INTEGRATED SAFEGUARDS DATA SHEET
APPRAISAL STAGE

Report No.: ISDSA5999

Date ISDS Prepared/Updated: 12-Nov-2013

Date ISDS Approved/Disclosed: 20-Nov-2013

I. BASIC INFORMATION

1. Basic Project Data

Country:	Congo, Republic of	**Project ID:**	P143849
Project Name:	Health Sector Project (P143849)		
Task Team Leader:	Hadia Nazem Samaha		
Estimated Appraisal Date:	28-Oct-2013	**Estimated Board Date:**	16-Jan-2014
Managing Unit:	AFTHW	**Lending Instrument:**	Investment Project Financing
Sector(s):	Health (100%)		
Theme(s):	Child health (25%), Health system performance (40%), Population and reproductive health (35%)		
Is this project processed under OP 8.50 (Emergency Recovery) or OP 8.00 (Rapid Response to Crises and Emergencies)?	No		
Financing (In USD Million)			
Total Project Cost:	120.00	Total Bank Financing:	10.00
Financing Gap:	0.00		

Financing Source	Amount
BORROWER/RECIPIENT	100.00
International Development Association (IDA)	10.00
Health Results-based Financing	10.00
Total	120.00

Environmental Category:	C - Not Required
Is this a Repeater project?	No

2. Project Development Objective(s)

The project development objective is to increase utilization and quality of maternal and child health services in targeted areas.

3. Project Description

Component 1: Improvement of utilization and quality of health services at health facilities through Performance-Based Financing (PBF)

1. This component would be supported by the Government's own funds, IDA resources and a grant from the Health Results Innovation Trust Fund (HRITF). A PBF approach will be introduced throughout the entire health system covering health facilities, first level referral hospitals, and health administration at district (CSS), departmental (DDS) and select departments at central Ministry of Health (MOH) level. Local civil society organizations will be selected and trained to become contract management and verification agents. Grassroots organizations will be engaged to measure service use and client satisfaction and community health committees (COSAs) will be strengthened. As there is a considerable and growing private sector in ROC, Component 1 will also strengthen public-private engagements in the health sector via PBF by introducing regulation mechanisms such as ensuring that private health care providers are licensed or certified by the Government as a pre-requisite to the awarding of a PBF contract.

2. Component 1 will help set the foundation for Universal Health Coverage (UHC) by promoting the adoption of benefit packages at the ambulatory and hospital levels, developing a system of exemptions and waivers for health services, and adopting a provider payment system that promotes a greater number and better quality of services, and empowers communities to influence the performance of the health system.

Subcomponent 1.1: Performance payments to health facilities

3. Two health service packages have been designed for use in the PBF approach. They are the Minimum Package of Activities (MPA), which contains 23 preventive and curative health services for the community and health center level, and the Complementary Package of Activities (CPA), with 18 services for the first level hospitals. These benefit packages were designed during a technical meeting in Brazzaville 24th July 2013 and are based on international best practice. About 60-70% of all resources are allocated to pay for health services for women and children. Hence, the services selected provide good potential for accelerating ROC’s achievements for the health related MDGs 4 and 5 (see the list of services in Annex 7). However, considering the burden of disease in ROC. (Global Burden of Disease Study 2010), the project will also focus on MDG 1 (which targets nutrition) and MDG 6 (which targets infectious conditions such as HIV/AIDS and tuberculosis.

4. A quantified quality checklist will be designed for each level of the service package incorporating lessons learned during the pilot and taking into account international best practice. For each level, for health centers and hospitals, a quantified quality checklist will be designed. The checklists used in the PBF pilot will provide the foundation for these checklists, while incorporating experience from other contexts on process oriented quality of care measures with increased weights for these process measures. They will also introduce measures related to rational prescribing of generic drugs, essential drug management and tracer drugs.

