Updated Project Information Document (PID)  

<table>
<thead>
<tr>
<th>Project Name</th>
<th>CONGO, REPUBLIC OF - HIV/AIDS and Health (MAP program)</th>
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</thead>
<tbody>
<tr>
<td>Region</td>
<td>Africa Regional Office</td>
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<tr>
<td>Sector</td>
<td>Other social services (65%); Health (35%)</td>
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<td>Theme</td>
<td>Other communicable diseases (P); Other social protection and risk management (S); Gender (S)</td>
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<td>Project</td>
<td>P077513</td>
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<td>Borrower(s)</td>
<td>REPUBLIC OF CONGO</td>
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</tbody>
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| Implementing Agency(ies) | NATIONAL AIDS COUNCIL  
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1. Country and Sector Background  
1.1 Context  

*The country and its resources.* The Republic of the Congo covers about 342,000 square kilometers and has a population of about 3 million and a population growth rate of 3%. About two-thirds of the population reside in the capital city of Brazzaville (home to about 800,000), the port city of Pointe Noire, and the agricultural town of Dolisie. Agriculture employs about 40% of the population, but contributes only about 5% of GNP. The country's economy is dominated by production from off-shore petroleum wells, which contribute about 50% of GNP. Forests cover more than half the country and the forestry sector is recovering gradually.

August 15, 1960. In the 1980s, poor economic management and falling petroleum prices led to the accumulation of large domestic and foreign debt, put downward pressure on domestic spending, and thereby reduced consumption of the urban population. The resulting social and political unrest and the end of the Cold War brought about the *Conférence Nationale Souveraine* in 1990, which reestablished a multi-party system. However poverty and competition for national resources contributed to social stresses and to violent conflicts in the 1990s, sometimes along ethnic lines.

*Emergence from violent conflict.* At present, the Republic of Congo is emerging from civil unrest, with three rounds of violent conflicts in 1993-94, 1997, and 1998-99. Large parts of the country were affected: the 1993 and 1997 civil wars were fought with particular violence in the capital, Brazzaville; the 1998-1999 war spread further, in particular in the most populated Central Congo and Southern areas. At the height of the crisis in late 1999, an estimated 810,000 people, or approximately one-third of the Congolese population, were displaced. Many of the almost 3 million Congolese endured terrible ordeals; some sought refuge in the forest and survived in miserable conditions.

Significant progress has been made to restore security. Following a first agreement on the cessation of hostilities in November 1999, a cease-fire accord was signed on December 29, 1999. Hostilities ended
without much international support. The peace process has thus largely been homegrown, an important
title feature for it to lead to lasting peace. Still, sporadic eruptions of violence continued, mainly in the Pool
region, particularly after March 2002, with a significant impact on economic activity in Brazzaville (since
the main transport link to the sea was regularly cut by attacks). Passengers train traffic is still suspended
between Brazzaville and the coast. The Government reached an agreement with the last rebel group
(Pastor Ntumi’s Ninjas) on March 17, 2003, paving the way for the disarmament, demobilization, and
reintegration of about 4,000 militia fighters. As a result, in spite of recent violence in Brazzaville in
December 2003, nearly all of the country seems at peace.

**Damage to infrastructure.** The effects of the recurrent conflict and of neglect of maintenance severely
damaged operation of the economy. The railway line and road between Pointe Noire and Brazzaville forms
the country’s central conduit for export abroad and for supply of Brazzaville. This conduit was damaged
and passage was blocked during much of the war. About half of the 17,000 km road networks are no
longer passable and most regional capitals do not have reliable access to major roads; and most feeder
roads are inoperable. Because of lack of maintenance, entire provinces do not have access to clean water.
Educational buildings in the four southernmost provinces suffered considerable damage. Moreover an
estimated 50 percent of agricultural tools were destroyed and 75 percent of livestock lost.

The results are visible in national economic performance. Although the offshore economy in the oil sector
continued to function throughout the wars, GDP per capita has dropped from about US$1,100 per capita in
1990 to US$630 per capita in 2001, almost back to the level at independence.

**Damage to public well-being.** At least 70% of the Congolese live below the poverty line, compared to
about 30% at the beginning of the conflicts in 1993. The Human Development Index declined by more
than 12% over the last ten years, and Congo ranks 136 out of 173 countries. In parallel, life expectancy
dropped from about 52 years in the early 1990s to 48.6 years in 2002. The infant and child mortality rate
is high at 110 per thousand. The deterioration of health services has reduced the infant immunization rates
for measles from 99.4 percent in 1979 to 58 percent in 1999.

