazard pay and health and life insurance coverage to all personnel in health care facilities to incentivize stability; those measures are supported under this operation.

2.49 **Sustainability.** The operation supports the response to an unprecedented crisis which warrants using mechanisms guaranteeing fast implementation, be it through non-institutional channels. It is not equipped to address key factors of sustainability, such as ensuring a more stable national budget allocation towards health. However, key aspects of the IPHR-HA will leave a better capacity to respond to future health crisis, as intended under the WHO's COVID-19 SPRP guidelines: such as the strengthening of coordination mechanisms and surveillance, training in infection prevention and control, and basic public health promotion, all relevant beyond the context of the pandemic. The implementation partners all have explicit deliverables aiming at transferring capacity to MSPP, at the central and local levels (technical assistance to DDS in key management aspects as supply logistics and clinical management). Finally, the community-based and integrated network approach for the deployment of both COVID-19 and essential health services by MSPP, PAHO and PIH in this IPHR-HA proposal are likely to help establishing a local base for improving access to health care in the future.

H. Summary of implementation arrangements

2.50 **Beneficiary and executing agency.** The beneficiary is the Republic of Haiti and the EA of the IPHR-HA is the MSPP (see ¶2.46). As indicated above (¶2.18), technical, clinical as well as ample operational responsibilities are expected to be undertaken by three implementing partners that MSPP will directly hire - and for which contract development is well underway based on proposals received by each partner(¶2.57).

2.51 For subcomponents 4.1, and 4.2, PIH and PAHO will receive a portion of their payment corresponding to the variable cost of attention[41] based on meeting specific thresholds in terms of number of patients and rate of occupancy. To that effect, both implementing partners will record care as per MSPP norms and standards, allowing to account for the cost of care, as a fiduciary matter (¶2.59), and to ensure that the record of service provision informs health management, through the determination of coverage achieved and other key indicators. This will also be part of the final evaluation of the IPHR-HA program.

2.52 **Execution and administration.** The UEP, MSPP's planning directorate, will coordinate implementation with support from the UC to carry out the processes included in the Procurement Plan (PP, REL#3) approved by the Bank, and from the UGP (dedicated to managing donors funding) for financial processes. The UEP will be responsible for the timely presentation of specific operations plan- per Bank request- and the quarterly progress reports, coordinating with other substantive areas through the Crisis Room created by the CMGP, as those MSPP areas are staffing this mechanism. The Operation Manual (see draft under OEL#15) will set

[41] Medical supplies for diagnostic testing, treatment, and preventive acts that vary by volume of patients attended.

the norms and guidelines for execution in technical and fiduciary terms. UEP, UGP and UC are part of the General Director's office, who co-chairs the CMGP and has the mandate to engage with the DDS, (¶2.4), and experience interacting with the implementing partners.

2.53 **Interagency coordination.** The design of this IPHR-HA has been coordinated with the main donors and stakeholders including PAHO and the WB and will be on-going as implementing partners with funding from this and the WB's operation will share their progress reports with both agencies to ensure the optimal use of resources (OEL#5).

2.54 **Special contractual conditions prior to the first disbursement of the grant proceeds: The EA will provide evidence to the satisfaction of the Bank of: (i) the entry into force of the project's operation manual under the terms previously agreed upon with the Bank, which will include a prioritized list of COVID-19 sites and other health facilities eligible to be supported by the project[42] and the environment and social requirements of Annex B of the ESMR (REL#2, see Section C); (ii) the signing of the contracts for services with the project's implementing partners under the terms previously agreed upon with the Bank; and (iii) its hiring or assignment of a financial specialist, two financial controllers and an inventory manager for the execution of the project.** This will ensure that the basic conditions for fast and transparent implementation are met when the Bank disburses resources.

2.55 **Procurement** financed in whole or in part with proceeds from the Bank financing will abide by the Policies for the Procurement of Works and Goods Financed by the IDB (document GN-2349-15) and the Policies for the Selection and Contracting of Consultants Financed by the IDB (GN-2350-15). REL#3 details the procurement plan.

2.56 **Special and temporary procurement measures** approved by the Board of Executive Directors and established in document GN-2996, ¶2, and Resolution DE-28/20, ¶2 may apply to the Bank's procurement policies as indicated in Annex III.

