TECHNICAL REPORT
IN COLLABORATION WITH:

An Assessment of the Haitian MSPP's Readiness to Establish a Contracting Function

July 2012
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## Acronyms

<table>
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<th>Acronym</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>ACDI</td>
<td>Agence Canadien de Développement International</td>
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<tr>
<td>CDC</td>
<td>Centre for Disease Control</td>
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<td>CDS</td>
<td>Centres pour le Développement et la Santé</td>
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<tr>
<td>CHAI</td>
<td>Clinton Health Access Initiative</td>
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<tr>
<td>CNMP</td>
<td>Commission Nationale des Marches Publiques</td>
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<td>CMMP</td>
<td>Commission Ministérielle des Marches Publiques</td>
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<tr>
<td>CU</td>
<td>Contracting Unit</td>
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<tr>
<td>DAB</td>
<td>Direction d’Administration et Budget</td>
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<td>DG</td>
<td>Director General</td>
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<td>DOSS</td>
<td>Direction d’Organisation de Services de Sante</td>
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<td>DSA</td>
<td>Direction Sanitaire de l’Artibonite</td>
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<td>DSF</td>
<td>Direction de Sante Familial</td>
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<tr>
<td>DSN</td>
<td>Direction Sanitaire du Nord</td>
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<td>DSNE</td>
<td>Direction Sanitaire du Nord Est</td>
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<td>DSS</td>
<td>Direction Sanitaire du Sud</td>
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<tr>
<td>DSSE</td>
<td>Direction Sanitaire du Sud Est</td>
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<tr>
<td>GHESKIO</td>
<td>Groupe Haitien d’Etude du Sarcome de Kaposi et des Infections Opportunistes</td>
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<tr>
<td>GDP</td>
<td>Gross Domestic Product</td>
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<td>GoH</td>
<td>Government of Haiti</td>
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<td>HSIS</td>
<td>Haïti Système d’Information de la Santé</td>
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<td>MEF</td>
<td>Ministère de l’Economie et Finances</td>
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<td>MPCE</td>
<td>Ministère de Planification et de la Coopération Externe</td>
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<td>MSH</td>
<td>Management Sciences for Health</td>
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<td>MSPP</td>
<td>Ministère de la Santé Publique et Population</td>
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<td>NGO</td>
<td>Non Governmental Organization</td>
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<tr>
<td>PADESS</td>
<td>Projet d’Appui au Développement du Système de Santé</td>
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<td>PAHO</td>
<td>Pan-American Health Organization</td>
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<td>PEFA</td>
<td>Public Expenditure and Financial Accountability</td>
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<td>PEPFAR</td>
<td>Presidential Emergency Plan for AIDS Relief</td>
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<td>PMS</td>
<td>Paquet Minimal de Services</td>
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<td>PSPI</td>
<td>Paquet de Services Prioritaires Intégré</td>
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<tr>
<td>SDSH</td>
<td>Santé pour le Développement et la Stabilité d’Haïti</td>
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<td>SWAP</td>
<td>Sector Wide Approach Program</td>
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<tr>
<td>UCS</td>
<td>Unité Communal de Santé</td>
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<td>UJ</td>
<td>Unité Juridique</td>
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<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<td>UNFPA</td>
<td>United Nations Fund for Population</td>
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<td>UPE</td>
<td>Unité de Planification et Evaluation</td>
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<td>USAID</td>
<td>United States Agency for International Development</td>
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<td>USG</td>
<td>United States Government</td>
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<td>WB</td>
<td>World Bank</td>
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<td>WHO</td>
<td>World Health Organization</td>
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EXECUTIVE SUMMARY

The United States Agency for International Development (USAID), together with the World Bank (WB), is seeking to strengthen host country systems by directing funding to channels that involve greater government participation. Acknowledging that Haiti is a country with weak government and fragmented donor support, the USAID mission sought to explore the possibility of refocusing part of its support to the health sector using a more direct government-to-government approach, where aid is delivered using local systems and seeks to follow the principles of the Paris Declaration on Aid Effectiveness. This new approach is being designed in the context of a country with a per capita total health expenditure of 40 USD (WHO 2009), very low access to care (24% of sick people did not visit a health institution, MSPP 2006), low consumption of health services, with less than 1 consultation per inhabitant per year (MSPP 2007) and an extremely fragmented health service delivery system, dominated by parallel funding mechanisms and multiple unregulated stakeholders.

USAID and the WB share a desire to see a more coordinated and harmonized approach to health service provision in Haiti whilst not losing focus on results. Hence their approach of strengthening capacity needs to be founded on a mechanism that links resources spent with results. This approach has led to the idea of exploring the possibility of establishing a contracting function within the MSPP, through which US Government and World Bank funding would be channeled. This idea resulted in USAID commissioning a study to assess the capacity of the Ministry of Public Health and Population (MSPP) to manage a contracting function that would be instrumental in strengthening the MSPP’s regulatory role and capacity.

The USAID mission in Haiti engaged ThinkWell to conduct a rapid assessment of MSPP capacity with the following objectives: (a) to analyze the abilities of relevant existing MSPP technical units and directorates at central and departmental level to perform the functions laid out in the *Loi Organique*; (b) to provide recommendations of options for institutional modalities of a contracting function and (c) to make recommendations as to

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1 Décret Portant sur l’Organisation et le Fonctionnement du Ministère de la Santé Publique et de la Population, Le Moniteur 161st Year No. 1, 5 January 2006
what type of capacity building would be needed. In order to fulfill these objectives, the
team prepared a structured interview tool, centered around the main aspects that a
contracting function should ensure: (i) definition of services / package; (ii) licensing
providers to be contracted; (iii) planning; (iv) establishing an information system that
allows monitoring of what is being purchased; (v) financial management; (vi) setting and
monitoring contract conditions; and (vii) definition of costs and provider payment
mechanisms. The team interviewed the key units and directorates at the MSPP, visited
five departments and studied existing partner projects that have contracting components.

Assessing MSPP capacity vis-à-vis the contracting functions requires analyzing whether
these functions are currently performed and what are the critical elements required to
make them happen. The MSPP has developed a Paquet Minimum de Services (PMS) but it is
not fully implemented and, although no comprehensive costing exercise has been
carried out, the implementation of this PMS would appear to be unaffordable, considering
both the very broad range of interventions therein and the level of health expenditure per
capita of the country. In respect of licensing, the Direction d’Organisation des Services de
Santé (DOSS) of the MSPP has developed standards for autorisation de fonctionnement,
accreditation and certification of ancillary hospital services. However these standards are
neither mandatory nor implemented on a large scale. The lack of a regulatory framework,
cumbersome procedures, a shortage of skilled supervisors and a lack of resources may
explain this to some extent. The local health information system is implemented
countrywide but its reliability is compromised and reporting is incomplete. Moreover it
does not produce the level of detail of information that some partners require, leading to
the development of sub-systems not managed by the MSPP. The lack of support to the
Haitian Système d’Information Sanitaire (HSIS), in contrast with the well-supported sub-
systems, has contributed to its sub-optimal accuracy and completeness. Haitian public
finance management systems do not meet international acceptable standards. The lack of
internal controls and unclear reporting indicates that risk mitigation measures are not in
place. MSPP capacity to contract health providers is weak. The MSPP has contracts in
place with non-governmental organizations to run certain services in public facilities, but
these contracts neither include financial clauses nor have a robust monitoring scheme.
Lastly MSPP resource allocations are based on historical trends and these trends are
relevant to less than 10% of the budget, as 90% of operational public spending on health
goes to pay personnel.

The five departments visited (Nord, Nord-Est, Sud, Sud-Est and Artibonite) showed similar
performance in the roles that they would play under a contracting arrangement. Their
planning capacity is reasonable, producing detailed plans linked to health programs,
mostly funded by partners. The existence of technical assistance at the departments’
offices helps in preparing plans at that level and at health facility level. The
implementation of the HSIS is widespread but reporting is delayed and there are issues
with respect to accuracy and completeness, ranging from 60% to 90% reporting.
Assessments of the accuracy of the data have yet to be conducted, but anecdotal
evidence from the field suggests deficiencies. Different partners’ funding schemas, ranging
from having financial supervisors executing funds to channeling resources through
departments’ administrative offices, show that they can manage resources if procedures
and supervision are in place. This includes health facilities, since some partners, such as
PAHO and MSPP-PEPFAR provide financial assistance directly at that level.
Existing donor experiences provide substantial lessons to be learned from but also issues to reconsider within the process of contracting design. MSH/SDSH’s pared down version of the PMS is a good example of horizontal funding, covering primary health care activities. All major programs have introduced robust planning routines, combining bottom-up planning and budgeting with top-down allocations. However while bottom-up plans are detailed and informative, top-down allocation criteria are unknown to providers, creating uncertainty. Also fragmented planning multiplies administrative efforts and workload for local institutions. Most donor programs favor the development of health information sub-systems, serving their funders’ requirements but not helping the development of the HSIS. While none of the donors programs uses the Haitian public finance management system, they have helped to create local capacity in terms of budgeting, financial management, reporting and audit. However the fact that each partner uses their own system makes for a cumbersome and unwieldy arrangement. In terms of provider payment mechanisms, there are examples of performance based payments for service delivery, linked to clinical indicators, and to processes, linking disbursements to compliance in reporting.

The establishment of the contracting function should follow certain principles, which aim to put in place the best practices of the Paris Declaration on Aid Effectiveness. Hence both the MSPP and partners should be guided by: (i) using the establishment of the contracting function as a platform to coordinate donor efforts; (ii) using, where possible, Government of Haiti systems in order to strengthen them, (iii) buying a defined package of services instead of parallel disease-based programs, (iv) putting together all government and partner efforts under a single plan in order to enhance the resource allocation function of the government, and (v) making an explicit differentiation between funding service delivery and stewardship activities, in order to ring-fence resources for the former.

Consistent with these principles and this assessment, the team recommends three options for the establishment of a contracting function within the MSPP. The first option would establish the financial management mechanism within the Direction de l’Administration et du Budget (DAB) and contract content and development at the Unité de Programmation et d’Evaluation (UPE). The second option would use the existing MSPP-PEPFAR Unité de Gestion de Projets (UGP), which manages mostly HIV funding but also some other resources. Finally the third option involves the creation of a Contracting Unit (CU) that would shoulder the responsibilities of managing financial resources and drawing up contracts. All three options would have common features in other respects, including the medium-term goal of prioritizing interventions for an essential package, the use and strengthening of the local information system, and so on. Nonetheless not all the options score well in all respects.

While the MSPP-PEPFAR UGP (option two) is ready to manage large funding flows, it is by the admission of its funder a project management unit, designed to accommodate a single funding stream. This makes it difficult to accommodate other funders as well as to carry forward a broader vision to support the development and implementation of sector-wide local systems. Options one and three share almost all features except as it relates to the fiduciary aspect. During the design phase, both MSPP and partners will need to detail which arrangement fits their goals best.

The management of this new arrangement would require the creation of governing bodies at each level. At the strategic level, a steering committee, with top members of the
Government (MSPP, MEF and MPCE) and the representatives of donors would set policies and major guidelines. This group should be seen as the seed of an eventual Sector Wide Approach to Programs Steering Committee. At the technical level, another group should be created to follow up day-to-day operations. Finally, at the departmental level, a forum ensuring integrated planning, adequate reporting and monitoring of the purchasing of services should be established, with both department directorates key staff and partners.

The establishment of a contracting function would require simultaneous efforts in terms of strengthening MSPP capacity. A team of embedded technical assistants would need to be deployed at the MSPP, integrating them within the MSPP structure and helping the key areas of the contracting function, such as planning, health information reporting, procurement processes, costing, design of incentives, licensing and so on. During the design phase to follow, the details of the technical inputs would be defined. The implementation of a contracting function would face several risks. There is a need to come up with a risk mitigation strategy. The key risks are: (i) delays in decision-making, especially regarding decisions triggering payments; (ii) fiduciary risks, ranging from delays in disbursements, unacceptable reporting or deviations in use of funds; and (iii) the information system(s) not performing, rendering it difficult to monitor performance and thus affecting incentive payments. Such risks must be reduced by a combination of skilled technical assistance in key MSPP departments and the establishment of robust financial procedures acceptable to partners.

The road map for establishing the contracting function would include: (a) developing its legal basis; (b) making a formal agreement between the Government of Haiti and partners who would channel funding through it; (c) mobilizing the necessary technical capacity to accommodate the fiduciary aspects and the technical support to the MSPP and departmental directorates; (d) developing the manuals, procedures and fiduciary arrangements to channel the resources; (e) designing the details of the contract, including the package, provider payment mechanisms, incentives scheme, among others. These steps should take no more than one year, with the initiation of contracting by the end of the first quarter 2013.
1 SECTOR CONTEXT AND BACKGROUND

1.1 HAITI’S HEALTH SECTOR – HEALTH AND FINANCING

Haiti is the least healthy country in the Western Hemisphere. Under-five mortality has decreased since the 1980s but remains high at 87 per 1,000 live births (three times the regional average) as of 2005 data from the Demographic and Health Survey (DHS) and is not decreasing at a pace fast enough for Haiti to achieve the 4th Millennium Development Goal. Six out of ten Haitian children (12-23 months old) are not fully vaccinated, and one in ten did not receive any vaccine at all. Finally, nearly one-third of all children under-five suffer from stunted growth and three-quarters of children 6-24 months are anaemic, almost 60 per cent of school-aged children are iodine deficient, and one third of children are vitamin A deficient. Maternal mortality in Haiti is the highest in the region at 630/100,000 live births (six times the regional average), up from the previous assessment five years earlier of 523/100,000 live births. The fertility rate in 2005/6 stood at 4, down from 4.8 in 1998, however, access to family planning services is low with 40 per cent of women who do not want any more children or who would like to wait to have children, not having access to modern methods of contraceptives. HIV prevalence was 2.2% of adults aged 15 to 49.

There is little data on utilization of services in Haiti, however anecdotally the consensus is that the level stands at one visit per citizen per year. The reasons for this low utilization of services are common to many developing countries, namely financial barriers, lack of physical access due to inconsistent geographic dispersion of health facilities and mistrust of modern medicine. Socio-economic factors determine physical and financial access to health services. Almost one in five Haitians (20 per cent) visit a health center when sick that is 5 km or further away from their home; however, among the poorest, one in three have to travel further than 5 km and almost half (46 per cent) have to reach the health center by foot. In rural areas, health centers are more dispersed, and only half of the population (48 per cent) visits a health center that is within a 5 km radius of their house, and a further 13 per cent visit one within a 5-10 km radius. However, financial access is the most important barrier to service utilization across socio-economic quintiles. Out of those who were seriously sick in the 30 days preceding the DHS and did not seek treatment (24 per cent of all those who reported being sick), almost half cited financial reasons and 20 per cent physical accessibility. The problem is most acute in rural areas (48 per cent).

The delivery of health services relies on a network of public, private non-profit, mixed non-profit (institutions owned by the State, but operated by non-governmental organizations), and private for-profit providers, resulting in a highly fragmented system

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with NGOs providing an estimated 70 per cent of health services. Poor coordination of these actors in the past led to an overlap of services in some areas of the country and a lack of access to essential basic health services and low coverage in other areas, particularly peri-urban and rural communities.