5. Intersectoral collaboration with a new Social Protection Program: the social protection sector is planning the LISUNGI social safety net project in ROC (P145263). This project will pilot active targeting of the poor using existing community mechanisms to identify beneficiaries for project subsidies and to stimulate access to health services. The LISUNGI project is planned to have a national poverty registration system (known as the Unified Registry) for enrollment into conditional cash transfer (CCT) programs linked to health and education behavior. As there will be

substantial geographical overlap between the two projects, the health and social protection teams are working closely on the design of both projects, in order to enhance synergies between the two projects. There is large potential for complementarity, and for economies of scale. For example, the health project will benefit from LISUNGI's Unified Registry system for identification of the poor and those identified will in turn benefit from fee-exemptions for essential health services targeted by PBF.

6. PBF output budget, costing and PBF approach: a costing of the variable costs (excluding human resources) of the basic and complementary package of health services is planned as part of the preparatory phase of the project. Also, human resources studies will be conducted that will inform the project on the actual take home income, expense patterns of health workers and will shed light on their coping strategies. These costing and human resources studies will help to inform the fee setting and the overall PBF budget. Looking at similar contexts, and taking into account the salary structure, and the objective to finance fee-exemptions for the poorest of the poor, an output budget of about US $5 per capita per year would be necessary.

a) The PBF approach could also rewards quality improvements by providing a 25% top up earnings based on the quality measure.
b)Geographic equity adjustments are also planned to take into account rural hardship criteria.
Subcomponent 1.2: Governance, purchasing, coaching and strengthening health administration through Performance-Based Financing - US$20 million

7. Contract management and verification: a purchasing arrangement will be created covering batches of 500,000 persons. An innovative strategy will be followed to build local capacity in PBF contract management and verification functions. Local civil society organizations (ACV - Agence de Contractualisation et Verification) will be selected through a contracting process. Their capacity for PBF contract management, verification, counter-verification and coaching will be built through PBF experts housed in the PBF unit (Cellule Technique du PBF – CT-PBF) in the MOHP. These local organizations will be under a performance contract in which the timely and correct execution of their tasks will be measured and rewarded through a quarterly performance framework applied by the CT-PBF.

8. In Performance-Based Financing approaches, performance contracting is done throughout the health system. Based on experience gained in two-scaled up health systems (Rwanda and Burundi), the PBF approach involves a re-definition of tasks throughout the health system and hold organizations accountable for these tasks through incentive mechanisms. Internal contracts with performance frameworks clearly outline the expected performance of the different institutions vis-à-vis their roles in the health system and lead to successfully scaled up PBF approaches. Performance frameworks are assessed quarterly through a mix of internal and external verifications before payment is made (ex-ante), and are randomly counter-verified (ex-post; after payment) using a third party agent to ensure reliability of the ex-ante performance assessments. A system of sound/reliable penalties will be instituted to discourage gaming.

9. Performance frameworks will be introduced at all levels for the health administration and the central medical stores. Performance frameworks linked to performance contracts will be designed for the CSS, the DDS, the CT-PBF/MOHP; the Pharmaceutical department/MOHP, the health management information system (HMIS) department/MOHP and the COMEG.

10. The PBF unit will manage the project and will be staffed by a mix of government staff and

international and national consultants recruited through a merit-based process. Each quarter, the PBF unit will be assessed through a performance-framework by a designated committee consisting of development partners. This performance framework will contain indicators related to (i) timely processing and execution of the PBF payment orders for health facilities and health administration; (ii) timeliness and management of the national PBF steering committee meetings; (iii) maintenance of the PBF web-application front and back-end; (iv) technical support to the ACV related to contract management and verification activities and related to strategic purchasing; (v) timely and correct application of the performance framework of the COMEG and the DDS; and (vi) capacity building and coordination of the overall PDSS II.

11. Verification and counter-verification of the DDS, ACV, CSS, Pharmaceutical department/ MOHP and the HMIS/MOHP department performance will occur each quarter. An external evaluation agency (ACVE - Agence de Contre-Verification Externe) will assess the performance of the ACV, DDS, CSS, HMIS department/MOHP and the Pharmaceutical department/MOHP. This agency will be recruited under component 2. This ACVE will carry out each quarter:

a) verification of the performance of the HMIS and Pharmaceutical departments/MOHP;
b) counter-verification of the quantity of services through a lot quality assurance sampling protocol with intense use of mobile phone technology and a community client satisfaction survey component;
c) counter-verification of a random sample of CSS and DDS performance assessments;
d) counter-verify a random sample of health center quality checklists; and
e) counter-verification of a random sample of hospital quality checklists. In the case of discrepancies surpassing 5% score in any of the verified samples (whether quantity, quality or performance frameworks for the CSS), a significant penalty will be applied to the performance earnings of the institution that reported this performance. The penalties for fraud will be clearly outlined in the various contracts and procedures and will be detailed in the PBF manual.

