Project Information Document (PID)

Appraisal Stage | Date Prepared/Updated: 28-Apr-2021 | Report No: PIDA31056

BASIC INFORMATION

A. Basic Project Data

Country	Project ID	Project Name	Parent Project ID (if any)
Congo, Republic of	P167890	Kobikisa Health System Strengthening Project	
Region	**Estimated Appraisal Date**	**Estimated Board Date**	**Practice Area (Lead)**
AFRICA WEST	05-Apr-2021	26-May-2021	Health, Nutrition & Population
Financing Instrument	**Borrower(s)**	**Implementing Agency**	
Investment Project Financing	Ministry of Planning	Ministry of Health	

Proposed Development Objective(s)

The objective of the project is to increase utilization and quality of reproductive, maternal and child services in targeted areas, especially among the poorest households.

Components

Co-financing PBF and supporting the implementation of free health care for pregnant women and children and fee exemptions for poorest households
Support sector sector PFM and health system strengthening
Project management, and monitoring
Contingent Emergency Response

PROJECT FINANCING DATA (US$, Millions)

SUMMARY

Total Project Cost	50.00
Total Financing	50.00
of which IBRD/IDA	50.00
Financing Gap	0.00

DETAILS

World Bank Group Financing

International Development Association (IDA)	50.00

IDA Credit	50.00

Environmental and Social Risk Classification

Substantial

Decision

The review did authorize the team to appraise and negotiate

Other Decision (as needed)

B. Introduction and Context

Country Context

1. **The Republic of Congo (ROC) is a lower middle-income country (LMIC)**[1] located in central Africa with a population of 5.4 million people[2]. Congo is one of the most urbanized countries in the world. Sixty-five percent of the population lives in an urban area, 25 percent higher than the average for sub-Saharan Africa (SSA), with more than half of Congo's population living in its two largest cities of Brazzaville and Pointe-Noire. The country is highly endowed with natural resources, including natural gas and oil, and the majority of Congo (63 percent) is covered by tropical forests; in addition, 31 percent of its surface area consists of abundant cultivable land. Congo's stock of wealth was estimated at US$68,779 per capita in 2014, which makes it the 6th wealthiest country in SSA.[3]

2. **Government revenues in Congo have declined severely in recent years due to a sharp decline in oil prices and the COVID-19 pandemic.** The Congolese economy experienced its fifth consecutive year of economic contraction with a negative growth of 3.5 percent in 2019. The economy is still undiversified, and oil accounted for 86 percent of exports in 2014. On the supply side, the hydrocarbon sector shrank by 8.8 percent because of technical difficulties in some oil fields and the non-hydrocarbon sector grew at a sluggish rate. On the demand side, fiscal consolidation negatively weighed on growth while exports stagnated. In the wake of the commodity-price bust of 2014, the economy contracted with an accompanying deterioration of public finances and the external position.

3. **Significant gaps in human capital investments persist, and ROC's score of 0.42 on the Human Capital Index (HCI) is below the average of 0.48 for lower-middle-income countries.** This means that a child

[1] The gross national income (GNI) increased from US$600 in 2000 to more than US$2,500 in 2014
[2] World Development Indicators (2019 data)
[3] The Changing Wealth of Nations, World Bank (2017).

born today in Congo will be 42 percent as productive when she grows up as she could be if she enjoyed complete education and full health. This is slightly higher than the average for SSA but lower than the average for LMICs. Between 2010 and 2020, the HCI value for the ROC increased from 0.41 to 0.42. Poor health outcomes are a key driver of the country's HCI underperformance. The five indicators that make up the HCI score for the ROC are: the probability of survival to age five (95 out of 100 children), a child's expected years of schooling (8.9 years of schooling by the 18th birthday), harmonized test scores as a measure of quality of learning (371 on a scale where 625 represents advanced attainment), adult survival rate (74 percent of 15-year old will survive to age 60), and the proportion of children who are not stunted (79 out of 100 children). In 2019, the Congo became an early adopter country of the Human Capital Program, and the government committed to improving these five key areas.

