

**PROJECT INFORMATION DOCUMENT (PID)
APPRAISAL STAGE**

Report No.: PIDA2190

Project Name	Health Sector Project (P143849)
Region	AFRICA
Country	Congo, Republic of
Sector(s)	Health (100%)
Theme(s)	Child health (25%), Health system performance (40%), Population and reproductive health (35%)
Lending Instrument	Investment Project Financing
Project ID	P143849
Borrower(s)	
Implementing Agency	Ministry of Health and Population
Environmental Category	C-Not Required
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Decision	

I. Project Context

Country Context

The Republic of Congo (ROC) is growing and urbanizing. ROC is a lower middle income country with vast oil revenues and a small population, estimated at 4.3 million in 2012. ROC has one of the fastest economic growth rates in Sub-Saharan Africa (average 5.8 percent over 2007-2012) and has the potential to become an emerging economy over the next decade. Sixty two percent (62%) of the population lives in urban areas, half of which are living in two main urban centers, Brazzaville and Pointe Noire. Nearly forty percent (40%) of Congo's population is under 15, and growing at a rate of 3 percent per year. This trend will lead to a doubling of the population in 25 years.

ROC's weak institutions delay progress on social and economic growth. Many years of conflict and unstable governments have severely weakened the country's administration, eroded public accountability, and undercut publicly funded services. This decline is reflected in the inability of the administration to transform its economic growth into better access to basic services and improved social outcomes for the majority of the population. Mindful of the need to modernize public administration and its human resources, the Government of Congo has initiated a civil service reform (including deconcentration) and allocated additional resources to the civil service apparatus.

In contrast with the country's high economic growth, poverty indicators remain high, especially among the rural poor. Preliminary data from the 2011 ECOM (Living Standards Measurement Survey) revealed that from 2005 to 2011 the overall poverty rate has dropped by 4 percentage points to 46.5 percent. This average decline masks important regional differences; in the urban areas, poverty is widespread (around 40% of the population lives on less than US\$2 per day); in the rural areas poverty levels are even higher (approximately 70% of the population lives on less than US\$2 a day). In addition, the economy is characterized by low earnings for the majority of the population, with the situation particularly dire for those in the informal sector, where monthly earnings are barely over US\$100 a month, in a country with a high cost of living. The political economy is such that no incentives are in place to promote results for the poor.

In the past seven years, there has been uneven progress toward the MDGs. There are significant improvements in (i) MDG 2, achieving universal primary education, completion rates have increased to 83 percent (target is 100 percent) but there is no indication of significant quality improvements; (ii) MDG 3 which promotes gender equality, the ratio of girls/boys in primary schools has improved to 0.97(target is 1/1); and (iii) MDG 4 which aims to reduce child mortality, the under-five mortality rate is down to 68 per 1000 (target is 35 per 1000). The likelihood that these three targets will be achieved by 2015 is quite low, assuming that current trends continue. In contrast, the likelihood that extreme poverty and hunger will be eradicated (MDG 1), that maternal health indicators will be improved (MDG 5), that HIV/AIDS will be halted and reversed, universal access to treatment will be achieved (MDG 6) and that half the number of people with access to safe drinking water and sanitation (MDG 7) targets will be reached by 2015 is low. Overall, the performance of the health sector in ROC remains poor.

Sectoral and institutional Context

Congo's progress towards better health outcomes is slow. According to the 2012 DHS data, maternal mortality ratio remains high, at 426 per 100,000 live births and the under-five mortality and infant mortality rates are 68 per 1000 live births and 39 per 1000 livebirths respectively. Neonatal mortality on the other hand showed a small decrease from 28 to 22 per 1000. Similarly, the adolescent fertility rate for 15–19 year olds remains high at 147 per 1,000 women in the 2011-12 DHS. In addition, Congo suffers from a general chronic malnutrition prevalence of 24.4 percent (stunting), including areas in which 38.6 percent of all children less than 5 years old are chronically malnourished.