12. Communities will be empowered in their roles as co-managers of health services. This will be a two-way process with both PDSS II (supply side) and community (demand side) perspectives.

13. Health-seeking behavior studies will inform the design, monitoring, and evaluation of the above mentioned community based strategies. These studies will have two modules: the first one will be knowledge, attitudes, and practices (KAP) of the Congolese towards health and health care seeking. The second module will be an ethnographic illness narrative study aimed at understanding the psychological rationale and anthropological beliefs underlying the most notable findings of the KAP.
Component 2: Strengthening Health Financing and Health Policy Capabilities

14. This component would be supported by the Government's own funds, IDA resources and a grant from the Health Results Innovation Trust Fund (HRITF). Its aim is to strengthen health care financing policy and practice in ROC both to improve equity and efficiency in health financing and to pave the way for UHC. Accordingly, the component includes the provision of technical assistance to the MOPH, Ministry of Finance and other key ministries in order improve budget formulation and allocation practices and, more generally, to strengthen health policy capacity; and the support to these institutions in their efforts to formulate a health insurance policy.

Sub-component 2.1: Introducing fee-waivers for the poor and fee exemptions for selected services

15. This sub-component will draw on the experience of the LISUNGI project under preparation, to promote the adoption of fee waivers and fee exemptions (as a general rule fee waivers or discounts

are granted to qualifying individuals for all services, whereas fee exemptions are applied to some services, for all qualifying individuals). Project activities will seek to identify households that will benefit from fee waivers using in some cases the strategies or criteria proposed by LISUNGI. However, the project may consider alternative definitions of target groups to address observed differences in health status and more effective access to health services. For example, as is shown in Tables 5 access to some key maternal and child health services is bi-modal, with those in the two or three bottom quintiles exhibiting rather similar and lower access to services, and the top two quintiles exhibiting similar but higher access.

16. Furthermore, the high prevalence of poverty in some regions (most departments outside of Brazzaville and Pointe Noire) may justify geographic (or group) targeting, where the group might be the population of an entire department or a subset of districts and communes in a department, where poverty rates are very high. In such areas, individual targeting may not be advisable given the high administrative costs of individual identification. By providing a waiver to all inhabitants in such areas, the leakage of subsidies may be low enough to avoid the cumbersome process of individual identification. This sub-component will also promote the adoption of fee exemptions for selected health services with high externalities and those which tend to be under-valued by the population. These exemptions will apply to all patients, not just the poor. For example, some preventive services for mothers (including some obstetric services) and children may be included in the list of exempted services.

17. This sub-component will include the following activities:

a) The project will collaborate with experts from the Social Protection Program to develop and implement instruments and procedures for the identification of the poor (through community-based targeting). These citizens will benefit from improved financial access to health services through enrollment into a fee-waiver program for PBF-targeted services.
b) The project will also support the government in the development of criteria to determine which health services will be free for all citizens irrespective of socioeconomic status. Currently, the government has adopted exemptions for some medicines to treat high-prevalence infectious diseases, such as malaria and HIV/AIDS. The project will review the feasibility of this policy and may include other medicines and services such as preventive services for mothers and children. Finally, the project will also support the development and evaluation of pilot programs to test alternative waiver and exemption mechanisms (for example, via the impact evaluation).
18. Budget formulation. As already noted above, a preliminary review of budget allocations by the MOHP to the departments suggests that certain inequalities would be overcome if the MOHP adopted an explicit budget allocation formula. An allocation formula or criterion could consider the department's population, the per capita cost of the minimum and complementary benefit packages, the degree of remoteness, poverty, and other variables. The project will support the assessment of resource allocation, and carry out a fiscal space analysis. To this effect, project activities will include:

a. The development of formulas or explicit criteria for the allocation of government budgets across departments to bridge gaps in resources and in access to quality health services. These formulas or criteria will be constructed in close collaboration with those responsible for the development of the PBF component of the project, to ensure consistency in allocation rules;

b. The drafting and implementation of a plan for the progressive adoption of these new budget allocation formula or criteria; and support to the MOHP and the Ministry of Finance for the incorporation of these new methods into the formulation of the national government budget for

health; and

c. The development of a mechanism for a technical exchange with government officials and other stakeholders regarding the suitability of the government's current budget allocation to the health sector, the adoption of alternative criteria, the potential need to expand the current budget amount, and the sources of any such expansion (the question of fiscal space will arise in this context).

Sub-Component 2.2: Capacity building in health policy and management

19. Technical support in the area of health insurance policy. The government of ROC has embarked on the path to reach UHC through health insurance. The Project will provide technical assistance to the government of ROC to further refine the draft law while discussing the feasibility of such a reform and looking at different options and developing a timeline for implementation. Project activities in this sub-component will include:

a) Providing technical assistance to the government of ROC to discuss the feasibility, content, and timing of a UHC law. With this aim, the project will commission a document that will summarize the experience of other developing countries with similar income and development levels as those of ROC and identify the indispensable institutional, financial and other prerequisites for the development of a UHC law. The document will outline the prerequisites needed to enact such a law in ROC and it will identify a way forward including a list of enabling factors necessary to move forward with UHC. The starting point for this review will be the work already carried out by government on the health insurance initiatives of Ghana and Rwanda.
b) Conducting policy workshops with government to discuss the findings and recommendations from the above review, with the aim of formulating a national consensus about the path to UHC. Participants in these workshops will include staff from the MOHP, Ministry of Finance, national experts, experts from reference countries, and members from the parliament dealing with health laws.
c) Carrying out a feasibility study of health insurance schemes which would present the Government with a series of options which can be piloted at a later stage.
20.Capacity building in health policy and m anagement. The pervasive lack of knowledge about health policy concepts, management skills, best practices and policy developments limits government's ability to further strengthen its health system. The project will:

a) In consultation with the MOHP, develop or adapt training materials in health policy, using as a starting point those currently available from the World Bank Institute's Flagship Program for Health System Strengthening on priority topics such as: Setting priorities in health; development and costing of health benefits packages; methods for the targeting of government health subsidies; provider payment methods; results-based financing; and/or other topics that government may consider relevant.
b) Along with Ministry of Health-designated counterparts, write national case studies based on actual circumstances and data from the ROC to use as complementary training materials.
c) In collaboration with the MOHP, develop and implement a five-year training program for policymakers, and also one for health managers, both from the central and regional levels.
d) Furthermore capacity building to support research, analytical work, institutional strengthening of national institutions such as the Statistic Bureau, the Planning Department and other government entities will be developed and executed during the project time.

Sub-component 2.3: Health Sector Monitoring and Evaluation (M&E) Strengthening

21. Inadequacies in ROCs health information system do not allow for proper monitoring and evaluation (M&E) of health sector performance. Inaccurate and incomplete Health Management Information System (HMIS) data combined with infrequent household surveys and the absence of health facility survey data to assess quality of care mean that policy makers do not have the information they need to make evidence based decisions. This sub-component will strengthen the HMIS system, support a number of population based surveys as well health facility surveys (some of which will be done thru the Impact evaluation) and other relevant surveys as the need emerges. Furthermore capacity building of the National HMIS unit at Central and district level will be done to ensure the skills needed for data collection, recording, and analysis is reinforced during the project