Sectoral and Institutional Context

4. **Despite its middle-income status, Congo's epidemiological profile remains comparable to low-income countries, with 62 percent of deaths still caused by communicable diseases and poor maternal, prenatal, and nutrition conditions (2012**).[4] While the maternal mortality ratio was halved between 1990 and 2015[5], it remains very high at 436 deaths per 100,000 live births (MICS 2015). While this is better than the average for Sub-Saharan Africa (534), the level in middle-income countries is considerably lower (less than 190 in 2015). Under-five mortality is also high at 52 per 1000 live-births (MICS 2015) only slightly decreasing from 68 per 1000 in 2011 (DHS 2012). Approximately 21 percent of children under-five years of age are chronically malnourished (stunted), of which 8 percent are severely stunted (MICS 2015). Two-thirds (67 percent) of children under-five suffer from anemia (DHS 2012). In the second largest city of Pointe-Noire, the proportion of anemic children is astonishingly high, with a 75 percent prevalence. Malaria places an enormous burden on the Congolese healthcare system, being the leading cause of consultations (54 percent), hospitalization (40 percent) and mortality (42 percent); and prevalence remains high. Congo did not achieve any of the health-related Millennium Development Goals (MDGs)[6]. Any progress that will be made in the coming years in terms of health and nutrition indicators is expected to be hindered by climate change particularly among the most vulnerable populations that depend on rain-fed agriculture that is highly-climate sensitive.

5. **Access to essential reproductive maternal and child health services is often inadequate and does not necessarily translate into good outcomes due to the poor quality of care.** Only 69 percent of infants (aged 12-23 months) had received three doses of diphtheria-pertussis-tetanus (DPT3) vaccination (WHO/UNICEF 2017). Despite low public financing for primary health care, maternal health service coverage is high. In 2015, 92 percent of deliveries occurred at health facilities, 94 percent of births were attended by skilled birth attendants, and 79 percent of pregnant women

[4] WBI, 2015. death by communicable disease and maternal, prenatal, and nutrition conditions (% of total) was 62 percent in 2012.
[5] National Health Development Plan (PNDS) 2018-2022
[6] Source: MDG report 2015: Assessing Progress in Africa toward the Millennium Development Goals

attended four or more antenatal care visits (MICS 2015). However, the high maternal mortality rate is largely attributed to the poor quality of services, as 89 percent of maternal deaths are linked to the third delay – which occurs upon arrival at the health facility (delays in receiving care).[7] The 2018 maternal death audit report revealed that many deaths could be prevented if the quality, organization, and provision of care services were optimized, with maternity wards better structured, and access to medical supplies for women presenting obstetric complications guaranteed. In 2016, 98 percent of all reported maternal deaths occurred in health facilities, making the quality of emergency obstetric, neonatal care and contributing factors a major challenge for the health system. In reproductive health, the contraceptive prevalence rate is extremely low at 30 percent, and the proportion of health facilities offering modern methods of contraception is only 18 percent (MICS 2015).

6. **The entire health system needs strengthening and access to quality care in the Republic of Congo is hampered by a series of factors**. First, RoC allocates significantly fewer public resources to health than other countries with the same income level. While LMICs spend on average US$80 per capita, in RoC, Current Health Expenditure from Government sources dropped from US$38 in 2010 to US$27 per capita in 2015 and US$ 19.20 in 2018. Second, the limited public resources for health are not allocated in a way to prioritize access to essential services for all. Curative hospital care and health sector administration together account for more than 75 percent of health expenditures and frontline primary health care, essential to address the burden of diseases, is not prioritized. Further, free care programs are underfunded. The limited financial management and procurement capacity within the Ministry of Health (MoH) is described as a major impediment to executing the budget and constitutes a major bottleneck for the health sector. Finally, the emergence of COVID-19 in RoC on March 14, 2020 now threatens every aspect of human capital development by putting pressure on an economy already under stress as it puts pressure on the health system, has threatened livelihoods, food security, nutrition, and schooling.

7. Important PFM challenges continue to affect the performance of the health sector in RoC. Among those challenges, the limited financial management and procurement capacity within the Ministry of Health (MoH) is described as a major impediment to executing the budget and constitutes a major bottleneck for the health sector. All past and recent assessments of the PFM system in Congo point out to weaknesses in several areas, including the linkages between sector planning and budgeting, budget preparation and execution, transparency, and overall credibility. The weaknesses of the PFM system are also attributable to various reasons, including technical and political economy considerations.

8. **The Ministry of Health is committed to the goals of Universal Health Coverage (UHC) but government-funded initiatives face enormous challenges due to limited public resources available in health**. Congo developed a new health policy for 2018-2030 and an accompanying National Health Development Program 2018-2022 (PNDS). A key strategy outlined in this policy is to build on a

[7] Maternal Health surveillance report, 2018

successful Performance Based Financing (PBF) pilot to strengthen services delivery, accountability for results and operational management on the frontline.

C. Proposed Development Objective(s)

Development Objective(s) (From PAD)

The objective of the project is to increase utilization and quality of reproductive, maternal and child services in targeted areas, especially among the poorest households.