The 2011-12 budget analysis produced by the GoH shows a 6.87% allocation of the national budget to the MSPP (up from 5.84% the previous year), which represents 2.37% of nominal GDP. Of the allocation to the MSPP, 27% went to operational costs ($54 million, managed by the MSPP) and 73% to investment costs ($146 million, managed by the Ministry of Planning and External Cooperation). This represents a substantial bias towards investments on which this assessment did not focus, however questions posed in interviews revealed little transparency regarding how investment funds are spent. Analysis of publicly available figures show a low relative contribution by the Government of Haiti over time to its health system, between 1% and 2% of GDP, as shown in the chart below. However analysis of the 2011-12 budget suggests this might be slightly increasing.

Figure 1: Total Health Expenditure and Government Spending on Health as % of GDP, Total Health Expenditure in current USD, 1995 - 2009

Source: WHO NHA database

Due to the weak capacity of the MSPP, multiple donors (USAID, CDC, ACDI) have largely bypassed the Ministry, directly funding non-state organizations to provide health services to the population of Haiti. Other donors (WHO, UNICEF) provide funding directly to government agencies at sub-national level without the involvement of the central-level MSPP. Further some independent international donors (PIH, various other small

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3 Projet de Budget, 2011-2012, Résumé, January 2012
international foundations) are engaged in direct service provision to the population. Lastly some of this funding goes from one international donor to another, e.g. CDC funding to PIH.

In this context, coordination of funding into the health system is critical to ensure better access to essential services, improve the quality and equity of these services, increase the efficiency of sector resources and provide tools to the MSPP to effectively regulate and reduce fragmentation of the system. However such coordination is complex and requires advanced tools to understand what funding from what sources are directed to which ends. Simply having a comprehensive overview of all the funding would be an important first step. Coordination would be significantly simpler however if there were fewer funding channels and fewer decision-makers. Moreover, the use of sectoral instruments such as sector wide approaches (SWAp) can maximize the impact of financing and results on the ground by bringing together government, civil society and development partners around a common vision of effective service delivery and improved governance and accountability. By reducing fragmentation of financing provided to the sector, improved coordination through a SWAp can improve the technical and allocative efficiency of public expenditures and thus contribute to the effectiveness of investments.

Crucial to the success of the MSPP’s ability to address access and quality issues is the development of adequate capacity to effectively put in place, manage and supervise the relevant contracting and monitoring arrangements.

A new health sector policy and a new health sector strategic plan are under development. There is a push to deconcentrate / decentralize in the health sector, however there is little evidence of that in practice. All important decisions require the authorization of at least the Director General, if not the Minister, including hiring of any type of personnel down to the lowest level health facility.

1.2 LE MINISTERE DE LA SANTE ET DE LA POPULATION (MSPP)

The Ministry is organized, per the Organic Law of 2006 (Décret portant sur l’organisation et le fonctionnement du Ministère de la Santé Publique et de la Population), with a Minister at its head (with a Cabinet reporting to the Minister) and a Director General reporting to the Minister. Four administrative units, ten directorates, four program management units, ten departmental directorates, two national teaching hospitals and the Centre d’Information et de Formation en Administration de la Santé (CIFAS) all report to the Director General’s office. This represents more than 30 direct reports to the Director General, an unwieldy number to manage and not characteristic of efficient management practices.

The Organic Law sets out the following entities reporting directly to the Director General⁴.

Administrative Units

1. UADS – Health Services Decentralization Support Unit
2. UPE – Programming and Evaluation Unit
3. UJ – Legal Unit

4. Secretariat

Directorates

1. DPDH – Population and Human Development Unit
2. DOSS – Organization of Health Services
3. DFPSS – Training and Scientific Improvement Unit
4. DSF – Family Health Unit
5. DSI – Nursing Health Unit
6. DPSPE – Health Promotion and Environmental Protection
7. DPM/MT – Pharmacy & Pharmaceuticals and Traditional Medicine
8. DELR – Epidemiology, Laboratories and Research
9. DAB – Administration and Budget
10. DRH – Human Resources for Health

Program Management Units

1. Infectious Disease PMU
2. National Vaccination PMU
3. National Nutrition PMU
4. Hospital Security PMU

Furthermore the Loi Fixant les Règles Générales Relatives aux Marchés Publics et aux Conventions de Concession d’Ouvrage de Service Public of July 2009 (henceforth the Procurement Law) states that a Commission Ministérielle des Marchés Publics (CMMP) should be created in each Ministry. Article 6 of the Procurement Law states that these CMMPs are the “administrative organ” for procurements and that they report to the relevant authority in their respective ministries. The Organic Law for the MSPP defines this person as the Minister. Further Article 6 of the Procurement Law states that the criteria for choosing the members of the CMMP are defined in the bylaw (arrêté) which details the organizational modalities and functioning of the Commission Nationale des Marchés Publics (CNMP), the national body which oversees the CMMPs in all the Ministries. The role of the CMMP is regulatory in nature, ensuring the proper procedures are followed in procurements made by the Ministry. The CMMP of the MSPP is however not yet functional.

Haiti is divided into ten geographic administrative units, called departments: North-West, North, North-East, Artibonite, Central, West, Grand’Anse, Nippes, South and South-East. Each department has a Director of Health with a staff which includes an Administrator, an Accountant, an M&E Officer and a Statistician.

There are five principal types of health facility: national referral / teaching hospitals, department hospitals, communal reference hospitals, health centers (with or without inpatient beds) and dispensaries. In some areas, the last three types of facility are organized into networks, managed either by a government structure, as in the Communal Health Units in Artibonite department, or by NGOs of which there are many examples.
1.3 UNDERLYING PRINCIPLES FOR A SECTOR WIDE APPROACH

The United States Agency for International Development (USAID), as part of its USAID Forward strategy, and the World Bank, are seeking to channel their funding through the MSPP with the objectives of increasing the leadership of the MSPP in the allocation of resources, contributing to the creation of a SWAp and reducing the transaction costs associated with managing multiple donor projects.

USAID Forward is a set of reforms initiated a year ago in seven areas aimed at changing USAID’s approach to its work. The key area of the seven relevant to this assessment is Implementation and Procurement Reform. Taken from the USAID website:

“USAID is changing its business processes—contracting with and providing grants to more and varied local partners, and creating true partnerships to create the conditions where aid is no longer necessary in the countries where the Agency works. To achieve this, USAID is streamlining its processes, increasing the use of small businesses, building metrics into its implementation agreements to achieve capacity building objectives and using host country systems where it makes sense.” 5

Additionally in a document entitled ADS Chapter 220, “Use of Reliable Partner Country Systems for Direct Management and Implementation of Assistance” 6, the following is stated:

“USAID Missions planning projects using partner country systems should consider coordinating with other donors on sector program approaches, joint funding arrangements, and other coordination measures….as part of the design phase.”

As part of USAID Forward, the Agency will look to contract with local partners, such as those local NGOs already working in health in Haiti, and will look to use host country systems. In addition the Agency is open to using this as a platform for donor coordination and potentially joint funding arrangements. These positive approaches will be explored and in some cases underlie the recommendations of this assessment.

USAID and the World Bank are undertaking an assessment of options and mechanisms based on these principles, in complementarity with previous and concurrent assessments of public expenditure management and fiduciary systems and controls within the MSPP and the Ministry of Finance.

5 http://forward.usaid.gov/about/overview, accessed 12th March 2012
2 OBJECTIVES AND METHODOLOGY

2.1 TERMS OF REFERENCE AND SCOPE OF WORK

The objective of the current assessment is to evaluate the readiness of the MSPP to manage funds and coordinate and oversee the activities and sector programs of various donors, particularly related to the country-wide provision of an essential package of health and nutrition services through standard procurement procedures, financial and technical management of health service delivery contracts, in coordination with corresponding MSPP departments and relevant stakeholders.

As stated in the terms of reference for this assessment: “Prior to assisting the MSPP in implementing its key governance or health systems priorities and guide the development thereof, the World Bank and USAID require short-term consulting services to assess the readiness of the Ministry of Population and Public Health (MSPP) to create a Contracting Unit (CU).”

The scope of work detailed in the terms of reference is:

a. An analysis of the abilities of relevant existing technical units and directorates (DRH, DOSS, DAB, UADS, UPE, MSPP-PEPFAR) at the central level and at the ten departmental levels to perform the functions laid out in the Loi Organique. This analysis would a) identify strengths and weaknesses of specified units and directorates within the MSPP (human resources capacity, budget planning capacity, technical capacity, tools/operating systems, equipment, space) at central and departmental levels to perform essential public health functions as defined by WHO; and b) the reporting lines and relationships among the key technical units/directorates at the central level and between the central and departmental levels.

b. Recommendations of options for institutional modalities of the Contracting Unit (location, structure, capacity needs, staffing, reporting lines, and timeline for creation and functionality).

c. Recommendations to feed into the development of a Capacity Building and Technical Assistance Plan.

This report will set out an initial sketch of the functions the CU might carry out and the functions which other units in the MSPP would be required to fulfill in order that funding related to programs overseen by the CU can be implemented effectively. Finally it will provide recommendations for the key areas which would require capacity building and/or technical assistance.

2.2 METHODOLOGY OF ASSESSMENT

The assessment of the MSPP and the departments has been based on interviews conducted with MSPP directorate directors (UPE, UADS, DAB, DRH, DOSS and UJ) and their staff, directors of departmental health units and their staff and representatives of organizations which provide funding and/or technical assistance to MSPP directorates, departmental offices or health facilities.
An interview tool was drawn up to ensure consistency of questions across interviews and a semi-structured approach, allowing for discussions to develop as information arose. The tool’s dimensions include the capacity to develop a service, the capacity to manage contractual relationships, the capacity to manage and regulate health service providers, the capacity to manage a health information system, the capacity to manage financial resources, the capacity to set prices for services, the coherence of the health sector policy and the management of the MSPP in general. Each dimension details a list of essential functions which must be performed and indicates whether that function is currently being performed and if yes, by whom and if not, whether the expertise and resources exist to carry them out.

Figure 2: Methodology and Assessment Tool

The assignment included the visit of five departments (Nord, Nord-Est, Sud, Sud-Est and Artibonite). In each visit, the team visited the departmental office, the department hospital, one private facility, one public facility supported by donors and another public facility without any external support. The objectives of the visits were to have a good understanding of the entire health system and evaluate how management is performed at each level. A detailed calendar with facilities visited is annexed to the report.
3 EVALUATION OF MSPP VIS-À-VIS THE CONTRACTING UNIT FUNCTIONS

In order to ensure the delivery of an essential package of health and nutrition services through health service delivery contracts, a contracting unit should:

a) define what to buy (package of services);
b) select from whom to buy (licensing);
c) develop plans according to, and consistent with, overall MSPP policies (planning function);
d) monitor what is bought (information system);
e) define the type of relationship between the purchaser and the provider of services (contract definition);
f) determine at what price and how services rendered would be paid for (price setting and provider payment mechanism); and
g) ensure that resources are properly spent and accounted for (fiduciary aspects).

The capacity of the MSPP to operate such a contracting unit depends on several factors, including the institutional setting of its components, availability of tools and competency/motivation of staff, among others. The mandate of each directorate and unit has been used as the benchmark of functions in this assessment of MSPP readiness. Each sub-chapter will deal with the functions that a contracting unit should cover, concluding whether each function is (and how it is) currently being performed by the MSPP.

An organizational audit, funded by the US Government and carried out by Dalberg in 2010, has already evaluated the overall capacity of the MSPP. Hence this analysis will focus only on issues related to contracting.

3.1 PACKAGE DEFINITION

In 2006, the MSPP defined a Basic Health Package (PMS – *Paquet Minimum de Services*) which should be available to the entire population. This defined package was not comprehensively costed and is likely to cost well in excess of the amount of funding available. Health expenditure per capita in Haiti, including expenditures at all levels of care, was at 40 USD in 2009\(^7\), which would be enough to cover the minimum threshold of 38 USD per capita defined in 2001 as being necessary to secure the provision of all basic health interventions in low-income countries\(^8\). However, there are various parallel packages in use (i.e. for HIV/AIDS, for maternal health, for child health), which include different services and different costs, depending on who funds them. Fragmented funding, with both overlap and gaps in funding of operational costs at the facility level also make it difficult to use current cost data as a basis for the future.

The USAID-financed *Santé pour le Développement et la Stabilité d’Haïti* (SDSH) program implemented by Management Sciences for Health (MSH) is currently undertaking a costing exercise of a reduced version of the PMS, called the *Paquet de Services Prioritaires*

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\(^7\) WHO National Health Accounts 2009

\(^8\) Report of the Commission on Macroeconomics and Health, 2001, pages 54 and 55
Intégré (PSPI). The methodology used, which mixed current costs based on current consumption of services and standard costs with forecasted consumption scenarios, may be a good basis to inform the process of standard cost definition (and reimbursement prices) of a basic package.

According to the DOSS, the MSPP has the intention of upgrading the PMS definition by 2012. The definition should take into account the services already being implemented by partners, especially on maternal and child health and infectious diseases. Moreover, the MSPP would need to bear in mind that current packages are not implemented countrywide, so current funding versus services would need to be projected to reach the entire population when readjusting the scope of the package. In this context, a detailed costing exercise (or a simulation using existing data projecting costs of each component) that leads to the implementation of an affordable package is required, considering what funds are available and also the technical capacity of the existing health facility network. Hence a revised, costed essential package (i.e. a prioritized version of the PMS) should be part of the process of establishing a contracting function at the MSPP.

3.2 ACCREDITATION AND LICENSING

The MSPP, through the DOSS, has already carried out some steps towards setting quality standards and ensuring that health facilities meet a minimum level of conditions to provide service. These steps are: (a) definition of criteria to open a health facility (licensing or Autorisation de Fonctionnement), (b) development of quality standards (accreditation), and (c) definition of quality standards of certain ancillary service such as laundry, kitchen and waste management (certification).

Defined licensing and accreditation standards have not been supported by enforcing regulations. The lack of a policy framework obliging health facilities to secure operating permits and a lack of incentives behind the use of quality standards has resulted in lax supervision from the central level and disinterest from health facilities. Moreover knowledge of the rules remains weak, most health facilities are unaware of such procedures and there is little or no enforcement by the MSPP. In terms of implementation, DOSS officials have evaluated 80 facilities in the last five years, which represents very low coverage (considering that the entire health sector has 908 facilities according to the Liste des Institutions Sanitaires –UPE 2011). During the field visits, virtually no facility could produce a copy of the PMS upon request and only one facility (a small and well organized private health center in Jacmel) could show a letter confirming operating approval. Lack of resources (both material and human) in addition to cumbersome procedures contributes to this poor performance.

These cumbersome procedures should be reviewed. Currently a facility must request a license via the departmental directorate. The request is then forwarded to the DG, then to the DOSS to undertake the appropriate evaluation, then back to the DG for approval, up to the Minister for final approval and then back to the department and the facility. The DOSS believes that departments must be much more involved in this process in order to make it work. The system needs to be more pro-active rather than reactive (thus not waiting for requests to facility licensing or accreditation, since most will not).