2.57 **Single Source Selection**. The program will single source the following contracts: PIH (US$11 million), PAHO (US$7 million) and UNOPS (US$5.9 million), as implementation partners. The direct contract of these services is allowed under ¶3.7 (e) of GN-2349-15, "in response to emergency situations", considering as well the qualifications of all three partners as indicated in ¶2.13, including their extensive local capacity and emergency-support experience (see Annex III).

2.58 **Disbursements** will be made through advances of funds to MSPP based on liquidity needs for the portion of resources under direct MSPP execution (4%), while implementing partners will receive direct payments made by the Bank at the request of the MSPP, based on the terms of payment, deliverables and other conditions defined in the respective contracts (representing 96% of total budget).

[42] This list may be adjusted to respond to changing needs as the epidemic evolves, modifications will have to be requested and justified by MSPP and approved by the Bank.

Supporting justification will be provided pursuant to the Financial Management Guidelines for IDB-financed Projects (OP-273-12). They will be determined based on payment needs, following the same guidelines and the Fiduciary Arrangements and Requirements (Annex III). Expenses incurred by the Beneficiary between March 19th, 2020 and the date of approval of IPHR-HA may be reimbursed up to the equivalent of US$6.32 million (or 23.4%), provided that requirements substantially similar to those established in the grant agreement are met. The expenses would be related to the early purchase of equipment, supplies and other related expenses to activate COVID-19 sites identified by MSPP and included in the initial prioritization of this operation, as described in subcomponents 2.1, 2.2, 3.2, 3.3 and 4.1, for up to US$2 million. Another US$4.32 million also may be included the cover an initial payment by the Beneficiary to the three implementation partners to accelerate the execution of their respective work.

2.59 **Audit.** A single financial audit covering all reformulated components will be required, within 120 days of the date of last disbursement of the resources executed under IPHR-HA, and will include a technical component to establish reasonable assurance that the reported volumes of attention are accurate and that care was given adhering to clinical protocols, by reviewing a sample of patient records at the six months mark and at the end of the program. The audit will be conducted by a Bank-eligible independent audit firm. Its scope and related considerations will be governed by the Financial Management Guidelines (document OP-273-12) and the Guide for Financial Reports and Management of External Audit, see also ¶2.51 and ¶2.54. Audit costs will be financed with program resources.

I. Summary of arrangements for monitoring results

2.60 **Monitoring.** The executing agency will be responsible for implementing the Monitoring and Evaluation Plan (REL#1). The main monitoring tools for this program will be the results matrix and the PP. The main sources for monitoring impact, outcome, and output indicators will be MSPP's reports on service delivery (supported by the implementing partners) and epidemiological reports. MSPP will prepare an annual execution plan once the emergency situation has stabilized. The main reporting tool will be the Progress Monitoring Report (PMR), which will use the program's most recent quarterly report as its source of information.

2.61 **Evaluation.** The evaluation of the IPHR-HA will assess its contribution to the specific objectives to: (i) strengthen the leadership of the response; (ii) improve detection and monitoring of cases; (iii) support efforts to interrupt the chain of transmission of the disease; and (iv) improve the capacity of provision of care, using the information on outcome indicators outlined (¶2.40). To that end, a "before and after" analysis will be conducted using information from available time series on outcome indicators. To attribute the observed results to the intervention, the quantitative analysis will be supplemented with a qualitative analysis, and a review of the theory of change supported by relevant evidence of the effectiveness of similar interventions in comparable contexts. Wherever feasible and appropriate, the evaluation will also consider epidemiological evidence and models, as well as qualitative evidence and impact analyses.

III. RECOMMENDATION

3.1 Based on the information and analysis presented in this document, it is recommended that the Board of Executive Directors of the Inter-American Development Bank approve by Short Procedure, pursuant to paragraph 6 of document CS-3953-4 (List of matters that can be considered by the Board via Short Procedure), this reformulation proposal, in the terms and conditions described in this document.