Reproductive health indicators are worse than expected. The maternal mortality ratio, total fertility rate and contraceptive prevalence rate, which are widely used to assess the vulnerabilities of women and children, fall well below those expected in a low middle income country. With a Total Fertility Rate (TFR) of 5.1 in 2012, ROC belongs to the group of twenty countries (all of them low income, besides ROC) with the highest fertility rates in the world. Notably, ROC's TFR has increased from 4.8 in 2005 to 5.1 in 2012 despite an increase in the usage of modern contraception (see footnote 1). This increase took place in both rural and urban areas from 2005 to 2012. In comparison, Ghana has a TFR of 4 and emerging economies (such as Morocco, Egypt, Tunisia, Viet Nam) have TFRs between 2 and 3, with modern contraception rates between 60 and 85 percent.

The HIV/AIDS epidemic is being successfully addressed by the national program, which benefited, inter alia, from Bank support. The current prevalence rate among adults is estimated at 3.3 percent (down from 4.2 percent in 2005) and the incidence rate (new cases) is below 1 percent. HIV

prevalence in pregnant women attending antenatal care is 2.7 percent (down from 5.2 percent in 2005). Access to ART is estimated to be at 40 percent and will require continuous efforts from the government to reach universal access.

The availability and allocation of resources in the health sector is a major concern in ROC. While ROC ranks among the countries with the highest per capita income in Sub-Saharan Africa (rank of 35 out of 45 countries, its total health expenditure per capita, at 2.5% of GDP in 2011, is the second lowest in the region and fifth lowest in the world. Public health expenditure as a share of total health expenditure is the 6th lowest regionally and the country's reliance on out-of-pocket health spending out of total health financing, at 64%, is among the highest (rank of 39). According to the Public Expenditure Review for Health underway, government spending on hospital care is twice as high as spending on ambulatory care. This skewed allocation results in inadequate financial protection for lower income groups against high-cost health treatments. The lack of health care financing in ROC is much more severe than the lack of human resources and hospital beds at the country level, as is illustrated in the Figure 4 below. At the local level, however, the lack of resources, both financial, human, and physical, is compounded by a poor territorial allocation of these resources.

Out of pocket spending is high due to the imposition of user fees and a charge for medicines. These high costs prohibit utilization of government health facilities, especially among the poor. Currently government spending in the health sector is very low, (2.5 % of total GDP, and US\$67 per capita per year – NHA2009-2010) this means that health facility budgets are insufficient to cover the actual costs of services. In order to supplement the limited resources, the health ministry has adopted a cost-recovery policy at the facility level, thus enabling health facilities to raise their revenue to cover their operational costs. Over 50% of all financing of government health care providers comes from user fees (NHA 2010). User fees are set for curative services as well as for preventative services such as growth monitoring for children under 5, ante-natal and post-natal care. It also includes payment for most medicines (except for generic medicines for malaria), hence dramatically increasing the cost of care for patients attending public sector facilities. This in turn leads to lower utilization of services especially among the rural poor who are unable to afford the care and the medicines.

The private sector delivers about one third of all health services and one half of all ambulatory care. It has the potential to help the country improve its primary health care coverage if a formal public-private- partnership were to be established (Private Health Sector survey – 2011).The private sector provides about half of all curative care in urban areas which houses about 68% of the population of ROC, however it is very expensive. Furthermore, whereas the private sector (which is a mix of providers; private for profit; private non-for profit and pharmacies) provides 70% of curative care visits at the primary level, in urban areas, it does not offer a complete package of services at the primary level nor does it offer hospital services. The relatively high use of private services is explained by more flexible payment mechanisms including delayed payments or even free services (6% of services were provided free of charge at private health facilities). The main reasons for not using the public sector include low quality of care, poor attitude of health workers, requests for informal payments, and services not being offered if the patient has no money. Private sector health centers are largely inexistent in rural areas and due to their relatively high costs, are inaccessible for the majority of the poor.