While DOSS claims that plans types (health facilities model plans) are available, a range of infrastructure (quantity and quality) as well as medical equipment was evident during
facility visits. Moreover the fact that investments in health infrastructure are under the authority of the Ministry of Planning and External Cooperation and that most interventions are donor funded complicate the enforcement of standards in this area. Anecdotal evidence shows that additions being made to facilities in terms of infrastructure or equipment only need to be approved by a public authority if public funds are being used, as all financial requisitions of public funds must pass through the DG and Minister. If non-public funds are being used there is currently no function of a public authority, be it centrally or at department level, to approve additions against norms and standards.

The supervision function currently cannot be performed due to a lack of skilled supervisors. The result is that most health facilities operate without a permit (either license or accreditation). Given this, the regulatory function of the MSPP is clearly compromised. Aid agencies have acknowledged this situation and some support has been provided. For instance, the Canadian-financed Projet d’Appui au Développement du Système de Santé (PADESS) supported the DOSS central office, helping to define standards and supporting general operations.

### 3.3 PLANNING

Per the Organic Law of 2006, the UPE exists to perform the monitoring and evaluation and implementation of normal health plans and programs, the development and monitoring of all aid-related socio-health activities conducted by bi- and multi-lateral or international actors.

A contracting unit would need, on the one hand, to forecast activity to be purchased, according to MSPP priorities and, on the other, lead the process of helping all health sector actors in developing their own plans. On the macro level, it is within the mandate of the MSPP to develop policies and strategies to translate the government’s vision on health into practice. Currently the MSPP is undertaking a re-thinking process which should culminate in a new health policy, which in turn should lead to a new long term sector strategy and a new organic law. It is worth pointing out that no clear policy on health financing is defined and current talks point to divergent models, which results in uncertainty and a potential waste of efforts if opposite models are pushed from different parts of the sector.

In this context of redefinition, most policy issues remain variable, as they can be changed as part of the ongoing process. Related to the two dimensions on planning that a contracting unit should pursue (forecasting purchasing of services and providing guidance to health facility planning), current MSPP capacity is weak.

Health sector-wide reporting is not produced on time and completeness is a recognized issue. The 2010 annual statistics report has not yet been released and its completeness will not exceed 70%.

Fragmented funding sources and few reporting requirements for non-public funding results in an unclear picture of resources allocated and services delivered. This function is scattered amongst project units but should be within the purview of the UPE. National Health Accounts (NHA), which were already produced in the past, are currently being planned for and should shed considerable light on the funding available to the health system. Institutionalizing the NHA process should be a goal albeit that this will likely take several years, considering that the Institute Haitien de Statistique et d’Informatique may
not be able to accommodate this as a routine in the short run. Furthermore, there is an argument for producing forward-looking (i.e. budget) financial information to provide a platform for sector-wide discussion of allocation of resources in real time, rather than in reaction to backward-looking data.

Although plans at central and departmental levels are prepared, budget spending is not guided by these plans. At department level, integrated plans (PDI), which include some partners’ funds, are prepared on a regular basis, with support of CIDA-PADESS. However the detail of PDIs is limited, having a list of objectives that are not translated into a format that could be used for day-to-day operations or reporting. According to key informants, departments’ staff lose interest in the exercise, as they do not see the value it brings.

The MSH/SDSH planning processes allow for accommodating other partners’ funds in order to have a comprehensive and coherent resource allocation process. However plans reviewed in departmental directorates visited only included MSH/SDSH resources.

In conclusion, overall MSPP capacity on planning is compromised by incomplete reporting, non-detailed plans and fragmentation of funding, which prevents consistent resource allocation.

3.4 INFORMATION SYSTEM

Haiti’s health sector has several sub-health information systems. The main system, implemented in most public and mixed institutions (the Haiti Système d’Informations Sanitaires, HSIS) includes a mix of outpatient service data, morbidity, mortality, inpatient care and aggregated revenue and expenditure data. Although reporting tends not to be produced in full and on time\(^9\) by all facilities, the system is well established and known within the public sector. However anecdotal evidence from field visits showed that personnel in charge of reporting do not know how to calculate some basic indicators, such as inpatient days. Private facilities do not always report, or send annual reports using ad hoc formats.

Basic epidemiological data is also reported in parallel, including the mandatory reporting of disease-specific information. The weaknesses of these systems, already described in recent analysis\(^10\), in addition to extra data requirements from donors has led to the development and implementation of parallel systems. These sub-systems are normally related to specific diseases, especially HIV, or sub-components of the basic package, such as maternal health. Perhaps the most prominent example of these systems is MESI, a system managed by CDC to collect data required for the USG PEPFAR program. MESI is in place in a handful of sites in each department and is a relatively lengthy and detailed

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\(^9\) The Directorate of Health of Artibonite had a 94% reporting compliance in 2011, although only 46% of reports were submitted on time. Directorate of Health of South East had a 75% level of HSIS reporting.

\(^10\) According to the Summary of the Report of the Organizational Audit: the findings of all analysis are always the same: “weakness of financial, human and technical resources, multiplicity of tools, and inadequate needs for information, weakness of the standards and procedures and lack of critical management functions of the SIS”
reporting system (close to 150 monthly indicators for those sites required to fill out forms for HIV, VCT, PMTCT, family planning, ante-natal care and births).

MSH SDSH also has a reporting system parallel to the HSIS, requiring many of the same indicators to be reported. The reporting requirement is 50 indicators and reports are collected from all SDSH sites. Measuring the completeness and accuracy of these systems is not within the scope of this assessment; however interviews with managers of both the MSPP UGP and SDSH programs confirm that both completeness and accuracy of data in their reporting systems are high.

The obligation to report in great detail in MESI, although not required by MSPP, has brought the development of relatively sophisticated and complex mechanisms to ensure on-time reporting, including hiring enumerators or securing internet in facilities with limited power supply. Linking funding to reporting, including giving financial incentives for timely reporting, has proved very successful, creating a richness of information not available in other parts of the system. The high level of accuracy and completeness of MESI data is also due to pro-active, timely follow-up of mistakes and missing reports by UGP staff.

The flow of information upwards to the MSPP does not appear to be systematic, although some departments state that they are sending reports to the DG, UPE and DELR (Directorate for Epidemiology, Laboratory and Research who maintain a separate database which forms part of the overall Ministry HSIS) each trimester. The fact that the 2010 MSPP annual statistical report is to be released more than a year late (and with data gaps) suggests that information produced by the system is not used for planning or monitoring, which discourages complete and accurate collection of data. Further there is no budget line in the MSPP budget for the HSIS which limits the ability of the MSPP to ensure regular, accurate reporting or to improve the system. The UPE has stated that they would like to see efforts to update the HSIS.

CIDA (the Canadian International Development Agency) and CHAI (Clinton Health Access Initiative) worked together with the MSPP in 2011 to produce a carte sanitaire, a listing of most sites in the country along with essential information about each site (including GPS coordinates, services offered and numbers of beds). This was a good initiative and will need to be built on as the information collected was very limited in scope. Appropriate allocation of investment resources, as well as planning what services can be offered given existing infrastructure, presupposes the existence of this information.

Health information plays a central role in a contracting function. In the absence of being able to measure the effect a health system has on the health of a population in real time, the best proxy is to use output indicators. This is the information provided by such health information systems as used by the MSPP (the HSIS), the UGP (MESI) and MSH SDSH. Using these indicators, a contracting unit can measure the results attained by service providers in a uniform way across all providers and disburse funds according to predefined targets.

There should be a coordinated, single information system for the health sector managed by the MSPP, with technical assistance as necessary. An effort should be put in motion to

engage relevant stakeholders to merge the previously mentioned health information systems, as well as others that may exist, into a single unified system. The completeness and accuracy of that system should then be a responsibility shouldered jointly by the MSPP and partners working in the sector.

3.5 Fiduciary Aspects

The Directorate of Administration and Budget (DAB) in the MSPP is, according to the 2006 Organic Law, the division of the MSPP which develops the Ministry’s budget and manages the financial resources of the MSPP. According to the Law, no other directorates within the MSPP have this mandate. In practice, however, several directorates in the MSPP manage their own funds and hold their own bank accounts. For example, the UCP manages direct funding from donors, as does the DSF (Direction de la Santé Familiale).

The DAB comprises four services (accounting, budget, general and for ambulances) as well as an information technology (IT) function, a procurement function, a secretariat and a public relations unit. Given the fact that over 90% of operational funds allocated to health by the Government of Haiti are salary-related and not managed by the DAB, this is an inflated directorate structure. However it is important to have this mechanism in place and to work to augment its capacities, in preparation for increased funding passing through it.

Salaries are managed entirely by the Ministry of Finance and released in Port au Prince to their Ministry of Finance counterparts in the departments. From there salaries are paid directly to Government of Haiti employees. Anecdotal evidence from field interviews indicates that salary payments by the GoH are frequently late and that some employees have not received their salaries for many months.

Non-salary operational costs are managed by the DAB, amounting to around 10% of the operational budget. However even these funds are managed by the Ministry of Finance, which maintains an account in the name of the MSPP. The Ministry of Finance maintains two employees at the MSPP, one financial controller and one treasury accountant. The process for disbursements follows procedures set out in a manual, a copy of which was available in the DAB Director’s office. This details that any procurements, i.e. of goods or services, require three proforma invoices to be provided by suppliers. A selection from among the three proposals is then made by the DAB Director who signs a requisition form and submits it to the Minister’s office for counter-signature. A check is then issued by the Ministry of Finance, drawn on the MSPP’s account.

Procurements over eight million Haitian Gourdes (US$200,000) require a competitive tender, which should be overseen by the Comité Ministériel des Marchés Publics (CMMP).

Investment funds are managed by the Ministry of Planning and External Cooperation for all sectors. As mentioned earlier, nearly three-quarters of public health sector funding for budget year 2011-2012 was allocated for investments and these funds are not managed by the ministry whose sector it relates to. Questions directed to the DAB Director as to how these funds are spent revealed that he has no visibility on these funds and only knew that the level of execution of those funds is very low.

At the department level, an Administrator manages the budget for the department. The Director of Health of the department is the budget officer who has approval power over
disbursements. However some disbursements still require approval by the Director General or even the Minister in Port au Prince when these involve the budget of the central level. Interviews with the DAB Director and department Directors of Health confirm that there are only fourteen budget units (defined as a unit which prepares budget requests, tracks expenditures and maintains budget reports for other offices) in the entire public health system. These include the MSPP (with responsibility therein placed with the DAB), the three referral / teaching hospitals (Hôpital Général in PaP, Hôpital Isae Jeanty in PaP and Hôpital Justinien in Cap Haitien) and the ten departmental Directorates of Health. Usually, as found in North East and Artibonite departments, the small budgets for the directorates are shared with the departmental hospitals and, such as in the case of Artibonite, with other major health facilities. This is further evidence that deconcentration / decentralization remains an effort based more on paper than reality.

The World Bank -funded fiduciary assessment, conducted in January 2012, concluded that hospital budgets are not well documented. Site visits conducted for this assignment, as well as the WB assessment, conclude that user fees may constitute a relevant source of revenue for hospitals (both department hospitals and communal hospitals), being vital for institutions without donor support. Revenues from pharmaceuticals sales, some of which they receive free of charge, are critical as they are then used to replenish stocks, implementing a de facto revolving fund mechanism for drugs. Pharmaceuticals are being charged at different prices in different institutions as there is no official regulation by the MSPP. The MSPP in general has little understanding of the financial receipts of health facilities, nor of how they manage their budgets in general. The WB study states that the only documented supervision visit to the field by representatives of the DAB was in 2010. The lack of supervision by the MSPP at either the central or departmental level indicates a worrying lack of accountability over these funds, however at several sites visited, a significant contingent of the staff were paid from these funds.

Government-wide there is no Medium Term Fiscal Framework, nor a Medium Term Budgetary Framework in place according to a Public Expenditure and Financial Accountability (PEFA) assessment commissioned by the European Union delegation. This reduces certainty over mid-term resource allocations, making difficult any strategic planning process.

While waiting for the findings and recommendations of a forthcoming USAID mission on general fiduciary risk (Public Finance Management Rapid Appraisal) scheduled for the end of March 2012, the current status of public financial management in general, as well as the current state of financial controls within the MSPP, seems to indicate that the MSPP is not ready for funding to be channeled through it. Hence other arrangements, ensuring that procedures meet international acceptable standards, should be explored.

### 3.6 Contract Crafting, Provider Selection, Rules Enforcement

The MSPP has been using contracts as tools to set relationships with the private sector for many years. For instance in 1988, the MSPP signed a contract giving the control of certain services at Fort Liberté in the North East to Centres pour le Développement et la Santé (CDS). This contract had no end date. A recent version of the contract, signed in 2011, is valid for five years and is renewable by tacit agreement. It transfers the management of
some, but not all, services within the facility to the NGO, which may lead to a lack of clarity as to who is in charge of the facility. Monitoring of the contracts seems not to be anyone’s responsibility within the MSPP and NGOs enjoy a quasi-exclusive status in each site, since there are neither performance evaluations nor bidding processes. The resulting public-private management mix, which entitles NGOs to capture donor funds on behalf of government, seems self-perpetuating, although no clear national policy exists in this regard.

The Unité Juridique (UJ) was not able to produce an example of a contract template used with service providers, i.e. NGOs. When asked to produce a copy of a contract with a health service provider, they produced the contract of an individual nurse working in a health center. Donors and their implementing partners appear to submit their own contract forms, which are checked by the UJ for compliance with Haitian laws and regulations. The UJ appears to be sufficiently staffed given that they have four lawyers and two others in training. The fact that no active engagement in contract verification takes place suggests that some capacity building would be needed.

Given a lack of experience, the capability of the MSPP to select providers on a competitive basis is limited. The capability to perform this function would therefore need to be built from scratch. Tender documents with specifics on the services to be offered and requesting costed proposals in response would need to be developed, and criteria for selecting the most desirable provider elaborated.

Laws and regulations appear in general to be poorly enforced. The reasons behind this are: (a) norms request conditions and funding that are not in place, including the PMS; (b) a historical lack of mandatory implementation of standards and rules has led to lax practices in facilities; (c) the MSPP being poorly equipped for licensing and monitoring. In addition the MSPP has had limited experience thus far with complex, condition-based contracting and competitive provider selection. Capacity would need to be built, and resources provided, both in terms of rule-enforcement and advanced contract management.