Development Effectiveness Matrix		
Summary HA-L1104 / HA-L1095		
I. Corporate and Country Priorities		
1. IDB Group Strategic Priorities and CRF Indicators		
Development Challenges & Cross-cutting Themes	-Social Inclusion and Equality -Gender Equality and Diversity	
CRF Level 2 Indicators: IDB Group Contributions to Development Results	-Beneficiaries receiving health services (#)	
2. Country Development Objectives		
Country Strategy Results Matrix		
Country Program Results Matrix		The intervention is not included in the 2020 Operational Program.
Relevance of this project to country development challenges (If not aligned to country strategy or country program)		This project is consistent with the Proposal for the IDB Group's Response to the Pandemic Outbreak of COVID 19 (document GN-2996), since one of its priorities is to strengthen the provision of health services for COVID-19 patients as well as strategic essential services. See ¶2.20 of the DPL. It is also relevant for addressing country challenges, as proposed in DPL paragraphs 2.10 to 2.16.
II. Development Outcomes - Evaluability		Evaluable
3. Evidence-based Assessment & Solution	9.1	
3.1 Program Diagnosis	3.0	
3.2 Proposed Interventions or Solutions	3.6	
3.3 Results Matrix Quality	2.5	
4. Ex ante Economic Analysis	9.0	
4.1 Program has an ERR/NPV, or key outcomes identified for CEA	3.0	
4.2 Identified and Quantified Benefits and Costs	3.0	
4.3 Reasonable Assumptions	1.0	
4.4 Sensitivity Analysis	2.0	
4.5 Consistency with results matrix	0.0	
5. Monitoring and Evaluation	7.9	
5.1 Monitoring Mechanisms	1.1	
5.2 Evaluation Plan	6.8	
III. Risks & Mitigation Monitoring Matrix		
Overall risks rate = magnitude of risks*likelihood	Specify risk rate on risk tab	
Identified risks have been rated for magnitude and likelihood		
Mitigation measures have been identified for major risks		
Mitigation measures have indicators for tracking their implementation		
Environmental & social risk classification	C	
IV. IDB´s Role - Additionality		
The project relies on the use of country systems		
Fiduciary (VPC/FMP Criteria)		
Non-Fiduciary		
The IDB's involvement promotes additional improvements of the intended beneficiaries and/or public sector entity in the following dimensions:		
Additional (to project preparation) technical assistance was provided to the public sector entity prior to approval to increase the likelihood of success of the project		

Note: (*) Indicates contribution to the corresponding CRF's Country Development Results Indicator.

***Evaluability Note:** The reformulation proposal of the Transport and Departmental Connectivity Program (4618/GR-HA) and the Sustainable Coastal Tourism Program (3383/GR-HA) in Haiti, proposes the reorientation of US$27 million to finance the "The Immediate Public Health Response to Contain and Control the Coronavirus and Mitigate its Impact on Service Delivery in Haiti" (IPHR-HA). The project is part of the Bank's operational response to the COVID-19 Pandemic and its general objective is to contribute to the reduction of mortality and morbidity from COVID-19 and to mitigate the indirect impacts of the pandemic on health. The specific objectives are: (i) strengthen the response coordination at the country level; (ii) improve detection and monitoring of cases; (iii) support efforts to interrupt the chain of transmission of the disease; and (iv) improve the capacity of provision of care.*

The loan proposal presents a solid diagnosis of the problem, as well as a review of international evidence. The proposed solutions are appropriate to respond to the identified problems and their contributing factors. The results matrix is consistent with the vertical logic of the project, presenting adequate indicators at the level of results and impacts. The outcome indicators are appropriately defined to measure the achievements of the project's specific objectives. The impact indicators reflect the contribution to the objectives of reducing morbidity and mortality from COVID-19.

With regards to the Reformulation of the Transport and Departmental Connectivity Program (4618/GR-HA) it preserves its general objective as well as its specific objectives. Its results matrix has been modified to consider the reduction of budget and the vertical logic of the Program has been improved. The Reformulation of the Sustainable Coastal Tourism Program (3383/GR-HA) affected some output, outcome, and impact indicators. These changes are thoroughly explained in the corresponding Annex. The results matrix has been updated to reflect the reduction of budget as well as the enhanced vertical logic of the Program.

The economic evaluation shows that the operation is efficient, with a benefit/cost ratio of 1.68 and a NPV of US$16.9 million. In a context of high uncertainty, the health cost-benefit analysis considers the benefits in employment and labor income derived from the reduction of the mortality and morbidity due to COVID-19, while the costs are those associated with the implementation of a standard intervention package proposed by WHO that is part of this operation.

The monitoring and evaluation plan proposes a reflective analysis of the outcome and impact indicators included in the result matrix, complemented by a review of the theory of change, an updated review of international evidence and qualitative studies. In addition, for those outcome and impact indicators with available data, an interrupted time series analysis will be implemented to empirically estimate the magnitude of the effects to which the program contributes. The monitoring and evaluation activities will be carried out by the MSPP in coordination with the Bank.