Key Results

PDO Level Indicators

9. The three PDO-level results indicators are:
   (a) **Reproductive, maternal and child services coverage indicators:**
      i. Number of people who have received essential health, nutrition, and population (HNP) services.
      ii. Use of post-natal care service (percentage)
      iii. Women aged 15-49 who have used modern contraceptive method (number)
   (b) **Health facility quality index:** The index, on a scale of 0 to 100, is computed for health centers based on a quality of care assessment checklist and the average score reported. Baseline value will be computed for the first PBF assessment.
   (c) **Use of service by poorest households:** health services received by poor people registered as exempted (Number).

D. Project Description

10. **The proposed project aims to assist the Government of Congo in addressing the health needs of the population by increasing access to essential health services especially among poor in targeted areas.** The project will directly support the delivery of and access to quality maternal and child health services by building on the previously tested PBF approach and incorporating specific measures destined to improve the implementation of the free-care policy to enhance access for the poor. The project will support system change by addressing critical steps in PFM reform, policy and program development and will provide institutional capacity to monitor results, expansion of domestic financing and budget execution.

To achieve these goals, the project will implement three main components:

Component 1: Financing PBF and supporting the implementation of free health care for pregnant women and children and fee exemptions for poorest households (US$ 43 million, IDA)

11. This component has 2 sub-components:
    (a) Sub-component 1.1: PBF payments and Free Health Care for pregnant women, children under five years and the poorest. This sub-component will primarily finance PBF payments to facilities in targeted regions. These payments will be allocated to facilities based on their achievements in delivering high-impact and quality health interventions to women and children.
    (b) Sub-component 1.2: PBF Coordination, Verification and Counter-Verification. This sub-component will finance payments to facilities and providers for services rendered based upon the criteria set out in the PBF manual and as validated by the verification and counter-verification activities.

Component 2: Support health sector public finance management (PFM) and health system strengthening (US$ 5 million, IDA).

12. The component has 2 sub-components:
    (a) Sub-component 2.1: Sector PFM, procurement, Transparency and Accountability. This component will support or leverage measures and reforms which directly support the implementation of the first component activities that are necessary to achieving the projects' objective. The subcomponent will support: (i) alignment of PBF approach with the national PFM systems, (ii) use of Public Expenditure Tracking Surveys (PETS) to inform the extent to which government budgets link to execution and desired service delivery objectives and beneficiaries, (iii) provide technical assistance on the development and the implementation of a health financing strategy, (iv) support enhancing health sector fiduciary capacities.
    (b) Sub-component 2.2: Health System Strengthening. The sub-component will: (i) support the pharmaceutical system to provide an affordable and predicable supply of safe and effective essential medicines, (ii) strengthen the capacity of RoC National Blood transfusion Center to provide safe blood and blood products, and (iii) support institutional strengthening of information systems monitoring and evaluation.

Component 3: Project management, and monitoring (US$ 2 million, IDA).

13. The component will ensure an effective and efficient technical and fiduciary management and implementation of the project. Kobikisa will support the coordination of the project and operating costs.

Component 4: Contingent Emergency Response (US$0 equivalent)

14. **A Contingency Emergency Response Component (CERC)** will be included under the project in accordance with Operational Policy (OP) 10.00 paragraphs 12 and 13, for projects in Situations of Urgent Need of Assistance or Capacity Constraints. This will allow for rapid reallocation of project

proceeds in the event of a natural or man-made disaster or crisis that has caused, or is likely to imminently cause, a major adverse economic and/or social impact.

Legal Operational Policies

	Triggered?
Projects on International Waterways OP 7.50	No
Projects in Disputed Areas OP 7.60	No

Summary of Assessment of Environmental and Social Risks and Impacts

The environmental risk rating is moderate at this stage, as the project does not anticipate any intensive or major civil works, and potential risks and impacts on the environment are not expected to be irreversible due to the current knowledge and practical experience of projects implementing activities similar to those planned by this project. Key potential E&S risks and impacts are related to the incremental increase in biomedical waste as a result of the increase in the number of people accessing health facilities, transfusion safety and access to quality blood products, blood transfusion, drug use, etc. Other potential impacts can be related to (i) release of effluents, including wastewater from health care and blood transfusion centers, (ii) occupational health and safety due to exposure to infections and diseases, hazardous materials and waste, and (iii) community health and safety. As it was the case in the prior health sector project in the ROC, there is a possibility that this new project could (indirectly) result in development of other downstream works, such as the fitting out of surgery rooms, enlargement of patient reception rooms, delivery rooms, refurbishment of offices for counselling, fitting out of boreholes or well. The project includes a CERC component and all activities to be financed through the CERC will be subject to the Work Bank ESF. These activities are not known at this stage.
The project will prepare an ESMF which include screening criteria for small works listed above, in the event that some facilities choose to undertake rehabilitation. This Draft ESMF will be ready before negotiations (mid-March) and should be disclosed (as draft) immediately after being considered acceptable by the Bank. Also, the draft ESMF will include the following elements :