22. Information and Communication Technology (ICT): the project will use a web-application (Open RBF: http://openrbf.org/) to manage the public front-end, and the back-end strategic purchasing. These open-source based solutions are driving the current two scaled-up PBF approaches (Rwanda; Burundi) and are used in an increasing number of PBF pilots in Africa and Central and South-East Asia. These ICT solutions also enable conditional cash transfer or voucher programs to be managed in an integrated manner, alongside the PBF program. The project will work together closely with the HMIS department, and assist in the introduction of the new DHIS-2 software. The PBF web-enabled application will be linked to the DHIS-2 software and it will be managed through the HMIS unit. The ICT solution is part of the system of intense monitoring and evaluation for PBF results. Verified and paid-for results including the results for the health administration will be visible on the public website whereas the raw data will be downloadable from the website. Benchmarking health facilities and the public health administration both quantity and quality wise, will lead to a powerful tool to further results monitoring and governance for results. Introducing an ICT sub-component to the project will benefit the MOHP tremendously by building the capacity of the health facilities to systematically record the data, funding, payment, and hence allow health planner at the Central level have quality data they can use to develop interventions and make adequate policies to improve the health system in ROC.

23. An impact evaluation will be embedded in the phased scaling-up of PBF: the HRITF will fund an impact evaluation (US$1.5 million), which will naturally fit into the phased scaling-up of PBF. The impact evaluation (see Annex 10) has a specific focus on the role of PBF, in combination with various demand-side interventions such as households visits for improved health-seeking behavior and targeting of the poor for improved financial access to a package of esse ntial health services (links will be made with the World Bank LISUNGI Social Protection project ‘FY 2014). The impact evaluation design will be finalized during the project appraisal mission in October 2013.

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

No civil works will be undertaken and no adverse environmental or social impacts are expected. The project does not require any land acquisition leading to involuntary resettlement and/or restrictions of access to resources and livelihood. Thus, the project is expected to have a positive impact for all direct and indirect beneficiaries, including vulnerable groups such as children, women and the poor who are the main target beneficiaries of the project.

However, this will be a nationwide project and hence part of the population targeted will include Indigenous Peoples (IPs). The expected impacts are positive as the IPs do not have access to quality care and hence the project will ensure that quality free care is provided to them to ensure better health outcomes. It was the project team’s understanding that an Indigenous Peoples Planning Framework (including a Health Needs Assessment) was conducted as part of the current PDSS

(P106851) project; this is not the case. Given that the Republic of Congo is a fragile state, OP 10.00 allows the task team more time to finalize most safeguard instruments. An IPPF is being prepared; it will be consulted upon and will be disclosed by negotiations.

5. Environmental and Social Safeguards Specialists

Antoine V. Lema (AFTCS)

6. Safeguard Policies	Triggered?	Explanation (Optional)
Environmental Assessment OP/ BP 4.01	Yes	The project has minimal environmental impacts that shall be governed by national and local laws and procedures. However, the increased use of medical clinics may generate more medical waste. A National Waste Management Plan does exist and will be updated during project implementation and disclosed in due time. It has been disclosed in the Infoshop on October 9, 2013 and in country on November 7, 2013.
Natural Habitats OP/BP 4.04	No	The project will not affect natural habitats.
Forests OP/BP 4.36	No	The project does not involve forests or forestry.
Pest Management OP 4.09	No	The project does not involve pest management.
Physical Cultural Resources OP/ BP 4.11	No	The project does not involve physical cultural resources.
Indigenous Peoples OP/BP 4.10	Yes	An IPPF has been prepared, consulted upon, and disclosed in country and at the InfoShop consultation has taken place on November 11, 2013. Since ROC is considered a fragile state, OP 10.00 applies and allows the project team more time to prepare some safeguard documents. Thus, the IPPF will be disclosed before negotiations.
Involuntary Resettlement OP/BP 4.12	No	The project does not involve land acquisition leading to involuntary resettlement and/or restrictions of access to resources and livelihoods.
Safety of Dams OP/BP 4.37	No	The project does not involve dams.
Projects on International Waterways OP/BP 7.50	No	N/A
Projects in Disputed Areas OP/BP 7.60	No	N/A