INDICATIVE RESULTS MATRIX

EXPECTED IMPACT

Indicators	Unit of Measure	Baseline value	Baseline Year	Year 1	End of project	Means of verification	Observations
GENERAL OBJECTIVE: Contribute to the reduction of mortality and morbidity from COVID-19 and to mitigate the indirect impacts of the pandemic on health.							
Number of deaths due to COVID-19	Deaths	85,000	2019	11,400	11,400	MSPP surveillance reports.	Baseline indicates projected accumulated COVID-19 incidence and mortality over the March-2020-February-2021 period, assuming no intervention. The EOP reflects the same, assuming interventions are implemented and effective. Vertical logic postulates that: *incidence* is reduced directly by curbing transmission, in turn by deploying proactive detection efforts to inform isolation and quarantine, guide contact tracing and general distancing and implementing infection prevention measures (use of PPE, hand washing); and *mortality*, by reducing lethality (deaths to case ratio) thanks to timely and effective case management (in Haiti: fever reduction, treatment of co-infections and co-morbidities and early, massive, non-invasive oxygenation therapy); and as a result of reduced incidence. Incidence and mortality data will be disaggregated by age-group.
Confirmed COVID-19 cases	Cases	4,852,000		1,213,000	1,213,000		

EXPECTED RESULTS

Indicators	Unit of Measure	Baseline value	Baseline Year[1]	Year 1	End of project	Means of verification	Observations
Specific Objective #1: Strengthen the response coordination at the country level							
Situation Room to Manage the Pandemic established and functioning.	Number	0	2019	1	1	Executive resolution designating Ministry of Health (MSPP) and Multisector-Commission (CMGP) staff for the situation room	
Percentage of activities as per WHO guidelines started as part of the country's Preparedness and Response Plan	%	0		75%	75%	MSPP-CMGP National Plan implementation report	
Specific Objective #2: Improve detection and monitoring of cases[2]							
Percentage of public/mixed status laboratories with molecular diagnostic capacity for COVID-19	%	7%	2019	27%	27%	Epidemiology-MSPP report	Numerator: Labs with capacity for COVID-19 Diagnostic by PCR Denominator: Total of Central, Teaching and Departmental hospital Labs

[1] Baseline year: will reflect value at the end of 2019 or right before the onset of the epidemic in Haiti unless otherwise indicated. "Year 1" covers the March 2020-February 2021 period.

[2] Indicators under specific objectives 2, 3 and 4, and components 2, 3 and 4 are for target area: Départements of Ouest, Sud-Est, Artibonite, Centre, Nord and Nord-Est.

Indicators	Unit of Measure	Baseline value	Baseline Year[1]	Year 1	End of project	Means of verification	Observations
Percentage of weekly epidemiological bulletins issued and published	%	100%	2019	100%	100%	Reports on MSPP website	Numerator: Number of published Bulletins Denominator: Number of weeks in Project executing period.
Specific Objective #3: Support efforts to interrupt the chain of transmission of the disease							
Percentage progress achieved in the implementation of the Community engagement and social behavior change plan	%	0	2019	80%	80%	MSPP-CMGP National Plan implementation report	Numerator: Actual number of spots disseminated at EOP Denominator: Planned number of spots to have been disseminated at EOP.
Percentage of health institutions with permanent availability of personal protective equipment (PPE) over the last trimester at time of report.	%	0		85%	85%	MSPP progress report	Numerator: Facilities offering emergency services in target area w/o stock-out in the last three months[3] Denominator: Facilities offering emergency services
Percentage of points of entry by land with epidemiological surveillance as per country standards	%	0		100%	100%	MSPP-CMGP National Plan implementation report	Numerator: Official Points of Entry with surveillance according to MSPP standards Denominator: Total official points of entry Only Points of entry by land are included in the calculation.

[3] Availability will be documented through the monthly progress reports, which should indicate the level of use of PPE in the previous month and current stock, by facility. If a facility has less than 30% in stock compared to previous month use, it would count as out of stock for that month. The indicator records no stock-out in the last three months.