Poverty has become a near-universal phenomenon and is aggravated by the vulnerability of those who are
above the poverty line. People living in rural areas seem particularly affected, especially because of the
collapse of the transport system, which restricts their access to economic markets and social services.
Several groups are particularly vulnerable as a result of continued poverty and conflict: at least 11 percent
of children under 15 are orphans, about 60,000 women and girls were victims of rape, and 5,000 children
fought during the war. According to UNICEF, an additional 70,000 people are still in need of urgent
humanitarian assistance (as of July 2003).

**Reconstruction.** The Government has tackled reconstruction with financial support from the IMF, the
World Bank, as well as the European Community and other donors. In parallel, the Government drew on
its petroleum income to finance a reconstruction program of $950 million, spread over two years. The
program focuses on housing and repair of public buildings, and the rehabilitation of transport
infrastructure, including rail, river ports and airports in isolated areas. The Brazzaville-Pointe Noire
railroad is now functioning, although not at full capacity and not for passengers. GDP has recovered
vigorously since the end of the last war in 1999, but the social indicators continue to perform poorly.

**Decentralization.** Since late 2002, some efforts have also been made towards decentralization, both to
improve service delivery at local level and to empower communities. The country is administratively
divided into eleven départements (counties), each governed by a Government-appointed préfet and an
elected local assembly, which are entrusted with significant responsibilities for service delivery. The six
urban areas with a population of over 20,000, are formed into municipalities, governed by an elected mayor and municipal assembly. This process enables political opposition to be involved in local political life, and is expected to strengthen local government’s accountability.

1.2 Dimensions of the HIV-AIDS pandemic in Congo

Although the overall situation in the Congo has improved, the HIV-AIDS pandemic is complicating the country’s social and economic recovery. HIV-AIDS was first diagnosed in Congo in 1983 among patients who had been evacuated to France. By December 31, 1996, a total of 10,777 AIDS cases had been reported, and AIDS had become a major cause of death among adults aged 15 to 45 (35% of all deaths in this age group in 1996). The national HIV sero-prevalence survey carried out in November 2003 indicates that for the adult population the rate is 4.2% with higher rates among women 20-35. The pandemic strikes more females than males: the ratio of males to females diagnosed with AIDS is estimated at 0.6 overall (in some regions it is 0.25), which shows a particularly large difference in infection rates between men and women.

1.3 Conditions in the health sector

The health system is badly damaged and cannot deliver minimum preventive and curative services to the population. There are several sources of this dysfunction.

**Health facilities.** Lack of physical capacity constrains delivery of public health services. Over half of all health facilities were ransacked during the civil conflicts and buildings and equipment deteriorated for lack of preventive maintenance or repair. Most of the remaining resources of the health system are concentrated in Brazzaville and, to a lesser extent, to other urban centers, where public health facilities are supplemented by the private sector. In contrast, there appears to be little usable infrastructure in the countryside.

**Personnel.** One of the major causes of dysfunction of the public health system is the lack of qualified personnel, their concentration in cities, and poor motivation. The number of health staff in the public sector declined from about 12,800 in 1985 to about 7,400 in 1995 and the Ministry of Health and Population estimates that there were about 4,500 staff in 2002. Over three-quarters of these staff are concentrated in Brazzaville and Pointe Noire and very few are assigned to rural areas. Moreover, motivation diminished when the Government cut the civil service salary scale by 30% in 1993, and the purchasing power of these salaries was further reduced by the devaluation of 1994. Lack of opportunities for promotion or for training may also contribute to this lack of motivation.

**Pharmaceuticals.** Three private wholesale firms dominate supply and distribution of pharmaceuticals. A public agency for purchasing essential pharmaceuticals (CENAMES) was created in 1995, with the assistance of the European Community. However, civil disorders prevented it from functioning well. The CENAMES is still not able to provide essential generic drugs to the entire public sector, in spite of the efforts of the European Community to assist in reforming this structure. This situation may impede implementation of the Project because the CENAMES has a monopoly on the legal purchase and distribution of anti-retrovirals (ARV). However, many pharmaceuticals, including ARVs, are available in the informal market.

**Public financing.** Inadequate public financing contributes to the weak situation of the public health system. The current-non-wage government budget for health was 9 billion FCFA in 2001 (US$ 1.73 million), but it appears that only 10% to 20% of the budget was actually spent. Estimated actual spending is about 1.6 billion FCFA (US$ 0.3 million), of which half went to the University Hospital Center in
Brazzaville. The total non-wage budget (current + investment) was about 1,720 FCFA per capita in 2000-01 (about $US 3.30).