### 3.7 Price Setting/ Provider Payment Mechanism Definition

Funding the fair costs of providing services requires exploring the service delivery production function of health facilities of each level. Risk sharing between payer and provider, understood as who bears the differential cost when services needed are higher than average, must be taken into consideration. The way health providers are paid also determines their behavior and the amount of services that they provide. The selection of provider payment mechanism is key to defining who would bear the risk (payer or provider) of, among other considerations, the cost of providing services. Mechanisms can vary from budget allocation (unconditional block transfer of funds from the payer to the provider based on a previously agreed formula), where all risk is borne by the provider (because they are bound to provide services to an unknowable number of patients for a set budget), to fee-for-service (each service provided by the provider results in an incremental fee to the provider, whether the payer is the patient or a third party), where the payer shoulders the risk (because the number of services which would be provided is unknowable to the payer when the agreement is made).
In Haiti, allocation of resources to health facilities is guided, in the case of government resources, by historical trends and by attribution of ceilings based on output indicators (number of deliveries, anti-natal visits, etc.) Once ceilings are established, a bottom-up planning exercise is undertaken, such as in the case of USG-funded services at health facilities. Resources allocated through work plans include budgets for the required personnel and operational costs. The allocation function is generally fragmented, as each donor allocates resources without consulting other donors. There is an exception, with SDSH apparently acting as “last call resource” allocating resources where funding gaps exist. Lack of completeness of integrated budgets prevents confirmation of whether this is done systematically or not.

### 3.8 SUMMARY

<table>
<thead>
<tr>
<th>Functions of contracting unit</th>
<th>Who should perform this function?</th>
<th>Tools available and its enforcement</th>
<th>Evaluation</th>
<th>Remarks to consider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Package definition</td>
<td>DOSS with UPE support</td>
<td>PMS defined, not fully implemented</td>
<td>Package defined but too ambitious</td>
<td>Adjust MSPP package according to feasibility. Definition to be made by DOSS/ TA (together with cost study)</td>
</tr>
<tr>
<td>Licensing/ regulation</td>
<td>DOSS</td>
<td><em>Authorization de fonctionnement</em>, accreditation and certification of Laundry, Kitchen and waste management</td>
<td>Standards defined. No enforcing policy. Heavy administrative procedures</td>
<td>Provide funds (MSPP work plan) to run evaluation. Streamline procedures. In the future, link payments to quality (meeting the standards)</td>
</tr>
<tr>
<td>Planning</td>
<td>UPE, UADS for departments</td>
<td>Integrated plans developed but not followed for implementation No health financing strategy</td>
<td>Strategic and annual plans prepared with some TA support Plans not integrated.</td>
<td>Need to link policy with strategy and annual operational plans. Develop a MSPP annual single plan, under the SWAp concept (donor coordination align to MSPP priorities)</td>
</tr>
<tr>
<td>Health information system</td>
<td>UPE and Department Directorates for implementation</td>
<td>HSIS is well established but incomplete and inaccurate</td>
<td>Local HSIS could cover basic needs. Procedures established. Not full compliance</td>
<td>Link budget allocation (and bonus) to info provided in the HSIS. Support (MSPP workplan) the merging with existing donors sub-systems</td>
</tr>
</tbody>
</table>

**Table 1: Summary table of MSPP capacity to perform basic functions of a contracting unit**
<table>
<thead>
<tr>
<th>Functions of contracting unit</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Contracting/ content/ selection of partners</td>
<td><em>Commission Ministerelle de Marches Publics</em> (CMMP), with UJ and UPE support</td>
<td>No operative procurement unit, although defined by law. DAB performing such role (3 proforma) MSPP contracting NGO (no transfer of money) for more than 20 years UJ using partners contract templates</td>
<td>MSPP not having the tools and the capacity to perform the purchasing/ procurement function</td>
<td>Build on the introduction of the CMMP and develop a monitoring framework (technical and financial)</td>
</tr>
<tr>
<td>Price setting</td>
<td>UPE</td>
<td>Partial PMS cost studies available. Government provider payment mechanism is budgets</td>
<td>Budgets not link to activities/ volume</td>
<td>Use cost studies for projecting readjusted package per capita cost Develop a formula of budget allocation</td>
</tr>
</tbody>
</table>
4 PARTNERS EXPERIENCES WITH SERVICE DELIVERY FUNDING

4.1 USAID – MSH/SDSH

SDSH (Santé pour le Développement et la Stabilité d’Haiti) is a USAID project managed by Management Sciences for Health in Haiti. The goals of the SDSH project are to increase access to basic social services for approximately 50% of the population in Haiti public and private sector health system and strengthen the Ministry of Health and Population public sector executive function to efficiently manage the health sector.

SDSH’s mandate is to ensure the delivery of a priority package of services mainly focused at strengthening health services delivery at community level. The priority package is a reduced basic health package (a less ambitious version of the Paquet Minimal de Santé of the MSPP) which covers five technical areas: to reduce transmission and improve treatment of HIV; reduce transmission and improve treatment of TB; contribute to reduction of maternal mortality in targeted populations; contribute to the reduction of infant mortality in targeted populations by immunizing 85% of children <1 year; Community Case Management for most common childhood illnesses; and to increase access to and use of modern FP methods, including long term and permanent methods.

At the departmental level, SDSH uses two funding streams to strengthen the governance role of the health departmental directorates. The first is direct cost reimbursement of activities based on an action plan to facilitate supervision, trainings and other activities related to the stewardship role of the MSPP(activities linked to its regulatory role). The hard-to-reach areas called zones ciblées (ZCs), or targeted zones served by public health facilities, are financed through performance-based contracts, and a percentage of the total amounts of ZCs income is awarded to departmental directorates based on the performance of the ZCs.

MSH/SDSH maintains an office in Port au Prince with a permanent staff of 50. In each of the ten departments, SDSH maintains a staff comprised of one technical adviser, one financial officer and one or two drivers. Additionally they provide customized assistance on demand from the department.

Two types of service providers are funded by SDSH: ZCs and NGOs. ZCs are areas of the country identified by the MSPP as being particularly in need of support. These communes can contain within their boundaries, depending on the area of the country, between one and ten health facilities. Facilities in zones ciblées are funded directly by the SDSH office in Port au Prince. Accounts in the names of each of the facilities are maintained at a commercial bank, under the general supervision of the SDSH financial officer at the department. Additionally, each of the ZCs has an accountant (ergo the accountant may be managing the accounts for one site or several). ZC receipts are kept at departmental offices and must be available on request for audits and supervision teams. The SDSH financial officer is in turn supervised by an SDSH representative in Port au Prince. In total SDSH funds services at 79 public sites aggregated into 33 ZCs as of October 2011 through partial performance-based financing agreements.
In the case of channeling funding through NGOs, SDSH contracts NGOs that have formal agreements with MSPP to provide certain health services within public facilities. The relationship between SDSH and NGOs is in the form of fixed-priced contracts, which link funds to agreed service delivery targets. In this case, the NGO is fully responsible for the financial management, planning and reporting. Receipts not sent to SDSH and are kept by the NGO for eventual audits.

At the beginning of the year, each ZC is given a budget ceiling by the SDSH office in Port au Prince. The formula for determining the budget ceiling is the role of the Performance Management Unit at the SDSH office in Port au Prince, however it does not appear to be well known by any of the departmental SDSH offices. Additionally, one of the SDSH financial officers interviewed felt that the budget ceilings provided didn’t make sense. Once the budget ceiling has been received, the heads of facilities, together with the SDSH technical adviser and representatives of the department, put together work plans for the year. Work plans are then sent for review to the MSH Contracting Office. There follows an iterative process of plan revisions leading to final agreement from all parties. SDSH then signs contracts with NGOs and agreements with the MSPP, on behalf of departmental directorates. SDSH and the department then agree on a disbursement schedule of funds with corresponding targets to be met.

The work plans and budgets prepared for sites in zones ciblées show costs being covered for salaries and other non-salary operating costs. Medicines and equipment are expressly not covered in the agreement between SDSH and the zones ciblées. The outputs on which

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**Figure 3: MSH SDSH Model for Financing Service Provision**

MSH directs the funding provided by USAID for both service delivery and MOH strengthening

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12 Taken from a report compiled by Dalberg Associates
the disbursements are based are defined in the finalized agreement. The clinical output indicators each have targets to be reached. If the provider achieves all deliverables, they will receive 100% of pre-agreed funding for the year. There is a bonus of 6% to be awarded by SDSH if all of the targets for the clinical output indicators are surpassed. On the other hand, the site can also lose 6% of their funding (i.e. only received 94% of pre-agreed funding) if they fail to reach any of the targets for the clinical output indicators.

An example disbursement schedule for a zone ciblée is outlined in Table 2.

Table 2: Disbursement triggers for the MSH/SDSH program

<table>
<thead>
<tr>
<th>Trigger</th>
<th>Disbursement</th>
<th>Bonus percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>MoU signed</td>
<td>25%</td>
<td></td>
</tr>
<tr>
<td>Monthly reports</td>
<td>10%</td>
<td></td>
</tr>
<tr>
<td>Training report</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Success stories</td>
<td>19% third month</td>
<td></td>
</tr>
<tr>
<td>BCC / Community mobilization</td>
<td>20% sixth month</td>
<td></td>
</tr>
<tr>
<td>Tracking against work plan</td>
<td>20% ninth month</td>
<td></td>
</tr>
<tr>
<td>Supervision visit reports</td>
<td></td>
<td></td>
</tr>
<tr>
<td>% Children vaccinated</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>% New mothers w/ 1 post-natal visit</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>% Pregnant women w/ 3 pre-natal visits</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>Client satisfaction survey</td>
<td>0.5%</td>
<td>0.5%</td>
</tr>
<tr>
<td>Functioning internal receipts mgmt system</td>
<td>0.5%</td>
<td>0.5%</td>
</tr>
<tr>
<td>7 other indicators – 1 chosen at random for review</td>
<td>2%</td>
<td>2%</td>
</tr>
</tbody>
</table>

The indicators used are all quantitative clinical output indicators. Quality is captured through the client satisfaction survey.

4.2 CDC – M S P P / P E P F A R U G P

CDC has developed a scheme that mixes funding services (mostly for HIV) through NGOs and through the MSPP’s Unité de Gestion de Projet (UGP), which has been established by a Cooperative Agreement between the MSPP and CDC. Staff has been hired by MSPP although their salaries and conditions do not follow civil servant rules. In 2011, UGP managed USD 17 million and had 1,382 HIV patients under anti-retroviral treatment. Operations of the UGP, including its annual plans, are elaborated by the UGP and validated by the UGP and the Minister.

Planning and budgeting procedures starts with a bottom up exercise where beneficiary institutions prepare a plan, which covers HIV services and, more recently, mother and child health and tuberculosis services. After consolidation, the plan is approved by the
MSPP and CDC. Each annual plan is translated into a quarterly plan, which leads to disbursements, once approved. Money flows to specific bank accounts of each institution. Financial management is the responsibility of accountants hired with the grants, although in some cases the work can be accommodated by existing MSPP paid accountants. Every MSPP staff with some relationship with MSPP-PEPFAR funds receives a financial incentive (a top-up), including administration staff. Financial audits are performed in order to ensure the proper use of resources.

Financial flows depend on extensive reporting supported by MESI, a customized database for PEPFAR indicators. Reliability of the information system is guaranteed by exclusive data collectors, IT maintenance support and servers installed in health facilities. In addition to technical and financial support at sites, MSPP-PEPFAR also funds specific technical assistance at the MSPP central office (DOSS, UPE) and activities such as training and supervision. On financial management, UGP is introducing accounting software (ACCPAC) at beneficiary facilities although, during field visits, only one facility claimed to be using the software and only for MSPP-PEPFAR funds. Training on the software and the required license is supported by UGP funds.

4.3 CIDA - PADESS

The PADESS project, funded by the Canadian International Development Agency (CIDA) provides advice and technical assistance to improve the governance of Haiti’s health sector. It focuses on: (i) strengthening the regulatory role of the MSPP; (ii) developing a shared vision of the health sector among stakeholders; and (iii) strengthening the effectiveness of Canada’s aid to Haiti’s health sector.

PADESS financial support covers several areas at the central and departmental levels (three departments), normally using local civil servants to manage resources, although in separate bank accounts and not using the Government’s financial system. Supervision and audits from central level are conducted on a regular basis. While funding technical assistance, many activities of PADESS are directly implemented by local technical staff, including the development of the “Carte Sanitaire”. Technical assistance has been provided to the DAB, the UPE, the DOSS and UADS. At the DOSS they have helped develop standards and funded licensing activities, including a limited number of site visits. The UPE received substantial support to develop the new national health policy and strategic plan, to support four departments to hold donor coordination meetings and to support central level donor coordination meetings. The DAB received support to finalize the financial management procedures manual and print 200 copies, followed by training workshops on its contents. PADESS also supported the UADS in their support to departmental health units. These activities encompassed helping departments define their annual priorities, create departmental operational plans, creating disaster management plans as well as others.

The general approach of PADESS is to strengthen the MSPP and three departmental directorates’ capacity through using regular public workers but channeling its financial resources through parallel schemes. The program is operational in three departments where comprehensive organizational diagnoses were also performed to create more efficient management structures. According to the DOSS Director, technical assistance supported by PADESS was very useful to the needs of her directorate. Activities conducted
under PADESS are agreed upon and submitted through an annual plan that is approved by the Minister and the DG of MSPP.

4.4 UNICEF

UNICEF has traditionally supported specific areas of the sector, including vaccine supply and all vaccination related activities. Annual work plans do frame UNICEF support for both central and departmental level. Money flows are separated between central and departmental level, since a tentative to move financial resources from central level resulted in substantial delays. Disbursements of resources are made for every semester and a specific administrative team controls every receipt. Internal audits are secured by UNICEF administrative staff.

UNICEF also uses a contractor (AEDES) to help three departments (Sud, Grand’Anse, Nord Est) on institutional strengthening in issues like planning and donor coordination. Contracted staff (Public Health specialist, finance manager and an assistant) is embedded inside the three department offices.

4.5 PAHO-WHO

PAHO was implementing until April 2012, the “Soins Obstetrics Gratuits” (SOG) program, which aims to improve access to obstetric care through waiving user charges of patients in exchange of providing funding linked to the number of deliveries and other related services. This scheme is implemented in 62 health facilities across the country. The method used to pay providers is retrospective fee-for-services, and governed by direct contracts between PAHO and health facilities. Financial resources are paid every four months and reports received trigger subsequent disbursements. The resource ceiling for each facility is decided based on past activities, as demonstrated through specific health information subsystem. Financial resources are channeled directly to facilities, although the departments have an oversight role, as well as the DSF and UADS at the central level. Receipts must be kept at the facility level for eventual audit inspections.

After SOG, a new program, “Manman ak Timoun”, is being launched. Some SOG characteristics will be replicated, including the four month disbursements. However, a new approach on incentives will be put in place, with bonuses linked to some progress indicators, such as completeness of baseline, introduction of patient charts, setting a follow up committee and achievement on quality measured through a patient appreciation survey. The Departmental level will also play an oversight role which will be reinforced with incentives to patient chart compliance and quality of reporting.