Indicators	Unit of Measure	Baseline value	Baseline Year[1]	Year 1	End of project	Means of verification	Observations
Specific Objective #4: Improve the capacity of provision of care							
Percentage of facilities offering emergency care with triage capacity.	%	28%	2019	80%	80%	MSPP-CMGP National Plan implementation report	Numerator: Number of facilities offering emergency care and have the capacity to realize triage[4]
							Denominator: Number of facilities offering emergency care[5]
Percentage of Level 1 COVID-19 Sites with isolation and surveillance capacity	%	0%		100%	100%	MSPP	Numerator: Number of care facilities for suspected and/or confirmed mild COVID-19 cases (=level 1) with isolation and surveillance capacity[6].
							Denominator: Number of level 1 care facilities
Percentage of hospitalized confirmed cases receiving treatment with supportive care according to country protocol	%	0%		75%	75%	Clinical records	Numerador: Hospitalized COVID-19 Patients (both levels) who were attended according to protocol
							Denominador: Total of hospitalized COVID-19 Patients (both levels)

[4] Triage entails: (i) detection of suspected cases (=screening) or contacts and corresponding testing; (ii) a different flow within the facility for suspected cases and COVID-19 confirmed; (iii) a protocol to identify patients who require care in another health facility of greater care capacity; and (iv) the means of transport transfer with the corresponding biosecurity measures. Baseline is estimated based on 2017-18 SPA permanent availability of patient transportation, Table 3.13.

[5] Health Centers with Beds and Hospitals.

[6] Facility should have special sites to attend suspected and/or with mild confirmed COVID-19 both for outpatient and in observation beds, in which the flow of care and areas are completely separated from the rest of the flows and areas of care in that facility. Staff and patients should, in addition, use the recommended protective measures. Surveillance entails capacity to collect samples for PCR test and send them to accredited laboratory.

OUTPUTS

Indicators	Unit of Measure	Baseline value	Baseline Year[1]	Year 1[1]	End of project	Means of verification	Observations
Component 1: Response leadership at the country level							
1.1. Plan to extend the capacity for COVID-19 case management for the target area designed and approved	Plan document	0	2019	1	1	Approved Plan Document	
1.2 Tools for Surveillance and Reporting on interventions designed, in line with the WHO-PRSP	Number	0	2019	8	8	MSPP-CMGP National Plan implementation report	Expected reports: (i)Epidemiological notification reports (local to national level) ; (ii) Nominal COVID-19 case management by level and site; (iii) Census of pregnant women in care; (iv) Vaccination report (According to Expanded Immunization Program, by child); (v) Detection and Follow-up of Chronic patients; and (vi) Census of TB and HIV patients in care.
1.3. Weekly Surveillance reports and Monthly intervention reports delivered	Number of reports	0	2019	64	64	Monthly consolidated project progress report from the MSPP	
Component 2: Case detection and monitoring.							
2.1. Number of primary care, non-COVID-19 facilities with personnel trained and equipped to support early detection.	Number	0	2019	169	169	MSPP progress reports	Indicators under components 2, 3 and 4 are for target area[2] PIH and PAHO will provide contributions to MSPP.
2.2. Primary care staff and community health workers trained and equipped to strengthen community-based surveillance		TBD		1,300	1,300		
2.3. Number of laboratories in the diagnostic network with the capacity to perform PCR COVID-19 diagnostic testing.		1		4	4		
2.4. PCR diagnostic test samples collected at the primary care level.		TBD		300,000	300,000		

Indicators	Unit of Measure	Baseline value	Baseline Year[1]	Year 1[1]	End of project	Means of verification	Observations
Component 3: Interruption of the chain of transmission.							
3.1. Number of *Communes* in which the plan for risk communication and promotion of healthy behaviors is implemented	Number	0	2019	75	75	MSPP progress reports	PIH and PAHO contributions to MSPP project progress reports.
3.2. Entry points with surveillance protocol implemented		0		3	3		
3.3. Number of health facilities receiving PPE from project implementing partners		0		169	169		
Component 4: Improvement of the capacity for service delivery.							
4.1. Number of beds set up and available for management of COVID-19 patients	Number	0	2019	2,216	2,216	MSPP progress reports	Implementation partners will provide inputs to the MSPP
4.2. Number of health personnel active in COVID-19 sites trained in case management protocols		0		500	500		
4.3. Number of primary care facilities offering essential care to Child-bearing-age and pregnant women		TBD		TBD	TBD		
4.4. Number of primary care facilities offering essential care to children under 5 years of age		TBD		TBD	TBD		
4.5. Number of primary care facilities offering essential care to people living with HIV and to TB patients		TBD		TBD	TBD		
4.6. Number of primary care facilities offering essential care to hypertensive and diabetic patients		TBD		TBD	TBD		
4.7 Number of health facilities that receive support to implement their Environmental and Social Management Plan		0		21	21		