Incapacity to delivery HIV-AIDS prevention and care services. For all these reasons, many Congolese do not have access to basic services such as treatment of syphilis and other STIs. The lack of trained and motivated staff hampers delivery of information and care. In addition, there is also a lack of clinical security in health facilities and blood transfusions are safe only in few health facilities, mostly located in urban areas. In fact, blood banks have difficulties operating except in Brazzaville and Pointe Noire because of the lack of electricity and difficult access. This situation often forces health personnel working in rural areas to give their patients untested blood and to resort to direct arm to arm transfusions. Adequate HIV testing is also a problem: for example, only four centers conduct rapid serology tests for HIV and only the National Blood Transfusions Center (CNTS) had an ELISA chain for confirmation of positive HIV tests. Faulty management of medical wastes (or traditional practices) is a further factor that promotes the transmission of HIV and other germs, especially among health workers. In a further example, placentas are simply returned to the mother's family.

1.4 Risk and Vulnerability Factors

Inadequate management of STIs. Prevention of STIs through condom use is indisputably critical in the fight against HIV-AIDS because ulcerative STIs, such as herpes genitalis and syphilis, increase the risk of HIV transmission from males to females by 50 to 300 times. Discussions with health providers indicate that STIs are very common in Congo, although no data are available. Nevertheless, the country has not developed a strategy to adequately manage STIs, although the Government has envisaged, in collaboration with WHO, to adopt the syndromic approach to STI management. This approach combined with prepackaged STI treatment kits (preferably with one dose observed treatment, similar to DOTS for tuberculosis) may improve control of STIs in both the public and private health sectors. However, to do so, workers needs to be trained and drugs to be available.

Cultural aspects of risky behavior. In urban areas, some married men with relatively high incomes support women other than their wives in an institution known locally as 'bureaux'. This is, in effect, a form of polygamy and can favor the spread of HIV-AIDS. Traditional sexual practices such as 'dry sex' also favor transmission of HIV-AIDS. In addition, there are a few groups practicing scarification, which can lead to transmission of HIV.

Another cultural aspect of HIV-AIDS concerns information. Traditionally, sexual matters are not discussed in the family. Group discusions show widespread misconceptions regarding sexually transmitted diseases, including AIDS -- especially among youth.

Importantly, some Congolese believe that HIV-AIDS is transmitted by witchcraft and cannot be contracted from intercourse with an attractive and healthy looking person and some also believe that AIDS can be cured by sorcery or by participation in religious sects. Because, STIs are not feared as they can be cured, and there is little understanding of the link between HIV infection and STIs, the traditional high level of sexual activity with multiple partners, but without condoms, continues. Among youth, sexual activity is said to start, on average, at about 16 years of age.

Commercial sex workers. Commercial sex workers are numerous especially in Pointe-Noire and their clients are varied and most practice unprotected sex. Sexual activities are often unplanned, particularly among youth, and often occur in situations where the judgment of the individuals is clouded by alcohol consumption. Poverty also contributes to prostitution, with reports that some school girls practice
occasional prostitution to feed themselves and continue their studies (sugar daddy phenomenon). Migration of displaced persons may have increased the supply of sex workers while movements of young men in military units increased demand.

**Conflict & rape.** The three episodes of civil war between 1993 and 2000, resulted in the deaths of more than 35,000 people and contributed greatly to the dismemberment of the health system. In addition, there were numerous acts of sexual violence, particularly by men in uniform. A study of 4,890 persons who returned to Brazzaville after the conflicts found 1,745 women that had been raped. On this basis, it is estimated that a total of 35,685 women returning to Brazzaville had been raped. Many of these women suffered major injuries, in particular gynecological damage, including HIV infection, as well as psychological trauma.

**Soldiers.** Turning to the military, HIV-AIDS infection has been the leading cause of death in the Congolese Armed Forces for the past 15 years. About 35% of soldiers in the Army Hospital are there for pathologies linked to HIV-AIDS. Before the 1997 war, about 9% of soldiers in the armed forces were seropositive. The rate was 7% for recruits aged 18 to 33 over 1999-2000.

### 1.5 Congo’s response to the HIV/AIDS challenge: 1987-2003

**Pre-conflict response.** The Republic of Congo initiated activities to combat HIV-AIDS shortly after the first cases of AIDS were discovered. The National AIDS Program (PNLS) was established in 1987 within the Ministry of Health as a service of national scope; and, the National AIDS Council was established in 1988 to make policy. The PNLS was given the mission to "reduce the impact of AIDS on individuals and the community, to monitor the progress of the epidemic and to mobilize all national efforts against this scourge". Soon after its creation, the PNLS launched an emergency plan. This plan was followed successively by a short-term plan (1988), a first medium-term plan (1989-1991) and a second medium-term plan (1996-1998). The 1997 war prevented any implementation of the second plan.