a. Preliminary assessments of E&S risks and impacts to inform board and stakeholders, identifying the key environmental and social risks and impacts of the Project, including a summary of key findings and proposed mitigation measures;
b. Sufficient information on key risks, impacts and mitigation measures related to Land Acquisition and Involuntary Resettlement;
c. Labor Management Procedures (LMPs);
d. Preliminary assessment on indigenous people;
e. Preliminary assessment on health care waste management.

Social Risks are deemed Substantial at this stage. The likely impacts are expected to be reversible and can be managed with the application of appropriate mitigation measures. Key social concerns related to the project include (1) exclusion of vulnerable groups, Indigenous Peoples and other rural and marginalized groups where services are not available and who may as a result be excluded as project beneficiaries (for example, persons with disabilities, elderly, children and youth, including adolescent girls); (2) challenges in ensuring that the targeting of beneficiaries through the Republic of Congo Safety Nets Project (LISUNGI) and the Unified Social Registry is conducted in an transparent and inclusive manner; (3) lack of transparency and accountability in delivering project benefits under the current economic conditions could lead to lack of trust in the health system and underutilization of other public health interventions, (4) healthcare service delivery under the project in the targeted regions is likely to be constrained by COVID-19, and ensuring stakeholder engagement and adherence to COVID guidance may prove challenging, (5) stigma of Indigenous Peoples by healthcare workers, (6) the application of labor and working conditions for the PBF health centers, the Project Implementation Unit (PIU), the public and select private providers, the contracted departmental workers, as well as the community health workers; (7) seasonal migration and rural exodus of Indigenous Peoples (8) community health and safety related to a range of factors including worker-community interactions, and movement of chemicals and human bloods, etc. Labor influx is expected, as the project will provide for the rehabilitation of the existing health infrastructure. Occupational health and safety measures will be applied to the project. Contractors, healthcare and PIU workers/staff who will be involved in implementing the project will be required to sign and adhere to a Code of Conduct (CoC). GBV risk assessment will be included as a covenant to be prepared before effectiveness and measures to mitigate and address these risks will be included in the ESMPs and GBV Plan.

A Stakeholder Engagement Plan has been prepared by the client and includes strengthen project ownership and prevent potential conflicts between beneficiaries, local government and health providers. A Grievance Redress Mechanism (GRM) will be provided for all direct workers and contracted workers to raise concerns occurring at workplace. Measures will be put in place to make the grievance mechanism easily accessible to all project workers. In addition to workers GRM, the project shall create and operationalize project level GRM to handle disputes and resolve issues related to project affected and interested parties. Finally, some of the planned project activities to be implemented have already been carried out in previous Health sector Bank-financed projects. However, the implementation experience was considered weak (a dedicated social specialist position was never filled (the responsibility was covered by the project's communications specialist), and a GRM was never established. Moreover, there were no reports of beneficiary complaints in the supervision reports to the Bank or the ICR, completed in September 2020. From these lessons learned, and due to the fact that the PIU is still in the process of recruiting dedicated and trained staff to ensure E&S compliance, a capacity building exercise for the PIU will be necessary, in addition to active support from the Bank E&S team. The ESMF will take into account the risks that can be inherited from the previous activities.

The different actors involved in the implementation of the project (MOH, MOF, PIU technical committee) have no experience or capacity in applying the expanded ESF beyond aspects that are generally included in the World Bank Operational Policies, therefore significant efforts will be required to capacitate and familiarize the Ministry of tourism and environment (as a regulatory body) with the environmental and social framework requirements. The project will recruit an environmental safeguard specialist with good experience in the supervision of projects financed by the World Bank and the World Bank E&S team will provide a close support to the PIU in order to control the risks and potential environmental and social impacts of the project.

E. Implementation

Institutional and Implementation Arrangements

15. **The project will be implemented by the MOH.** The Ministry of Health will be responsible for the overall management as well as the monitoring and evaluation of the project.

16. **The Project will rely on existing institutional and implementation arrangements for REDISSE IV project.** It was established to provide integrated and coordinated project management interventions in health-related programs/projects. The same Project Steering committee as for REDISSE IV will oversee the achievement of the project's objectives.

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APPROVAL

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