Utilization rates in the public sector remain low both in rural and urban areas. 70% of the

population lives in urban areas thus theoretically having better physical access. This low level of access is attributed in part to poor quality of health services, lack of clear “catchment” areas, and high user fees. Indeed, when closely examining the quality issues, one notes the following obstacles to quality health services: (i) the performance of health workers (absenteeism, quality of care, poor on-the-job training, poor initial training at the school level, interpersonal skills) is weak, (ii) health facilities have limited funding for ensuring availability of drugs and supplies; (iii) the type of services available at the health facility level is limited; and (iv) the availability of the service in terms of convenience (operating hours, geographical proximity), and hotel services (such as meals, gardening, laundry) are inadequate, further reducing the likelihood of seeking health services from the formal health sector. Furthermore, use of traditional medicine and care from the informal sector contribute to the observed low utilization in the formal sector.

The distribution of human resources within the country is inequitable. The health institutional context is characterized by inadequate capacity for planning, poor motivation of health workers, and weak health systems, all of which culminate in the poor quality of service delivery. Further, the distribution of health personnel is unequal with higher concentrations of personnel in the two main cities, Brazzaville and Pointe-Noire; 68% of ROC’s population lives in these two cities but 93% of specialized doctors, 73% of general practitioners, 61% of nurses, 78% of midwives and 85% of pharmacists work in these 2 cities. Training, recruitment and allocation of health workers are managed by 5 different Ministries; these Ministries do not coordinate among themselves. Consequently, health workers do not receive adequate in-service training and are not deployed to health facilities that need their specialized skills, thus rural facilities which need certain specialists have vacant positions and urban facilities which do not need additional specialists have more positions than they require.

Availability of drugs at an accessible cost is uneven across the health facilities in ROC. This is mainly due to the fact that health facilities procure drugs from various sources including the private sector. The private pharmaceutical market is not well regulated and the price of the drugs on the market is relatively high while the quality of the drugs is suspect. Field visits show that on the whole, more than half of all drugs and medical consumables present have been procured from the private market, while about half of all products are generic products from the Congolaise de Médicaments Essentiels et Génériques (COMEG). The products from COMEG are known to be of good quality and affordable, mostly from well-known suppliers such as IDA and Missionpharma. Field observations show that the cost of the non-COMEG drugs is between 6 and 10 times higher than those of similar products originating from COMEG.

Health outcomes are poor throughout the country and there are large inequalities within the country between urban and rural areas and among different socio-economic groups. While there is a modest difference between urban and rural child mortality rates, there is a wide gap between the richest income quintile and the remaining population. This suggests that reducing preventable mortality will require a comprehensive approach that reaches segments of the population that are most in need.

The Government has recently taken clear actions that show its commitment to achieving Universal Health Coverage (UHC). The government of ROC has recently proposed a new law seeking to achieve UHC in the country (see law proposal named “régime d’assurance maladie universelle (RAMU) en République du Congo”). While per capita income in ROC is similar to that of other countries that have made important progress in moving toward UHC (such as Vietnam), in ROC,

the institutional setting and the current development of its health system may not yet be ripe to engage in the active promotion of UHC. Despite this, the proposed project is expected to bring about changes that will facilitate ROC's transition towards a health insurance system and UHC. Several important steps are necessary prerequisites to the promotion of UHC. They include: (i) the formulation and adoption of a benefits package, (ii) the development and nationwide implementation of standards of care, (iii) the use of mechanisms to identify and target the poor and vulnerable, (iv) the significant expansion of government health spending, (v) the improvement in the formulation and allocation of the government's health budget, (vi) a more equitable and rational distribution of health staff along the territory, and (vii) the adoption of provider payment methods that promote productive efficiency. The current project, through its components and subcomponents, will support the development and implementation of several of the above health system components, thus facilitating the path towards UHC.

II. Proposed Development Objectives

The project Development Objective is to increase utilization and quality of maternal and child health services in the targeted areas.