4.6 CUBAN COOPERATION

The Haitian health system has other types and forms of partnerships. Amongst them, the Cuban Government cooperation should be highlighted, as their presence is widespread in a few dozen public health facilities. The Cubans’ support, agreed at the highest level with the GoH, includes deploying medical specialists, administrative support, supplies and even rehabilitation or construction of health facilities. In health facilities where Cubans work, there are two sets of management, with medical directors and administrators from both Haiti and Cuba. Anecdotal evidence from three sites suggests that lack of cooperation and transparency are common. For instance while the Cuban direction waves all user fees, the
Haitian management believes fees should be charged in order to meet contingencies in operations. Drugs for ambulatory care that are not provided by the Cubans are sold and replenished by revenues collected. Cuban medical staff reports in separate forms from the Haitian system to their mission.

4.7 SUMMARY

The following table summarizes partner experiences in relation with the contracting functions. This analysis aims to identify activities that partners have been implementing in these areas, learning from their experiences in order to inform the process of establishing contracting within the MSPP. Only experiences that have contracting characteristics are included.

Table 3: Summary of select partners experiences related to the contracting functions

<table>
<thead>
<tr>
<th>Functions Contracting unit</th>
<th>USAID MSH – SDSH</th>
<th>CDC MSPP – PEPFAR UGP</th>
<th>CIDA PADESS</th>
<th>UNICEF</th>
<th>PAHO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Package definition</td>
<td>Funding Primary Health Care level – Adjusted package Implemented in zones cibles and NGO run facilities</td>
<td>Vertical approach: Mostly HIV, recently including TB and MCH in XX health facilities where PEPFAR is implemented</td>
<td>Funding activities strengthening the health system - stewardship</td>
<td>Vaccination activities Stewardship activities in 3 departments</td>
<td>Maternal and child health services SOG Mamma ak Timon</td>
</tr>
<tr>
<td>Licensing/ regulation</td>
<td>Not link to MSPP model</td>
<td>Not link to MSPP model</td>
<td>Supporting licensing development and implementation</td>
<td>No link to MSPP model</td>
<td>No link to MSPP model</td>
</tr>
<tr>
<td>Planning</td>
<td>Parallel planning (vocation of integration) Plans approved</td>
<td>Parallel planning (HIV patients related) Plans approved by MSPP and DSs – Own model</td>
<td>Helping both UPE and Departmental level to come up with integrated plans</td>
<td>Parallel planning</td>
<td>Parallel planning</td>
</tr>
<tr>
<td>Health information system</td>
<td>Parallel system Parallel reporting – HSIS is not enough</td>
<td>Parallel system: MESI HSIS cannot provide the necessary info</td>
<td>-</td>
<td>Parallel system collecting and reporting information on vaccination program</td>
<td>Parallel system Parallel reporting</td>
</tr>
<tr>
<td>Contracting/ content/ selection of partners</td>
<td>Fix priced contracts to NGO Memoranda with DSs Governance activities payments at DSs Zones ciblees: salaries and operations</td>
<td>Corporate agreement MSPP – CDC to create UGP Contract with NGOs from CDC Resources to facilities and directions départamentales</td>
<td>Agreement with MSPP and 3 departmental directorates</td>
<td>Working directly with departments</td>
<td>Agreement/ contracts directly with health facilities Departments have an oversight role</td>
</tr>
<tr>
<td>Functions Contracting unit</td>
<td>USAID MSH – SDSH</td>
<td>CDC MSPP – PEPFAR UGP</td>
<td>CIDA PADESS</td>
<td>UNICEF</td>
<td>PAHO</td>
</tr>
<tr>
<td>---------------------------</td>
<td>-----------------</td>
<td>------------------------</td>
<td>-------------</td>
<td>--------</td>
<td>------</td>
</tr>
<tr>
<td><strong>Financial management</strong></td>
<td>MSH/SDSH manages payments to NGOs and DSs. DSs based SDSH staff control zones ciblées funding.</td>
<td>UGP manages resources. Accountants hired with grant resources – to health facility level.</td>
<td>Resources transferred to and managed by Government institutions (MSPP offices and departmental directors). Program own supervision.</td>
<td>Resources managed by DSs and health facilities administration stuff. Separated bank accounts.</td>
<td>Resources transferred to health facilities and Department directorates. Project financial supervision.</td>
</tr>
<tr>
<td><strong>Price setting/costs</strong></td>
<td>Bottom up budgeting with predefined ceilings. Cost study ongoing – SD performance payment.</td>
<td>Bottom up budgeting with predefined ceilings. No cost estimation used.</td>
<td>Bottom up budgeting. No cost estimation used.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
5 SCOPE AND VISION OF A CONTRACTING UNIT

5.1 GENERAL APPROACH

5.1.1 Guiding principles
The creation of the contracting function should be guided by principles that reflect stakeholders’ goals as well as the GoH’s. Obviously these principles include the Government of Haiti’s policies, but also the new US Government government-to-government strategy and the Paris Declaration/Accra Agenda principles that should frame any aid program. Taking into account such references, the process of creating a contracting function should consider the following objectives:

a) **Donor coordination and SWAp.** The contracting function should be seen as a platform for donor coordination, which donors join to reduce transaction costs in terms of parallel planning and monitoring systems. With this in mind, the Contracting Unit should inform, and be a key mechanism for, the work of the Table Sectorielle (health sector coordination group which includes government and donor representatives) and the specific thematic groups created by partners. Moreover this unit should also be seen as the seed of an eventual Sector Wide Approach (SWAp) to programs for the sector. Note though that the eventual creation of a SWAp would not necessarily create a pooling fund arrangement; different donor efforts may be streamlined in a coordinated plan without pooling financial resources.

b) **Single plan.** The contracting function should fund GoH-set priorities defined in a single plan, which merges donors’ with government funding. This single plan should also be used as the annual translation of the mid-term strategic plan, which should also be consistent with the national health policy (currently under development).

c) **Separating service delivery from stewardship.** Funding service delivery, understood as providing financial resources to health facilities in order to fulfill their day-to-day routine operations, should be treated separately from the stewardship/ regulation function, which includes trainings, supervisions and even capacity building to make the regulatory function work. Securing funding for delivery provision should be seen as a priority.

d) **Using government systems.** Partner programs should use, where possible, government systems in order to build a strong local health sector. The model adopted for the contracting function should seek to build the capacity of the MSPP through a “learning by doing” approach. As much of the actual work and decision-making power as is possible, consistent with the controls required by donors, should be in the hands of MSPP staff.

e) **Single planning and budgeting process.** Partners should aim to reduce parallel planning and budgeting systems, along with using different health information systems. Note that weaknesses of some local systems might require agreeing between government and donors as to what should be considered a local system.
(perhaps among existing parallel systems). However the eventual end goal should be that a single information system meets the needs of government and donors.

f) **Incentives.** Funding of both service delivery activities and stewardship functions should include incentives that increase the overall performance of the system. Performance-based payments should be linked to final outputs but also to process and quality indicators, trying to cover the key areas where MSPP needs strengthening.

g) **Funding a basic package.** Funding services should move from the current vertical program focus towards a more horizontal approach, covering the package of essential interventions delivered at the primary and secondary levels. Donors may then select the services from the package that they wish to fund.

### 5.1.2 The efficacy and sustainability trade-off

Partner-supported programs implemented in Haiti face the trade-off related to securing measurable results and making efforts sustainable after the programs end. Results-oriented donors privilege the former, scoring low on sustainability of their activities. The fact that the major donor (USG) has been mostly results-oriented and that other donors have more limited leverage has not helped to build local systems, making sector performance almost totally dependent not only on donors’ resources but also capacities. Moreover the introduction of incentives targeting key permanent staff (civil servants) has proved ineffective for increasing sustainability and created extra problems. A recent study (Laroche, 2011) points out that most programs have failed to strengthen capacity and have brought about a deterioration in working relationships between workers because of perceived unfair incentive schemes. This should be borne in mind when the salaries of personnel in the contracting function are set.

As presented in the background section, the new USAID policy of working closely with government systems represents a shift towards more functional sustainability (defined as the sustainability of processes and skills, rather than sustainability of finances). Nonetheless this new focus would need to be backed by high-level decision-making and try to balance building local systems with achieving defined targets. The role of output- and performance-based payment mechanisms should be explored in order to foster this.

The deployment of technical assistance in key directorates of the MSPP would be needed as well in order to continuously build capacity and introduce new routines.

### 5.2 Institutional Setting of the Contracting Function

The institutionalization of the contracting function involves: (a) the definition of the reporting structure, having a clear description of whom it reports to within the MSPP organigram; (b) the definition of its relationship with MSPP headquarter directorates, the departmental level and health facilities; and (c) a description of the GoH-partner governing bodies at each level. The agreed setting of the contracting function would need to take into account the principles described above, seeking to find an arrangement that supports its goals.
Starting from the principles presented above, the objectives would be to create a function that manages partners’ resources (USAID and WB initially, others eventually), funds the provision of an essential package and uses local systems as a way to strength local capacities. The function itself does not, and in the view of the authors of this report, should not perform all the activities needed for contracting, instead placing that responsibility in the MSPP directorates whose original responsibilities (package definition, planning, licensing, etc.) they should be. Taking into account these objectives, the setting of the contracting function should use as much as possible existing MSPP institutions and, when this is not feasible, set mechanisms of interaction between the function and the MSPP.

The following subchapters present three options for the institutional setting of the contracting function. The first assumes that no new unit is created and partners use the UPE as the unit that centralizes the contracting function of the MSPP. The second option is to build on the existing CDC-funded MSPP-PEPFAR UGP. The third option considers the creation of a new Contracting Unit (CU) which would have control over financial resource flows while everything else is managed from the relevant MSPP units and directorates. The following subchapter (5.2.4) presents the pros and cons of each option, using as benchmarks the above-mentioned principles and other needed criteria such as acceptability to other partners and transaction costs.

The three options have many common features including: (a) a technical assistance package for central and departmental level would be attached; (b) the Minister and the Director General would approve all major plans and strategic resource allocations; (c) the partners and MSPP would engage in a formal agreement that would set the objectives and conditions of disbursements; (d) funding would be attached to an essential package; and (e) the contracting function would be enhanced consistent with the Procurement Law, working under the oversight of the CMMP (Commission Ministérielle des Marchés Publics).

5.2.1 Option 1: MSPP organic setting

The first option is to make use of the current MSPP organigram and existing units to establish the contracting function. In this model, the contracting function would be located within the UPE and financial resources would be managed by the DAB.
Partners in this option would channel financial resources through a controlled bank account in the name of the DAB to department directorates. Given that the GoH has only 14 budget units (the MSPP, the departmental directorates and the 3 national teaching/referral hospitals), resource management would be limited to 11 (removing the hospitals) of these budget units. It would be necessary to develop new modalities of contracts between MSPP and NGOs as the current ones do not involve transfer of money nor any performance measurement or compensation. A complete upgrade of financial management procedures, along with specialized technical assistance would be needed.

The other functions of contracting would be spread across UPE (planning and information system development), DOSS (licensing and package definition), UADS (planning follow up with departments) and UI (contract crafting and enforcement), all under the strategic oversight of the DG and the Minister.

5.2.2 Option 2: Adapting the MSPP-PEPFAR UGP model

The second option would be to make use of the existing UGP as the contracting unit. Partners’ financial resources would be managed by the UGP, where contracts with health facilities would be signed and monitored. The development of contractual arrangements with NGOs would be needed. Given the intention to fund an essential package, the UGP would either move towards using the HSIS or an expanded version of MESI that accommodates all essential package activities.

Currently the interaction of the UGP with the Ministry appears to focus primarily on having the Minister approve plans, budgets and disbursements for which the “heavy lifting”, i.e. the thinking, writing and financial management, is being performed by the UGP. In order to meet the underlying principle of this project to strengthen the regulatory function of the MSPP, the UGP model would need to be adapted to allow much greater involvement of the MSPP’s various units, particularly the UPE and the UADS, in the creation and approval of work plans, the monitoring of outputs and quality and the liaison with the department level.
5.2.3 Option 3: MSPP contracting unit

The MSPP Contracting Unit (CU) model consists in allocating the responsibility for financial management to a new unit, created by an MSPP-donor agreement, and leaving all the other functions within the relevant MSPP units and directorates. The CU would enter into agreements with other MSPP units, departmental directorates and health facilities, and would contract with NGOs who provide health services at GoH health facilities. Financial resource management for public health facilities entering into agreements with the CU would be controlled at the departmental level, using a similar model to that currently in use by SDSH. Under this option, the funding flows for stewardship would be linked to annual workplans, while the funding for service delivery would be linked to indicators related to delivery of the essential package.

The CU would contract with private providers, under the requirements of the Procurement Law. The CU would enter into memoranda of understanding with public providers, but with the same underlying performance targets and compensation. Contracting private providers (i.e. NGOs) would involve a substantial redefining of contracts vis-à-vis the contracts currently in place between the MSPP and NGOs. The contracting tools, including the content of contracts, the monitoring framework and the development of procedures for potential disputes, would be developed with CU staff support, following the Procurement Law and explicitly building capacity of the newly created CMMP and UJ.

The order of releasing funds would be made by each unit director (UPE, DOSS, departmental, etc.), although the CU technical staff would make sure that disbursements are linked to financial plans. The CU size would grow according to the volume of resources that it would manage and would be staffed by contractual personnel hired directly by the MSPP, with donor funds.
5.2.4 Evaluation of options

Each option must be evaluated based on the advantages and disadvantages of each vis-à-vis the defined principles. Option 1 has significant advantages in terms of sustainability but there are significant doubts regarding the absorptive capacity of the DAB, which has little experience with managing large sums of money, uses inadequate financial systems and does not have an adequate mechanism in place to track expenditures. The lack of experience of the DAB or any other unit of the MSPP with purchasing services from the private sector also plays against this option.

The MSPP-PEPFAR UGP option has demonstrated capacity to manage financial resources using systems acceptable to donors. However its vertical funding focus, built around HIV, cholera and MCH interventions, and the fact that the UGP manages most of the functions that should be run by MSPP units, make this option less attractive. The UGP would itself admit that it is a single project implementation unit, designed specifically for that purpose and not set up to absorb funding from multiple donors. It may be able to absorb additional PEPFAR and other USG funding via its existing funding mechanism, however not from any other donor. Again the UGP would admit that it was not set up with the goal of furthering objectives related to the SWAp, nor donor coordination. Considering the heavy focus on HIV of the UGP, a substantial re-focus towards accommodating other programs would be needed, as well as returning the monitoring function to the UPE, in order to strength MSPP capacity.
The MSPP Contracting Unit, while housing financial management in a unit other than the DAB, keeps the rest of the functions located within the MSPP, which should help to strengthen its capacity. It also gives the core contracting and triggering functions to a small separate unit, allowing the UPE to focus on its key planning and monitoring functions.

Considering the pros and cons of each option, the CU option seems the more balanced, maximizing the principle of using government systems while ensuring that partner resources would be managed according to acceptable standards.

5.3 WHAT TO CONTRACT AND FROM WHOM

As described above, the general aim is to spread the contracting functions across the MSPP units while channeling the financial resources through the CU. Hence definition of what would be purchased and from what type of institutions is required.
5.3.1 What to purchase
Following the principles described above, the CU would contract two types of products. On the one hand, it would purchase services delivered to patients by health facilities whilst on the other it would fund regulatory activities (the stewardship function) carried out by MSPP headquarters and the departments.