Country: Haiti **Sector: Health** **Project Number: 4618/GR-HA and 3383/GR-HA** **Year: 2020**

Co-financing: N/A **Co-execution: Yes**

Fiduciary Agreements and Requirements

Executing Agency: Ministry of Public Health and Population through its Project Management Unit (UGP-MSPP)

Project Name: Reformulation Proposal of Grant Programs 4618/GR-HA and 3383/GR-HA for the financing of the Immediate Public Health Response to Contain and Control the Coronavirus and Mitigate its Impact on Service Delivery in Haiti (IPHR-HA).

Reallocation of Resources			
No. Operation	**Name of Program**	**Agreement No.**	**US$ million**
HA-L1104	Transport and Departmental Connectivity Program	4618/GR-HA	15.00
HA-L1095	Sustainable Coastal Tourism Program	3383/GR-HA	12.0
Total			27.00

I. Executing Agency Fiduciary Context

1. Use of Country System in the Project[1] : The country's financial management and procurement systems require further improvements to conform to levels consistent with the fiduciary management of Bank-funded programs. Hence, no country financial management or procurement system will be used. The Bank will continue to: (i) rely on special project executing units for the execution of all projects while strengthening institutional capacities; and (ii) implement special fiduciary arrangements for project implementation and conduct close supervision of executing units. External control will be performed by independent audit firms acceptable to the Bank and in accordance with its financial reporting and audit guide.

Budget	☐	Reporting	☐	Information System	☐	National Competitive Bidding (NCB)	☐
Treasury	☐	Internal Audit	☐	Price Comparison	☐	Advanced NCB	☐
Accounting	☐	External Control	☐	Individual Consultancy	☐	Consultancy Firm	☐

Applicable National Laws:
a) *1987 Constitution* which defined the prerogatives of the executive and legislative powers in matters of public finance and the role of the "Court Supérieure des Comptes et du Contentieux Administratif" regarding enforcement of financial law;
b) *February 16th, 2005 Decree* established general rules of public accounting; and
c) *Law No. CI. 06 2009 009* established general rules on public procurement and concession agreements for work and public service.

[1] Any system or subsystem that is subsequently approved could be applicable to the operation, in accordance with the terms of the validation conducted by the Bank.

2. Executing Agency Fiduciary Capacity

The project will be executed by the Ministry of Health through its Project Management Unit (UGP-MSPP), which has extensive experience in managing funds from the World Bank and Center of Disease Control, and executed the Bank's Cholera response project HA-L0162 in 2011. A desk review of the financial management and internal control processes was completed using PACI. Financial Management risk is considered high due to increased workload, worsening existing weaknesses. UGP presents delay in recording financial transactions, submitting justification of advances with adequate supporting documentation and deficiencies in tracking distribution of purchased material and equipment to MSPP facilities.

3. Fiduciary Risk and Mitigation Actions

Fiduciary Risk: High ☒ ; Medium ☐ Low ☐

Risk	Risk Level	Mitigation Plan
Increased workload and the weak institutional capacity across different technical and administrative units of the MSPP may delay the recording of financial transactions, preparation of financial reports and justification of funds, affecting disbursements and project execution.	High	Contain the volume of transactions directly under UGP-MSPP, by including comprehensive support to EA by implementation partners, two specialized agencies (the United Nations Office for Project Services-UNOPS; the Panamerican Health Organization-PAHO) and one international health non-profit (Partners in Health-PIH), for the outfitting, provision of equipment, operation logistics and case management, including to prepare technical and financial reports. Strengthen financial management, procurement, logistics and stewardship by recruiting: (i) a financial specialist for the daily recording of transactions, to compile financial reports and submit disbursement requests to the Bank; (ii) two financial controllers to support MSPP with the preparation of justification reports and the review of supporting documents; (iii) an inventory manager to ensure up-to-date inventory auxiliary records, and availability of all necessary information on procurement and management of fixed assets including location. Implementation Partners will receive direct payments to ensure flow of funds.
Inefficient management of material and equipment due to inadequate staffing and the substantial increase in procurement.	High	