III. Project Description

Component Name

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

Comments (optional)

Component Name

Component 2: Strengthening Health Financing and Health Policy Capabilities

Comments (optional)

IV. Financing (in USD Million)

Total Project Cost:	120.00	Total Bank Financing:	10.00
Financing Gap:	0.00		
For Loans/Credits/Others			Amount
BORROWER/RECIPIENT			100.00
International Development Association (IDA)			10.00
Health Results-based Financing			10.00
Total			120.00

V. Implementation

The Ministry of Health and Population will implement the project through the Technical PBF Unit (CT-PBF). Project execution/implementation will be done at all levels (from the health facility one to the Central one) of the health system. The CT-PBF will be placed under the Director of the Cabinet (DC), with technical support from the relevant MOHP directorates. The CT-PBF is staffed by a multidisciplinary team including: a Project Coordinator (civil servant), a M&E specialist, a financial and an administrative management specialist, an accountant, a procurement specialist,

project specialist, health financing specialist, public health specialist, one administrative assistant, and two support personnel. Members of the CT-PBF have developed the skills and experience needed for project implementation through the implementation of the current Bank-financed PDSS (P106851).

The mandate of the CT-PBF will remain in place for the Health System Support Project II (PDSS II). The CT-PBF will extend the contract and revised the terms of reference of those members whose performance to date as part of the PDSS is considered good. Additional staff will be hired such as NGO/CBO specialists (who monitor the performance of health NGOs and will be awarded contracts to implement community-based micro projects), PBF experts, a financial and administrative management specialist, an accountant and a procurement specialist. The CT-PBF (under DC supervision) will carry out all of the disbursements and any procurement related to the project in accordance with the Bank approved procedures. It will serve as the fund holder, managing the operational accounts and transferring money to the health centers, and submitting withdrawals to the Bank. The Project Coordinator will supervise the implementation of the various project components, to be carried out by several Directorates or Divisions within the MOHP.

All entities involved in the Project's implementation will be overseen by a Steering Committee which will guide PBF implementation and draw lessons and policy implications for the health sector. It is chaired by the Director of Cabinet of the MOHP and includes key directorates of the MOHP, the Ministry of Planning and Economy, the Ministry of Finance, and representatives from the donor community (the Bank will not sit as a member of the committee but only as an observer, to avoid going beyond its mandate). The steering committee will oversee the implementation of PBF, document the lessons learned from various initiatives of PBF in the country, provide guidance to the CT-PBF, and generate policy direction for the institutionalization of PBF in ROC.

Performance framework for the PBF unit/MOHP: The PBF staff will be 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.

The project policies and procedures will be incorporated in an implementation manual, which will be adopted by the MOHP. It will be completed by a series of PBF manuals, each one prepared by a NGO as part of its offer of services and improved as practical experience develops from in-the-field implementation. The CT-PBF and the Bank will ensure that the PBF manuals prepared by the NGOs are consistent with each other and with the overall implementation manual.

VI. Safeguard Policies (including public consultation)

Safeguard Policies Triggered by the Project	Yes	No
Environmental Assessment OP/BP 4.01	x	
Natural Habitats OP/BP 4.04		x

Forests OP/BP 4.36		x
Pest Management OP 4.09		x
Physical Cultural Resources OP/BP 4.11		x
Indigenous Peoples OP/BP 4.10	x	
Involuntary Resettlement OP/BP 4.12		x
Safety of Dams OP/BP 4.37		x
Projects on International Waterways OP/BP 7.50		x
Projects in Disputed Areas OP/BP 7.60		x

Comments (optional)**VII. Contact point****World Bank**

Contact: Hadia Nazem Samaha
 Title: Senior Operations Officer
 Tel: 473-6441
 Email: hsamaha@worldbank.org

Borrower/Client/Recipient

Name:
 Contact:
 Title:
 Tel:
 Email:

Implementing Agencies

Name: Ministry of Health and Population
 Contact: Dr. Bernice Nsitou
 Title: Coordonnateur délégué Programme de Développement des Services
 Tel:
 Email: bernice_nsitou@yahoo.fr

VIII. For more information contact:

The InfoShop
 The World Bank
 1818 H Street, NW
 Washington, D.C. 20433
 Telephone: (202) 458-4500
 Fax: (202) 522-1500
 Web: <http://www.worldbank.org/infoshop>