5.3.1.1 Service delivery
The funds being provided to health service providers would go to pay salaries and non-salary operational costs, leaving out investments (capital) and medicines. It is recommended that investments not be part of the package, since setting up new facilities, renovating or equipping them should be managed taking into account access, situation of the network, etc. Medicines should also not be included and be carefully studied since MSPP is already making efforts to rationalize the efforts that aim to secure availability through improved supply chain.

The funding of inputs does not imply that the CU would focus on monitoring whether the inputs have been used or not. In fact the CU would measure the outputs produced with them. Hence the CU would purchase outputs from facilities, outputs being defined as the final products that health facilities deliver to patients (i.e. number of consultations, number of discharges, deliveries or coverage indicators such as vaccination rates), but would fund inputs (i.e. operating costs). Hence the contractual arrangements between the CU and health facilities would focus on numbers of outputs delivered (and some measures of quality), instead of inputs (salaries of personnel and operational costs) used.

In order to increase the system’s performance, some funding would be linked to meeting agreed targets between the CU and the health facilities. The amount of funding subject to performance would be relatively small in order to secure predictable funding for facilities and ensure that all basic inputs are funded.

5.3.1.2 The stewardship function
The stewardship function, according to Travis et al.\(^{13}\) involves 6 core domains: (a) generation of intelligence; (b) formulating strategic policy direction; (c) ensuring tools for implementation (powers, incentives and sanctions); (d) coalition building / building partnerships; (e) ensuring a fit between policy objectives and organizational structure and culture; and (f) ensuring accountability. These domains are under the primary responsibility of the MSPP and its funding involves funding activities such as preparation of reports, development of information systems, redefinition of packages, meetings, supervisions, etc. Hence the contracting unit would also fund these types of activities.

The CU would fund the annual work plans that both MSPP and departmental directorates would prepare. These plans, to be approved by the Minister and DG, would include all stewardship function-related activities. Performance payments would also be linked to the achievements of teams within the MSPP departmental directorates. The beneficiary units / directorates of funds would be linked to their mandate. For instance, DOSS would

\(^{13}\) Travis, P. et al., Towards Better Stewardship: concepts and critical issues, WHO, 2002
be the recipient of funds to perform implementation of the licensing process for facilities while the UPE would receive funds to ensure that the HSIS is fully operational.

Current funding of activities by donors pays for almost all these inputs and outputs in separate or mixed programs. For instance some programs pay on the one hand for salaries and operational costs of health facilities while on the other, fund “stewardship” activities at both facility and department level. Including health facility operational funding in health (vertical) program work plan funding responds to the need to keep facilities functioning while providing support to program-related activities. However this might lead to overlapping support and uncertainty. Therefore separating operational costs from programmatic costs would ensure that facilities have the minimum necessary to operate and should be encouraged.

The following table summarizes the type of inputs that would be funded through the contracts of the CU with health facilities and MSPP/departmental directorates (stewardship).

**Table 5: Types of inputs to be covered by the contracting unit**

<table>
<thead>
<tr>
<th>Personnel</th>
<th>Goods &amp; services</th>
<th>Drugs</th>
<th>Investment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operational costs of health facilities</td>
<td>Civil servant salaries</td>
<td>Supplies, fuel, energy, water, maintenance</td>
<td>Essential medicines</td>
</tr>
<tr>
<td>Contractual salaries</td>
<td>Lab reagents</td>
<td>Medical supplies</td>
<td></td>
</tr>
<tr>
<td>Bonuses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stewardship costs (trainings, supervisions, meetings, policy)</td>
<td>Per diems Fees</td>
<td>Travel Renting Fuel</td>
<td>-</td>
</tr>
</tbody>
</table>

5.3.2 From which providers

The Contracting Unit needs to deal with different types of institutions for different roles in the health system. On the one hand, the stewardship / regulatory function would require providing funding and support to MSPP central office and departmental directorates. On the other, service delivery to patients may be purchased from both public and private providers, using NGOs as intermediaries when they have a shared management scheme with MSPP or when bringing an extra added value such as building health facilities networks.

The division of buying services provided to patients and activities performed by MSPP central office and departmental directorates is key, since while the former can be built around paying for final outputs, the latter is linked to processes (supervision made, report submitted). Both aspects are needed but they must be treated separately.

It is also worth mentioning the possibility of considering networks of facilities as partners in the contracting process. In fact SDSH is already doing that when contracting NGO services that run/support more than one facility in a determined area, although they do
not play the role of a single network of services. In Artibonite, the UCS model in which 5 people (coordinator, administrator, statistics officer, nurse and driver) support each of the 7 communal networks, should be explored as a potential agent to contract / transfer / manage resources.

Lastly, differences in health facility ownership must not be ignored. In the long run, MSPP as purchaser of services may aim to contract services from all kinds of facilities but supply-side subsidies via salaries or aid agencies should also be taken into account. Currently facilities supported by the Cuban aid agency have a free services policy, thus fulfilling the access to services goal from the supply side (budget allocations managed by parallel Cuban administrative staff). In the short run, these facilities may not be included in the contracting of services.

5.3.3 Using procurement law to build government systems

The relatively new legal framework for government procurement (July 2009) represents a unique opportunity to develop the purchasing function of the MSPP consistent with local structures and legislation. Hence the setting of procedures for bidding processes, publication, transparency, evaluation, etc. should follow what the law defines under the guidance of the Commission Nationale des Marchés Publics (CNMP), which is in charge of overseeing procurement for the government. The procurement activities of the CU should be under the supervision of the CMMP and this approach should build CMMP capacity providing technical assistance and training. Details of the final arrangement would need to be set during the design phase.

5.4 HOW TO ALLOCATE RESOURCES AND WHO TRIGGERS PAYMENTS

5.4.1 The resource allocation process

The financial resources that every institution should receive should take into account: (a) the total amount of resources available; (b) the decision on the level of resources which should go to the stewardship function and to service delivery; and (c) the activities / services / inputs that they should cover. This process involves a top-down policy exercise (of ceiling definition) but also taking into account the bottom-up planning process, ensuring that the minimal resources required to function (securing that ceiling would cover salaries of the team that would secure the essential package, regardless of the volume of service) are in place.

These decisions should be taken by the MSPP at the highest level in coordination with partners (see next chapter), following the technical recommendation of MSPP offices and the CU. Concretely, UPE should be the office preparing technical tools to allocate resources that link ceilings to policy objectives. For instance, UPE should be the office developing formulas that mix different criteria, such as need (population), production of services (number of deliveries) or installed capacity (number of beds) and submit them to top management for approval. It is important to note that any tool used for this purpose should be transparently shared with the entire sector in order to increase transparency and make clear what is behind the budget allocations.
MSPP top management may also consider setting certain limits to administrative costs, i.e. CU costs and stewardship costs, as a way to protect and prioritize resources for service delivery.

5.4.2 What and who should trigger payment

As described above, while the CU would manage the financial resources, MSPP units and directorates would have the triggering function under their control, giving approval for the CU to disburse resources. The triggering function would be also linked to submission of information, reports, plans or other supporting documents. For the stewardship / regulatory function, the first release could be linked to the approval of the annual plan. In the case of service delivery, this could be linked to the approval of their annual operational budgets. Subsequent disbursements should be linked to the submission of statistical (HMIS in the case of health facilities) or activity reports (for departments and MSPP central office). While this approach would cover the agreed (in work plans or operational budgets) fixed components of funding, a variable part would be linked to predefined performance indicators, both final outputs and process-linked. Some funding would have to be disbursed prospectively to ensure non-interruption of services at facilities with few resources, however a mix of prospective and retrospective payments may be required to meet the needs of the MSPP, facilities and donors.

Payments for performance would build on the model that MSH/SDSH has been developing in recent years, where an extra budget allocation is linked to meeting certain clinical targets. In order to support the implementation of the basic health package, the CU should develop a performance balanced scorecard for health facilities, where most of the interventions are tracked. This scorecard should be based on the indicators reported in the HSIS as well as additional indicators to measure quality.

Increasing performance in the stewardship function, i.e. strengthening the regulatory function, monitoring, creation of policies, etc., might also need financial incentives for involved staff. Incentivizing individuals is however challenging in terms of methodology; there is a tendency to focus on quantitative outputs, such as numbers of meetings attended, rather than quality given that the latter requires defining clear deliverables (e.g. policy writing, developing information system) which are harder and more time consuming to track. While delivering of products may be linked to disbursements, the CU should study an approach that, through clearly defined top-ups to retain / mobilize skilled workers, links scopes of work with the necessary deliverables. Team performance incentives, financial or not, may also be considered.

As presented above, the triggering function would be located in MSPP offices, including at the departmental level. The reason behind this is to “return” power to local institutions. Triggering resources would involve giving clearance for disbursing allocations based on, for instance, reports received. The main difference from current models is that the triggering function would be performed by units and directorates, instead of the Minister and the Director General, which both would play a more strategic role. This would prevent bottlenecks in resource flows.

The directors of MSPP units with triggering responsibilities would play the role of giving the “go signal” to the CU for disbursements linked to the approval of defined deliverables. Notwithstanding, embedded TA and technical staff would have a determinant role preparing the necessary analysis and quality controls.
The following table presents some examples of the relationship between contracted institutions, what are the objectives to pursue in the contracts, what documents would trigger disbursements and which unit would have this function.

**Table 6: Examples of documents that should trigger disbursements and performance payments**

<table>
<thead>
<tr>
<th>Contracted provider/ institution</th>
<th>Contract objective</th>
<th>Triggering document</th>
<th>Triggering MSPP unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health facility</td>
<td>Payment to services delivered link to a list of agreed indicators (Resources for operation costs of health facilities)</td>
<td>Monthly statistical report complete and accurate sent to DDS</td>
<td>DDS</td>
</tr>
<tr>
<td>Departmental directorate</td>
<td>Consolidated HMIS reporting accurate and on time</td>
<td>Consolidate HMIS report submitted to UPE</td>
<td>UPE</td>
</tr>
<tr>
<td>MSPP/ UPE</td>
<td>Country’s Statistical Annual Report accurate and on time</td>
<td>Statistical Annual Report published and launched</td>
<td>UPE/ CU</td>
</tr>
</tbody>
</table>

**5.4.3 Verification**
A bi-annual (twice a year) or quarterly verification mechanism should be installed in the initial two years of the project. This mechanism would take the form of joint supervision visits to the field with members of the central MSPP (CU, UPE), departmental MSPP and funders. The supervision would involve at minimum: (a) a visit to the departmental health unit to review procedures and practices in respect of budgets, work plans and facility indicator reports; (b) a visit to one or two sites to verify progress against work plans, proper accounting procedures are being followed and verification of patient registers against HSIS reports. Elaboration of detailed procedures for the verification process should be led by the Contracting Unit in collaboration with partners.

**5.4.4 Embedded TA**
The setting of the contracting unit would be accompanied by a team of technical assistants that would provide technical support to key areas of the MSPP and departmental level. Beyond support on finance management and financing reporting (at CU and departmental level), a team of technical assistants should be embedded at UPE (plans development, health financing policy development and HSIS enhancement), DOSS (licensing development and implementation) and UADS (health facility and department planning and monitoring). The embedded TA would be reporting directly to each of the MSPP unit directors and would help them to assume the role of triggering disbursement, or performing their normal regulatory functions, while strengthening the capacity of each unit. Details on the scope of work or the amount of TA inputs needed should be defined in the design phase (see next chapter).
5.5 The Governing Bodies

The creation of the CU must be accompanied by establishing certain governing bodies that would follow-up CU operations and ensure that GoH and partner policies are respected, aiming to build a process for the development of a SWAp. The main mandate of the governing bodies would be ensuring that policies are implemented, identifying challenges and issues to be addressed. The governing bodies would be located at each planning / decision-making level, from the strategic / policy level (Minister level) to the departmental / operations level. The following scheme defines at which level the three governing bodies would be located.

At the policy level, the MSPP, represented by the Minister and the Director General, the Ministry of Economics and Finance, the Ministry of Planning and External Cooperation, which controls the investment budget, and partner representatives would create the Comité de Pilotage. This group would be in charge of approving the total envelope of available resources, the share of resources that should fund service delivery (the ESSENTIAL PACKAGE) and the stewardship function and annual plans. This group, which in the long run should be absorbed by the Steering Committee of a SWAp, would meet one or two times per year. The CU would play the role of secretariat and would be in charge of the follow up of recommendations and necessary reporting.

Figure 7: Governing bodies by level

At the technical level, the Director General, together with the national level MSPP directorates and the departmental directorates, would constitute the Technical Coordination Group (TCG). This group would follow up programs and budget execution and would meet every three months. Additionally, this forum would be used as the place to translate new policy directions, decided by the Strategic Coordination Group, to operations. The group would focus particular attention on the follow up of annual plans,
the development of the HSIS, the management of contracts and the regulation of health facilities. Lastly, this group would produce regular reports presenting the degree of absorption of new methodologies introduced by TA and suggest the reinforcement or removal of TA at MSPP level. Every MSPP unit / directorate would play the role of secretariat on a rotational basis, depending on the topics discussed in each meeting. The CU would also participate in the TCG, providing budget and expenditure related information and technical advice on request.

At the operational level, the key departmental staff and partners, including NGOs, working in each department would create the Departmental Coordination Group (DCG), which would be in charge of guiding and following the process of preparation of the Annual Integrated Plan and following it up. There would be one DCG per department. All TA present in the department would also be part of the group, which would meet on a monthly basis. The departmental directorates would be in charge of following up the decisions taken by the DCG, with the CU and TA support, ensuring the implementation and consistency of the activities to the policies and strategies decided at central level. Also the DCG would systematically report to the Technical Coordination Group. It is important to note that there are initiatives aiming to increase donor coordination at departmental level, such as UNICEF-funded embedded TA in three departments. In these provinces, the Departmental Coordination Group should use existing coordination bodies, not create new ones.
6 CREATING A CONTRACTING FUNCTION WITHIN THE MSPP: A CREDIBLE ROAD MAP

6.1 KEY STEPS TO BUILDING A CONTRACTING FUNCTION

The approach recommended here would make a distinction between three categories of key steps required to put in place the contracting function: (i) establishing the relationship between the MSPP and the donors who would put funds through the contracting function; (ii) putting in place the contracting mechanism; and (iii) steps critical for the proper functioning of the regulatory function of the MSPP. The strengthening of the regulatory role of the MSPP is an underlying principle of this approach.

6.1.1 The legal basis for the relationship between partners and the MSPP

The legal basis for the relationship between the MSPP and donors who would channel funds through the contracting function of the MSPP is not within the scope of this assessment and needs to be defined. One key element, which must be considered when establishing this relationship, is that Haitian laws and regulations be respected. With regard to the contracting function, two Haitian laws / decrees are relevant. The first is the Décret Portant sur l’Organisation et le Fonctionnement du Ministère de la Santé Publique et de la Population (MSPP) of January 2006, otherwise referred to as the Organic Law. This decree describes the organizational structure of the MSPP. This decree does not expressly provide a legal basis for the creation of new units in the MSPP. It is possible that another law or decree does confer this power on the Minister, however further research would be required to establish this. A new decree is currently being drafted, which might provide the opportunity to include the establishment of the Contracting Unit as a new unit in the structure of the MSPP.