II. Aspects to be considered in the Special Conditions of the Contract

- **Exchange rate**: For the rendering of accounts of the Program resources, the effective exchange rate on the date of conversion of the approval currency or disbursement currency to the local currency of the Borrower's country will be applied, as indicated in the subsection (b) (i) Article 4.10 of the General Standards. For the purposes of determining the equivalence of expenses incurred in local currency against the local contribution or reimbursement of expenses against the Program, the agreed exchange rate will be that of

the date of payment as indicated in subsection (b) (ii) of Article 4.10 of the General Standards will also be used. The Central Bank of Haiti exchange rate published on that date will be used as the reference rate.
• **Audit and financial reporting**: A single financial audit covering all reformulated components will be required, within 120 days of the date of last disbursement of the resources executed for the immediate health response. The audit will be conducted by a Bank-eligible independent audit firm. Its scope and related considerations will be governed by the Financial Management Guidelines (document OP-273-12) and the Guide for Financial Reports and Management of External Audit. Scope will include a technical component, to establish "reasonable assurance" that the reported volumes of attention are accurate and that care was given adhering to clinical protocols, by reviewing a sample of patient records at the six months mark and at the end of the project. Audit costs will be financed with program resources.
• **Opening of two designated accounts** (one in US dollars and one in Haitian gourdes) at the Central Bank, *Banque de la République d'Haïti* (BRH) and *Banque National de Credit* (BNC), under the name of the Project for management of project funds and send authorized signatures to the IDB via the Ministry of Finance (MEF).

III. Agreements and Requirements for Procurement Execution

Exception to the Policies and Guides:

No exceptions are provided; special and temporary measures may apply to the Bank's procurement policies as approved by the Board and indicated in Document GN-2996, ¶4.2 and Resolution DE-26/20 ¶2:

- That goods from countries that are not members of the Bank may be eligible for procurement;
- That the procurement policies of specialized agencies such as PAHO and UNOPS may be used by the Beneficiary and EA through the respective contracts with said agencies.

Retroactive Financing and/or Advanced Procurement	NA
Expenses incurred prior to the term of the Modified Agreement	The Bank may recognize eligible expenditures made by the Beneficiary between March 19th, 2020 and the date of approval of IPHR-HA, up to the equivalent of US$6.32 million provided that requirements substantially similar to those established in the modified grant agreement are met. To cover for the early purchase of equipment and supplies and related expenses to activate COVID-19 sites identified by MSPP and included in the initial prioritization of this operation (as described in subcomponents 2.1, 2.2, 3.2, 3.3 or 4.1), for up to US$2 million. Another US$4.32 million also may be included the cover an advance of funds by the Borrower to the three implementation partners to accelerate the execution of their respective work under those same sub-components.
Procurement Complementary Support	NA
Procurement Agents	NA

Direct Contracting	• The following direct contracting are authorized pursuant to ¶3.7 (e) of GN-2349-15:
	1. UNOPS for the comprehensive support to the outfitting, equipment, operation logistics including support to waste management, payrol administration and to the adequate disposal of cadavers, for the for COVID-19 case management platform of sites in the West, North, North-East and South-East departments. (US$5.9 million)
	2. PAHO for the clinical and operational support to sites prioritized by the MSPP for COVID-19 case management and continuity of essential care in the West, North, North-East and South-East departments, including the borders of Ouanaminthes and Anse-à-Pitres. (US$7 million)
	3. PIH, to expand the COVID-19 case management capacity including outfitting, clinical and operational management of the sites prioritized by the MSPP for COVID-19 case management and continuity of essential care in the departments of Artibonite and Centre, including at the Belladère border. (US$11 million)

Operational Expenses: ☐	**National Preference:** ☐ N/A

General Procurement Supervision Method of the Project:	
Supervision Method : Ex ante or ex post	**For:** As agreed in the project procurement plan

Thresholds by Country: www.iadb.org/procurement

IV. Agreements and Requirements for Financial Management

Programming and Budget	• For the allocation of funds to UGP-MSPP, adjustments must be made in the budget structures of the reformulated operations. • For the new project, UCP-MSPP will prepare a comprehensive financial plan, which will include budget and cash flow needs, based on activities identified in the 12-month Operating Plan (AOP) and Procurement Plan (PP). The execution of the project's financial plan will be evaluated quarterly. The Financial plan will coincide with the Haitian fiscal year and will respect budget lines defined in the new project (categories of investment).