II. Key Safeguard Policy Issues and Their Management

A. Summary of Key Safeguard Issues

1. Describe any safeguard issues and impacts associated with the proposed project. Identify and describe any potential large scale, significant and/or irreversible impacts:
The project will not support any investment (including civil works) that is likely to harm natural environment. The subsidies and other incentives in Component1 will certainly increase the number of healthcare beneficiaries, thus inducing an increase in medical waste production by health facilities. However the associated risks may be prevented through the implementation of an updated National Medical Waste Management Plan, including training of health workers and investments in equipment such as incinerators.
2. Describe any potential indirect and/or long term impacts due to anticipated future activities in the project area:
N/A
3. Describe any project alternatives (if relevant) considered to help avoid or minimize adverse impacts.
N/A
4. Describe measures taken by the borrower to address safeguard policy issues. Provide an assessment of borrower capacity to plan and implement the measures described.
The country has continued to build its capacities on safeguards management during the implementation of several World Bank financed projects. The Ministry of Health and Population will be in charge of implementing the project; the MOHP is familiar with World Bank safeguards policies since they have collaborated on several World Bank projects including the current health project, PDSS, which is still active.
5. Identify the key stakeholders and describe the mechanisms for consultation and disclosure on safeguard policies, with an emphasis on potentially affected people.
The project is a national level program that will involve and affect Indigenous Peoples. Given that the Republic of Congo is a fragile state, OP 10.00 allows the task team more time to finalize most safeguard instruments. An IPPF has been prepared; it will be consulted upon the week of November 4th, and will be disclosed by negotiations. The IPPF will enable the MOHP to better address the needs of the Indigenous people and will identify their needs based on a survey that is being conducted under the current PDSS so the response can be designed around the identified needs.

B. Disclosure Requirements

Environmental Assessment/Audit/Management Plan/Other	
Date of receipt by the Bank	02-Oct-2013
Date of submission to InfoShop	09-Oct-2013
For category A projects, date of distributing the Executive Summary of the EA to the Executive Directors	
"In country" Disclosure	
Congo, Republic of	23-Oct-2013
Comments: The disclosure in the country is an estimated date.	
Indigenous Peoples Development Plan/Framework	
Date of receipt by the Bank	23-Oct-2013
Date of submission to InfoShop	11-Nov-2013

"In country" Disclosure	
Congo, Republic of	11-Nov-2013
Comments:	
If the project triggers the Pest Management and/or Physical Cultural Resources policies, the respective issues are to be addressed and disclosed as part of the Environmental Assessment/ Audit/or EMP.	
If in-country disclosure of any of the above documents is not expected, please explain why:	

C. Compliance Monitoring Indicators at the Corporate Level

OP/BP/GP 4.01 - Environment Assessment	
Does the project require a stand-alone EA (including EMP) report?	Yes [ ] No [×] NA [ ]
OP/BP 4.10 - Indigenous Peoples	
Has a separate Indigenous Peoples Plan/Planning Framework (as appropriate) been prepared in consultation with affected Indigenous Peoples?	Yes [×] No [ ] NA [ ]
If yes, then did the Regional unit responsible for safeguards or Sector Manager review the plan?	Yes [×] No [ ] NA [ ]
If the whole project is designed to benefit IP, has the design been reviewed and approved by the Regional Social Development Unit or Sector Manager?	Yes [×] No [ ] NA [ ]
The World Bank Policy on Disclosure of Information	
Have relevant safeguard policies documents been sent to the World Bank's Infoshop?	Yes [×] No [ ] NA [ ]
Have relevant documents been disclosed in-country in a public place in a form and language that are understandable and accessible to project-affected groups and local NGOs?	Yes [×] No [ ] NA [ ]
All Safeguard Policies	
Have satisfactory calendar, budget and clear institutional responsibilities been prepared for the implementation of measures related to safeguard policies?	Yes [ ] No [ ] NA [×]
Have costs related to safeguard policy measures been included in the project cost?	Yes [ ] No [ ] NA [×]
Does the Monitoring and Evaluation system of the project include the monitoring of safeguard impacts and measures related to safeguard policies?	Yes [ ] No [ ] NA [×]
Have satisfactory implementation arrangements been agreed with the borrower and the same been adequately reflected in the project legal documents?	Yes [×] No [ ] NA [ ]

III. APPROVALS

Task Team Leader:	Name: Hadia Nazem Samaha
Approved By	

Regional Safeguards Advisor:	Name: Alexandra C. Bezeredi (RSA)	Date: 12-Nov-2013
Sector Manager:	Name: Trina S. Haque (SM)	Date: 20-Nov-2013