The second is the Loi Fixant Les Règles Générales Relatives aux Marchés Publics et aux Conventions de Concession d’Ouvrage de Service Public of June 2009, otherwise referred to as the Procurement Law. This law details the oversight function within any government ministry and therefore which would oversee the operations of a contracting function within the MSPP.

Equally the structure, rules and regulations of the contracting function of the MSPP would need, in a reasonable way, to meet the requirements of donor governments.

6.1.2 Putting the mechanism in place

The following are selected key decisions which must be made, regardless of the form the contracting function takes. This list cannot be made exhaustive, as some aspects would only be apparent once implementation begins.

6.1.2.1 Adopting a costed basic package of services which would form the basis of what would be purchased

One of the fundamental principles of this assessment has been that the contracting function should purchase a government-endorsed basic package of services, rather than one, two or three vertical interventions. The current Paquet Minimum de Services is a very broad document containing an unwieldy combination of services and other aspirational goals. It is apparent that little thought was given to the cost of providing the services and other objectives in the document and it is therefore of little practical use. It
would be impossible to use in its current form as a basis for what a contracting function would seek to have implemented in a healthcare setting.

Creating a costed essential package of services requires a symbiotic, near simultaneous identification of health priorities and their related contextual cost. In a setting such as Haiti, with the limited resources at its disposal, either from the State budget or from donors, it is clear that the essential package of services would need to be limited in scope from the beginning. In undertaking this process, a first key step is to have a broad understanding of the resource envelope. Then the goal is to identify essential health interventions, using both burden of disease and costs of interventions as the main criteria.

It is suggested to use the system costing approach, where costs are calculated taking into account the necessary resources (type of facilities, list of essential medicines, size of health team, etc.) to serve a determined number of population in a catchment area with a determined epidemiological profile and a forecasted level of consumption of resources (number of outpatient visits per inhabitant, expected deliveries adjusted by expected institutional delivery rates, etc.). One the cost of the identified list of interventions has been calculated, policy-makers would be able to make an informed decision as to what can and cannot be included in the basic package.

This process, however, takes time. There may be the desire to set up a contracting function to purchase a basic package in a shorter timeframe than would allow for the above-described process to take place. In this case, an interim solution would be to adopt a basic package already defined and costed for the Haitian context and to have the contracting function use that as its unit of purchase during a first phase. This could also serve as a pilot implementation period to learn lessons before moving to implementation of a broader package of services.

**6.1.2.2 Developing a budget allocation formula and publishing it;**

Several interviews conducted during the course of this assessment revealed that the recipients did not understand the level of funding being received by sites. A large part of the logic involved in allocating funds to providers appears to be historical in nature, i.e. the budget established for the year ahead is based on the budget that was provided in the year prior. This chain of reasoning continues several years into the past until no one can recall the original reason for the original division of resources among providers.

The development of the budget allocation formula could be a complementary/alternative approach to using the *per capita* budget allocation resulting from the package costed, providing transparency and fairness to resource distribution. One of the relevant features of formulas is that they reduce uncertainty and resources are not arbitrarily distributed.

In general, the fundamental factors to consider in developing a budget allocation formula are the populations to be served by the providers and the relative need for healthcare of those populations. This criterion (need) may also be included in the process of costing the package using the abovementioned system costing. However, formulas may include as many indicators, thus criteria, as wanted, offering several possibilities to policy-makers. For instance, relative poverty may be considered, hence introducing an indicator such as Human Development Index as part of the formula. Once the factors have been decided on (potentially with weights attached to individual factors, although this should be discussed
as part of the development process) the formula could be published and explained widely within the health sector.

6.1.2.3 Recruiting, hiring, and training key staff participating in the contracting function

The form of the contracting function would determine the numbers and types of people to be recruited. If a new unit is to be set up, there a greater number of people may need to be recruited, as opposed to an alternative option to house the contracting function within an existing unit. Further, there may be discussion on the roles and responsibilities to be carried out within one unit or another, depending again on the form of the contracting function. Regardless of the outcome of these discussions, it would fall to the Comité de Pilotage to assign responsibility to someone to recruit individuals into several new positions. The Comité de Pilotage should decide how many new positions should be created and approve the terms of reference of those positions, with assistance from the key donors who intend to use the contracting function from its inception.

The background and experience of those to be hired and whether the relevant profile is to be found locally should be taken into consideration. The success of the contracting function would depend largely on the individuals who are selected to lead the function and this is therefore an aspect to setting up the function that should be given careful consideration. However, in any case, the recruitment for these positions needs to be undertaken on a competitive and transparent basis, with possibilities to attract qualified diaspora back to the country.

6.1.2.4 Identifying key indicators to be tracked and ensuring their availability in the HSIS

A key aspect of the contracting function would be to measure the result of what has been purchased. In an ideal setting, it would be possible to measure the effect on the health of the population in real time of the interventions being purchased. Given the obvious impossibility of that type of measure, a proxy is to measure the outputs being purchased. For example, the numbers of children who have been vaccinated in a given month or the number of women using modern contraception. The MSPP has the Haitian Systèmes d’Information Sanitaire (HSIS) which provides much of this information. As discussed previously in this report, the HSIS is widely in use in the Haitian health system but suffers from important deficiencies in accuracy and timely reporting. Additionally there are multiple other parallel systems that have been put in place by donors.

The contracting function should identify the key indicators that would be measured as part of the contract with providers. Importantly the decision on what indicators to include and how many should consider existing evidence on the advantages and disadvantages of measuring more or fewer indicators, as well as the indicators which provide the best overall indication of a broader successful approach to healthcare provision. Further the selection of indicators should consider what types of behavior the contract with providers is seeking to incentivize and the overall extra costs of gathering more specific indicators, particularly those which are not collected in the HSIS as a routine. There is significant literature available of experiences elsewhere to guide this process.
Building on local systems and having a single health information system for the Haitian health sector is one of the principles underlying the contracting function, based themselves on the principles of the SWAp and the Paris Declaration. Harmonizing and eventually creating a single health information system is a significant undertaking and has been shown elsewhere to be a multi-year process. This is therefore listed as a process that should be undertaken in parallel as part of strengthening the MSPP’s regulatory function. However it would be important for the contracting function to make use of one system to monitor the outputs it is purchasing. It is recommended therefore that all indicators required to measure outputs for the contracting function be incorporated into the HSIS.

6.1.2.5 Establishing the financial flows arrangements

The recommendation of this assessment, as already discussed, is that funding not be directed through government treasury accounts or funding mechanisms. This is based on the assessment of the authors of this report as well as other assessments already conducted and which have been referenced earlier in this report. In this context it would be necessary for the contracting function to develop a system of accounts through which it can channel funding to the providers from whom it would be purchasing.

Key decisions would need to be made on aspects such as how many bank accounts to maintain both at the central level, department level and facility level (potentially also at the UCS level, should it be decided to use the UCS structure as part of the contracting model). This would partly be a decision based on the number of donors who would channel funding through the contracting function and whether they are able to contribute to a pooled mechanism or whether their funding needs to be kept separate from other funding. The decision as to whether to open bank accounts for each facility is important and is strongly encouraged. A positive aspect of at least one existing contracting function in the Haitian health system was the opening of bank accounts in the name of individual facilities, and the placing of an accountant at each of those facilities, thereby extending the management responsibility and skillset further down the health system.

Further, the Comité de Pilotage would need to decide who would be the ultimate authority on making disbursements and accounting for them. This would to a large extent depend on the model chosen for the contracting function, however the selection of the two people who would have signatory authority for disbursements would need to meet the requirements of the MSPP and the donors channeling funds through the contracting function, provide a robust system of checks and balances and finally ensure that disbursements are made on time and in full as provided for in the contracts. Equally the decision as to which individuals would have signatory authority lower down the chain of the health system would need to meet the same requirements.

6.1.2.6 Drawing up a policies and procedures manual for operations and procurement

Policies and procedures are important to have in place so that all actors in the contracting function have a guide at their disposal as to how to act in all scenarios. Having these manuals in place should be one of the first priorities of the contracting function. Its development should be acceptable to partners (in the first phase, to USAID and WB) and would need also to be consistent with the Procurement Law, following and/or building on its procedures, strengthening in this way MSPP capacity on procurement.
The existence of a manual is not only good in and of itself to guide the operation of the contracting function at all levels and remove uncertainty and doubt, but having to go through the process of defining the policies and procedures in the first place would have the beneficial effect of requiring the leadership to have an in-depth understanding of how the function would operate even before any contracts have been signed. This process should also create a positive direction for the contracting function at the outset and provide a substantive project, which the new hires can work on collectively as they take on their new roles.

Further with the inevitable turnover in staff, which would occur over time, having policies and procedures in place would contribute to the successful operation of the contracting function in the medium to long term. The manuals would reduce the potential for time-wasting discussions on what the procedures are, or on reinventing the wheel.

The Comité de Pilotage should approve these manuals, as they would serve as the guiding operational documents of the contracting function. The manuals should also be published on the MSPP website.

6.1.2.7 Designing the incentive scheme for service providers

Related to the process of designing the key indicators and how they would be compensated is the process of deciding what portion of service provider compensation would be performance-based and on what basis that performance would be measured. The incentives would differ for the case of health facilities, where output indicators may be used, from regulatory levels, where process indicators are needed. The design of incentive process shall be linked to the overall revision of provider payment mechanism. For instance, the introduction of per capita allocation to fund a list of interventions may be accompanied by incentivizing performance through a bonus scheme. All these issues would be discussed during the process of defining the contract’s content.

6.1.2.8 Identifying the initial sites and/or networks

The initial set of sites to be funded via the contracting function would depend primarily on (i) the resource envelope available, (ii) who the initial donor(s) is (are) who would channel funding through the contracting function, (iii) what are the existing programs in the pre-selected sites, including Manman ak timoun program and others, and (iv) any decisions made by the Comité de Pilotage or MSPP/UPE on whether a geographic or other division of sites by donor is to be pursued.

6.1.2.9 Drawing contracts to be used with NGOs

The relationship between the payer (MSPP through the CU) and the health providers would be different in the case of public facilities and NGOs. In the first case, an agreement setting the targets and conditions should be enough. On the contrary, with NGOs, the procurement law shall be followed, exploring all the possibilities of the contracting out model. The contracts with NGOs may require recommending revisiting the existing arrangements, where MSPP cedes part of many health facilities management to NGOs in an apparently non-competitive bidding process.
6.1.3 Strengthening the regulatory role of the MSPP

Some tasks which are important to the general regulatory function of the MSPP and which this approach should seek to strengthen but which are not of themselves key to the operation of the contracting function are:

- **Licensing and accreditation of health facilities**: setting, ensuring and supervising the use of basic standards in health facilities is a basic approach to quality. In a country like Haiti, the first steps should aim to ensure that facilities have the minimal required inputs to perform their work, including the basic health teams, medicines, equipment and basic services, such as water and energy. More demanding approaches to quality, including the implementation of good practices, procedures, status of hygiene, following clinical guidelines are also important but this should not be pursued until, at least, the first steps are done;

- **Developing and implementing a basic package of services**: although the MSPP has already developed a package, it should be updated to take into account available financing. Defining the basic health package is an exercise of explicit rationing, where Governments usually put borders to what should be available based on affordability and capacity. In the process, the MSPP can have two approaches. On the one hand, it can define a list of interventions and use it as a lobby tool to mobilize more public resources. This approach might work only if health is seen as a top priority for the Government and even in this scenario, the package may not be fully funded. On the other hand, a basic package may also be defined in an incremental way, selecting the list of interventions that can be afforded and expand this list when more resources become available. This scenario, if partners are committed to it, may be more effective for the Haitian context. In any case, the process should be highly transparent and visible in order to gain support from all stakeholders.

- **Harmonization of health information systems**: having a comprehensive health information system that feeds policy making is key for the MSPP. Hence, building and strengthening the HSIS should be a priority for both the MSPP and partners. The existence of the current parallel sub-systems should give way to a single system that accommodates all needs. To do it so would require the provision of technical support to central level (upgrading the HSIS) and at department level, supporting the management, following up facilities reporting and securing quality. Partners engaged in the contracting function must design the schemes consistent with these needs.

6.1.4 Risk management

In creating a contracting function at the MSPP, certain risks should be considered and mitigation measures put in place to reduce the likelihood of their causing adverse conditions for the smooth operation of the contracting function. Table 6 presents some of the potential risks that the setting of the contracting unit would face, their most probable causes and the mitigation measures that could help reducing them.
Table 7: Contracting unit setting risks, potential causes and mitigation measures

<table>
<thead>
<tr>
<th>Risks</th>
<th>Potential causes</th>
<th>Mitigation measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operational decisions (all kinds) slow to be made</td>
<td>Current modus operandi of the MSPP is a heavily centralized model of decision-making</td>
<td>Overall plans must be approved by top management</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Day-to-day operational approval to be delegated to MSPP UPE / CU</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(dependent on model selected)</td>
</tr>
<tr>
<td>Late disbursement of funds to operational entities</td>
<td>Delays in planning / lack of human resources</td>
<td>Embedded TA for planning at central level and department level</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Performance incentives to present plans on time</td>
</tr>
<tr>
<td>Late disbursement of funds to operational entities</td>
<td>Delays in approval / bottlenecks regarding disbursements</td>
<td>Develop a submission schedule over the course of the year</td>
</tr>
<tr>
<td>Mismanagement of funds</td>
<td>Strict controls not developed. Strict controls not adhered to.</td>
<td>Strict financial controls in place. Dual signatory on all disbursements.</td>
</tr>
<tr>
<td>Information system not performing</td>
<td>Delays in reports being submitted up from sites to departments and on to the central level</td>
<td>Introduce performance payments related to timely report submission.</td>
</tr>
<tr>
<td>Information system not performing</td>
<td>Reports submitted are not fully completed. Reports submitted are not fully accurate.</td>
<td>Introduce performance payments related to full completion of reports. Embedded TA. Training at department level.</td>
</tr>
</tbody>
</table>

6.2 THE TECHNICAL ASSISTANCE PLAN

As presented above, the creation of the contracting unit would need to be undertaken in parallel to efforts to strength MSPP technical capacities. The following sections explore areas where technical assistance should be deployed. As a general approach, all technical assistance would be embedded at the MSPP institution, reporting to their correspondent line manager.

6.2.1 Central level support

Various MSPP offices would require technical assistance in order to be able to do what they are supposed to in relation to the contracting functions and to capacitate their personnel. In order of importance, the following elements must be enhanced from the very beginning: (a) process of setting contracts, (b) fiduciary aspects, (c) planning, (d) information system, and (e) definition of the package functions. The revision of the licensing process may not be a priority in the first phase.
6.2.1.1  Technical assistance at UPE
UPE would require technical assistance, in the form of one-two experts, on planning, helping to develop and implement budgeted plans for the central level. The TA support UPE on health financing aspects, including the development of policies but also defining and adjusting the provider payment mechanisms, including the development of formulas, bonus, etc., and analyzing and using the HSIS for better planning/ resource allocation purposes.