Treasury and Disbursement Management	• Disbursement mechanism: Bank will temporarily accept submission of the disbursement request in PDF, duly signed by authorized personnel and scanned. • Treasury: Project funds will be deposited by IDB in project designated US$ account opened at the BRH and transferred to project designated local currency account at the BNC as needed by UGP-MSPP for the payment of expenses made in local currency. • Financial plan: Disbursements will be made based on a detailed financial plan based on the actual liquidity needs of the program. • Disbursement methods: The Bank will disburse resources under the advance of funds, direct payment and reimbursement of expenses modalities established in Guide OP-273-12. • Advance of funds will be used to finance activities implemented by the UGP-MSPP and for administrative and operating expenses. UGP-MSPP will submit to the Bank a detailed Financial Plan indicating cash flow needed for periods of up to three months. The supervision of disbursements will be ex-post, however the Bank may review a percentage of supporting documentation prior to the processing. • Justification of advances of funds will be submitted by UGP-MSPP on a quarterly basis, within 45 days after the end of each fiscal quarter. For each new advance, due to the emergency nature of the operation and given that activities will be executed in urban and rural areas throughout the Country, UGP-MPSS will need to justify 60% of cumulated advance received. • Direct payment will be used for the payment of specialized agencies and implementation partners based on payment modalities and submission of deliverables defined in signed contracts. • Reimbursement of expenses will be subject to eligibility of expenses including that payments were made using Government resources.
Accounting, Information System and Report Generation	• UGP-MSPP will use ACCPAC software system for the financial administration of the project which generates financial reports according the chart of accounts and investment components and sub-components approved for the project. • Modified cash basis will be used for accounting purposes and the International Public Sector Accounting Standards (IPSAS), in accordance with the established national criteria. • Financial reports will be presented in US dollars.
External Control	• The external audit of the Project will be carried out by an independent auditing firm (IAF) eligible to audit operations financed by the Bank, selected and contracted in accordance with the terms of reference and model contract previously agreed with the Bank.

Financial Supervision of the Project	• Financial supervision will be conducted quarterly on an EX-Post basis and will consider on-site supervision visits and "desk" reviews, as well as the analysis of the results and recommendations of the audits of the financial reports and the reconciliation of project accounts.

V. Information relevant to the operation

Policies and Guides applicable to the operation

Financial Management	Procurement
• GN-2811 [OP-273-12]	• GN-2349-15 [ES] [POR] [FRE] • GN-2350-15 [ES] [POR] [FRE]

Records and Files

The Ministry of Health and the UGP-MSPP will be responsible for maintaining the original files of acquisitions, contracting, payments and accounting records incurred and prepared during execution of the Project and for a period of three years following the last disbursement date.

DOCUMENT OF THE INTER-AMERICAN DEVELOPMENT BANK

PROPOSED RESOLUTION DE-__/20

Haiti. Reformulation of Nonreimbursable Financing Programs 4618/GR-HA and 3383/GR-HA for the financing of the Immediate Public Health Response to Contain and Control the Coronavirus and Mitigate its Impact on Service Delivery in Haiti (IPHR-HA)

The Board of Executive Directors

RESOLVES:

1. To approve the reformulation of the programs listed below to use the available resources in the amounts indicated to finance the Immediate Public Health Response to Contain and Control the Coronavirus and Mitigate its Impact on Service Delivery in Haiti (IPHR-HA), in accordance with the terms and conditions described in Document PR-____:

(i) Nonreimbursable Financing 4618/GR-HA "Transport and Departmental Connectivity Program" authorized by Resolution DE-60/18, up to an amount of US$15,000,000; and

(ii) Nonreimbursable Financing 3383/GR-HA "Sustainable Coastal Tourism Program" authorized by Resolution DE-194/14, up to an amount of US$12,000,000.

2. To authorize the President of the Bank, or such representative as he shall designate, in the name and on behalf of the Bank, to enter into such contract or contracts as may be necessary with the Republic of Haiti, as beneficiary, to amend Nonreimbursable Financing Agreements 4618/GR-HA and 3383/GR-HA for the purposes described in this Resolution.

(Adopted on _____ ___2020)

LEG/SGO/HA/EZSHARE-1537888330-11081
HA-L1104 and HA-L1095-Reformulation