Additional TA would also be needed in order to enhance the current HSIS, making it reliable in order to be used as the reporting tool linked to the service delivery purchasing function. Existing and/or planned TA in this area, especially the efforts aiming to merge the existing sub-systems would need to be considered before the final TA is designed, avoiding duplication of efforts.

6.2.1.2  Technical assistance at UADS
The UADS would have an important role overseeing departmental plans. Despite having plans already developed by other partners, these are currently developed in independent silos. A more systematic, joint method of planning, with integrated budgets is still needed. Hence, specific planning TA within the UADS may be necessary to support its director in the role of translating national policies into local implementation. This TA would build up on the PADESS and UNICEF experiences supporting departments.

6.2.1.3  Technical assistance at CMMP
Building MSPP capacity on procurement would require helping CMMP setting and supporting its procurement process oversight role. In this area, a TA would help in the development of the procedures defined in the new procurement law, including preparation of templates and tools for CMMP supervise all procurement activity within the MSPP. This TA role may be played by the CU staff, considering that the kind of expertise that the CU must have matches the procurement one.

6.2.1.4  Technical assistance at DOSS
Lastly, moving forward the licensing/ accreditation function of MSPP would require external support. Despite having developed quality standards, there is a need to streamline procedures and review the policy in order to make it implementable. The TA would play the role of revisiting the procedures and support DOSS activities of implementing them. Notwithstanding, this TA may be considered for phase 2.

6.2.2  Department level
At the departmental level, there are two different aspects that must be supported. On the one hand, planning and monitoring, thus securing that plans and indicators are produced with the sufficient quality and on time, shall be supported. At the same time, the TA would need to support health facilities, providing templates and following up its implementation.

On the other hand, another TA would support the proper use of financial resources, securing that reporting and internal controls do meet international acceptable standards. In the mid-term, this type of TA shall be phased out.

Both TA would have a double role, securing that the necessary steps for contracting are followed and providing broader assistance to the department. The two TA would support
different areas at each department. The following figure presents which areas would be supported by each TA, using the organogram of the DSSE as the model.

6.3 POSSIBLE STEPS TOWARDS A SWAP

The principles guiding the development of the contracting unit stress the need for better donor coordination, assisting the Government around a single plan and reducing the use of parallel systems. While USAID and the World Bank are committed to this approach, other major donors may also consider this possibility. Enhanced coordination and increasing Government’s capacity is in all donors’ agenda, hence there is space to make coordination more effective and build around Government systems. One modality already implemented in several countries is the Sector Wide Approach (SWAp). This modality builds on the idea of having a plan that involves the entire sector and aims, under the partner country leadership, to use partner country systems and processes (alignment), develop the partnership in support of short-, medium- and long-term goals (harmonization), and achieve tangible development outcomes and impacts. While this process has barely started, the following issues could help the donor community moving towards the development of a SWAp.

- **Establish common “rules of the game”:** partners should operationalize their commitment towards further coordination through agreeing formal agreement (possibly in the form of a Memorandum of Understanding) on the rules governing their interactions and those with Government. In the first instance, this may be a very basic agreement on shared goals with a more in-depth agreement at a later stage with participating partners on harmonizing procedures.

- **Go “On planning”:** partners should continue making efforts putting together their activities in a single Government backed plan. This should involve making predictable commitments and adopting/ adjusting to Government calendar. Going “on planning” reduces transaction costs and makes allocation more efficient.

- **Merge efforts on monitoring and evaluation:** sharing monitoring and verification tools, moving towards a single information system and reducing supervision missions would save resources.

- **Use and build on local systems:** building sustainability requires working with local systems. Partners should use and build on existing planning and monitoring systems, building local capacities on the way.

- **Pool funds:** although many donors may not be able to enter into this modality, partners should consider the advantages of pooling financial resources in terms of minimizing administrative costs and giving the full power of priority setting to host Governments. Nonetheless, pooling funds is an option that may only be considered in the long run.
## ANNEX 1 - CALENDAR OF ACTIVITIES

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ANNEX 2 – TERMS OF REFERENCES

TERMS OF REFERENCE OF MSPP READINESS ASSESSMENT TO MANAGE CONTRACTS AND PROGRAMS

I. TITLE

Readiness Assessment of the Ministry of Population and Public Health to Manage Contracts and Programs: Terms of Reference for a team of international experts

II. PERIOD OF PERFORMANCE

O/a January 16 – March 12, 2012 (8 weeks)

III. OBJECTIVE

Prior to assisting the MSPP in implementing its key governance or health systems priorities and guide the development thereof, the World Bank, Pan-American Health Organization, Canadian International Development Agency, and USAID requires short-term consulting services to assess the readiness of the Ministry of Population and Public Health (MSPP) to create a Contract and Program Management Unit.

IV. CONTEXT

a) Haiti’s health outcomes are among the worst in the region and far from the Millennium Development Goals (MDGs). Lack of access, both physical and financial, to health care plays an important role in Haiti having poor maternal and infant health outcomes, undermining the country’s ability to achieve the MDGs in 2015. The delivery of health services relies on a network of public, private non-profit, mixed non-profit (institutions owned by state, but operated by non-governmental organizations), and private for-profit providers, resulting in a highly fragmented system with NGOs providing an estimated 70 percent of health services. Even prior to the recent earthquake, the Ministry of Public Health and Population (MSPP) faced great difficulties in regulating the sector and providing essential public health functions. Poor coordination of these actors in the past led to an overlap of services in some areas of the country and a lack of access to essential basic health services and low coverage in other areas, particularly peri-urban and rural communities. Strategies are needed to provide better access to essential services, improve the quality and equity of these services, increase the efficiency of sector resources and provide tools to the MSPP to effectively regulate and reduce fragmentation of the system. These types of issues in such an environment can be addressed by ensuring strong government leadership and better coordination among key players to achieve pre-defined target outcomes.

b) Strengthening the stewardship role of Government to coordinate donors, development organizations, and private sector providers is the key to successful outcomes in Haiti. Programmatic coordination and communication by Government across the large variety of implementing agencies has been a huge challenge, exacerbated by the large inflow of aid organizations since the earthquake. Government has been forced to adapt to each institution’s way of functioning and implementation mechanisms, greatly increasing transaction costs. The complexity and quantity of these agreements hinders the provision
of sufficient and timely authorization, oversight, and evaluation, ultimately leading to a lack of control of the Government over sector activities as well as an inability to effectively guide new partners interested in contributing to social sectors.

c) Crucial to the success of the MSPP’s ability to respond to limited access as well as gaps in services is the development of adequate capacity to effectively put in place, manage and supervise the relevant contracting and monitoring arrangements. In order to build an institutional capacity of the MSPP in the long run, a Contracting Unit (CU) would be established. This Unit is expected to be firmly embedded within the MSPP to manage funds and coordinate and oversee the activities and sector programs of various donors, particularly related to the country wide provision of an essential package of health and nutrition services through standard procurement procedures, financial and technical management of health service delivery contracts, in coordination with corresponding MSPP departments and relevant stakeholders.

V. SCOPE OF WORK

Under the overall direction and supervision of the MSPP, with support from the Canadian International Development Agency (CIDA), Pan-American Health Organization/World Health Organization (PAHO/WHO), USAID and the World Bank, a small team of international consultants will assure completion of the following:

a) An analysis of the abilities of relevant existing technical units and directorates (DRH, DOSS, DAB, UADS, UPE, MSPP-PEPFAR) at the central level and at the ten departmental levels to perform the functions laid out in the loi organique. This analysis would a) identify strengths and weaknesses of specified units and directorates within the MSPP (human resources capacity, budget planning capacity, technical capacity, tools/operating systems, equipment, space) at central and departmental levels to perform essential public health functions as defined by WHO; and b) the reporting lines and relationships among the key technical units/directorates at the central level and between the central and departmental levels.

b) Recommendations of options for institutional modalities of the Contract and Program Management Unit (location, structure, capacity needs, staffing, reporting lines, and timeline for creation and functionality).

c) Recommendations to feed into the development of a Capacity Building and Technical Assistance Plan.

VI. DELIVERABLES

The team of consultants should complete the following deliverables prior to departure from Haiti:

a) Preliminary Institutional Modality Options (February 6, 2012)
b) Draft Readiness Assessment Report (end February 2012)
c) Contract and Program Management Unit Options for Institutional modalities
d) Capacity Building and Technical Assistance recommendations
e) Partner Validation Technical Meeting
VII. CONSULTANT SKILLS

The contractor will provide the following:

a) A Team Lead Consultant with the following skills:
   a. Advanced degree in business administration, finance, economics, development, or other relevant subject;
   b. Minimum of 10 years experience in public health administration and management in developing countries
   c. Demonstrated expertise in leading institutional and capacity assessments
   d. Speaks and writes in French

b) 1-2 Consultants to serve as Consultancy Team Members with the following skills:
   a. Advanced degree in business administration, finance, economics, development, or other relevant subject;
   b. Minimum of 10 years experience in public health administration and management in developing countries
   c. Broad experience with conducting government institutional and capacity assessments in developing countries
   d. Speaks and writes in French

VIII. LEVEL OF EFFORT

The team of consultants (2-3 international consultants) will work a total of 48 working days over the period of o/a January 16 – March 12, 2012 (8 weeks). The team of consultants is authorized to work a six-day week. A tentative schedule is as follows:

a) 1 week – preparation, reading, developing calendar and tools
b) 6 weeks – field work
c) 1 week – prepare final report and presentation

IX. BUDGET (Remuneration, Cost Estimate)

To be provided by firm.

X. CONTACT PERSON

Gratzon-Erskine Kovia, Senior Maternal and Child Health Advisor, kgrazon-erkine@usaid.gov; +509 2220-8566

XI. REFERENCE DOCUMENTS

a) Audit Institutionnel (final report, workshop report, MSPP ppt, Dalberg ppt)
b) WHO's Essential Public Health Functions
c) Loi Organique
d) MSPP Vision ppt presentation
e) Plan Strategic Resources Humaines
f) Evaluation of PARC
g) Evaluation of PADESS
h) Assessments of Human Resources in Haiti
# MSPP Readiness Assessment to Operate a Contracting Unit

<table>
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<tr>
<th>Dimension of Analysis</th>
<th>Functions That Should Be Covered</th>
<th>Yes/No &amp; Short Comment</th>
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<th>Is the Expertise Available in Haiti?</th>
<th>Evaluation</th>
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ANNEX 4 - DOCUMENTS READ

1. Laroche Mario (2011) Analyse des programmes et projets de renforcement des capacités de gestion d’entités publiques – rapport final, Port au Prince
3. Institutional Audit of the MSPP, September 2010, Dalberg
4. Governance Unit Options Chart, April 2011, Kelly Saldana, USAID
5. Health Systems and Service Delivery Program Concept Note, March 2011, USAID
6. Proposition d’Une Initiative D’approche Contractuelle Des Services De Sante Dans Le Departement De L’artibonite, June 2011, MSH Haiti
7. Loi Fixant les Règles Générales Relatives aux Marchés Publics et aux Conventions de Concession d’Ouvrage de Service Public, Le Moniteur 164th Year No. 78, 28 July 2009
12. Paquet Minimum de Services, (undated), MSPP
16. MSPP PEPFAR UGP, MSH SDSH, WHO, UNICEF, CIDA PADESS manuals, workplans and budgets
17. Strengthening MSPP Management Capacity, March 2011, presentation by Dr John Vertefeuille, CDC Haiti
18. Synthèse d’Action Globale dans le Secteur de la Santé, presentation by Dr Herby Derenoncourt
19. Indicateurs de Suivi et Resultats Attendus pour le Secteur de la Santé, November 2011, Dr Herby Derenoncourt
## Annex 5 - List of Key Interviewees (Outside of USAID and CDC)

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<td>28</td>
<td>Henande Niclas</td>
<td>Resp. Inform. Strategique</td>
<td>CDC – Sud Est</td>
<td>1-Mar</td>
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<td>Jeanne-Etienent</td>
<td>Nurse/ Responsible</td>
<td>Dispensaire Phaeton</td>
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<td>30</td>
<td>Jean Rommel</td>
<td>Accountant</td>
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<td>15-Feb</td>
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<td>Leurgiste Widnert</td>
<td>TB/HIV coordinator</td>
<td>CDS North East</td>
<td>15-Feb</td>
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<td>Leveille Guy</td>
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<td>14-Feb</td>
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<td>33</td>
<td>Maryse Renard</td>
<td>HIV Programme Nurse</td>
<td>CS 4 Chamin</td>
<td>29-Feb</td>
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<td>34</td>
<td>Mentor Pedro Brutus</td>
<td>Administrator</td>
<td>DSNE</td>
<td>15-Feb</td>
</tr>
<tr>
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<td>Michel L A Fritz</td>
<td>MSPP/ Cabinet</td>
<td>MSPP</td>
<td>14-Feb</td>
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<td>36</td>
<td>Nelson Frantsio</td>
<td>Medical doctor</td>
<td>CS Christian Fernandez</td>
<td>1-Mar</td>
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<tr>
<td>37</td>
<td>Pierre Sadate</td>
<td>Director</td>
<td>CS Ounamonthe</td>
<td>16-Feb</td>
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<td>H. St. Michel - Jacmel</td>
<td>2-Mar</td>
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<td>Robenson</td>
<td>Administrator</td>
<td>Centre Univers</td>
<td>16-Feb</td>
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<td>Ronald Pierre</td>
<td>Resp. Statistique</td>
<td>DSA</td>
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<td>Roland Charles</td>
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<td>CDC Aux Cayes</td>
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<td>Schemann Jean Francois</td>
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<td>MSPP - AFD</td>
<td>14-Feb</td>
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<td>43</td>
<td>Wilfred Pierre Noel</td>
<td>Director</td>
<td>Tous-du-Nord CDI</td>
<td>16-Feb</td>
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<td>44</td>
<td>Wilner Guerrier</td>
<td>Conseil Technique</td>
<td>CDC – Sud Est</td>
<td>1-Mar</td>
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</table>
ANNEX 6 - ORGANIGRAM OF MSPP ACCORDING TO THE LOI ORGANIQUE

MINISTÈRE DE LA SANTÉ PUBLIQUE ET DE LA POPULATION (MSPP)

MINISTÈRE

CABINET

SECRETARIAT

DIRECTEUR GENERAL

SECRETARIAT

UNITÉ D'APPUI À LA DECENTRALISATION SANITAIRE [UADS]

UNITÉ JURIDIQUE [UJ]

UNITÉ DE PROGRAMMATION ET D'ÉVALUATION [UPE]

CENTRE D'INFORMATION ET DE FORMATION EN ADMINISTRATION DE LA SANTÉ [CIFAS]

DIRECTIONS CENTRALES TECHNIQUES ET ADMINISTRATIVE

DIRECTIONS DECONCENTRÉES OU DEPARTEMENTALES

ETABLISSEMENTS HOSPITALO-UNIVERSITAIRES

UNITES DE COORDINATION DES PROGRAMMES