**Post-conflict response.** On December 1, 2000, AIDS Day 2000, the President of the Republic announced the Government's decision to relaunch the AIDS program it had adopted before the war. To this end, the President of the Republic signed Decree No. 2001-190 of April 11, 2001 creating the HIV Mother-to-Child Transmission Prevention Project (MCTP). This project was intended to run for a period of five years, and was to involve all the integrated health centers (CSIs) in Brazzaville and Pointe Noire. In the event, it was carried out successfully in Pointe Noire, but only in one location, and with little success in Brazzaville. The relaunching of the national AIDS program has also led to preparation of a draft ‘Three-year Strategic Plan to Combat AIDS (2002-2004); inclusion of Congo in the United Nations' "Accelerated Access to HIV-AIDS Care" Initiative (ACCESS), and introduction into the Congo of the Oubangui and Chari Rivers Initiative.

Under the three-year plan for 2002-2004, the Congo planned to: (i) prevent the transmission of STIs & HIV-AIDS; (ii) care for the sick; (iii) conduct epidemiological surveillance; (iv) decentralize activities for combating STIs & HIV-AIDS; (v) train health personnel; and (vi) carry out research. Unfortunately, none of these activities received appropriate funding and very few have been carried out. The ACCESS Initiative enables Congo to benefit from lower prices for anti-retroviral (ARV) drugs from the major pharmaceutical companies. The ARV acquired thanks to this initiative are managed through the Congolese Initiative Access to ARV (ICAARV) which provides some guidelines for patient selection and care. This intervention is presently financed by a Grant from the President. The Government has included a budget line in the 2004 budget to continue financing this initiative. The ‘Rivers Initiative’ is intended to reduce vulnerability and the impact of sexually transmitted infections and HIV-AIDS arising from travel on the rivers. During its
meeting of November 16, 2001, the Council of Ministers agreed to an annual expenditure of CFAF 1 billion as the Government’s contribution to treating patients infected by HIV. As of December 2003, however, activities had not yet started because of administrative difficulties.

The Ministry of Education, which has a vast structure covering the entire country, has joined the campaign against HIV-AIDS by developing a strategy that includes reducing the vulnerability of pupils to HIV-AIDS by providing them with information, and strengthening their decision-making and negotiating capacities. To this end, the Ministry has launched an innovative project known as AIDS Prevention in Congo Schools (PRESIEC), with the assistance of UNICEF, UNDP and some funds from the American oil company present in Congo. In addition, the Ministry of Education seconded about fifty teachers to the project, which intervenes with peer education and Youth Clubs.

Response of civil society. Because of the war and the growing incapacity of public services, the nongovernmental and nonprofit sector has begun to play a significant role in areas that were previously reserved to the State. The campaign against HIV-AIDS has now been joined by about 50 NGOs. As of April 15, 2002, 32 NGOs were grouped in a platform known as the National NGO Network against AIDS (RENOSI). These organizations offer a wide range of services, from information, education and communication to voluntary screening for HIV infections and nutritional assistance, as well as psychological support and medical care for persons affected and/or infected by HIV.

Partnership. A partnership between the Government and both local and international NGOs led to the establishment of two Ambulatory Treatment Centers (CTAs), one in Brazzaville and the other in Pointe Noire. The MCTP project is being run by a partnership of the Government, the Fondation Congo Assistance, the Pan African AIDS Organization (OPALS), the French Red Cross, the Cooperation Française and the NGO Afrique Santé Dispensaires. Moreover, Boehringer Ingelheim Laboratories has committed itself to supporting activities under the MCTP project for five years (of which three remain).

Private Sector. The private for-profit sector in Congo has begun to appreciate the impact of HIV in terms of reduced productivity and diminished capacity to retain human capital, as well as in terms of rising medical bills. The UNDP is working with the private sector to make them aware of the problems caused by HIV-AIDS and provide them with training for peer education.

Joint response of UN agencies. In August 2001, five United Nations agencies announced a joint effort known as the ‘United Nations Interagency Emergency Initiative’. This initiative aimed to deliver rapid interventions to high-risk groups (such as youth and orphans). Although it focused on emergency situations, the project was to invest in longer-term national capacity building as well. The project has supported a limited public information campaign aimed at changing behavior, and planned to provide AIDS training to some health-care workers, carry out an epidemiological survey, promote condom use, provide HIV voluntary screening, care for persons infected by HIV, build national capabilities, and implement sustainable financing mechanisms. However, this initiative was not funded and each Agency implemented few of the activities with their limited budget. The partnership is more tangible at the level of UNAIDS. Meetings of the Agencies, as UNAIDS members, are fairly frequent and serve mostly as a coordinating mechanism. UNAIDS, as an organization, has also contributed to the financing of some participative activities and to the organization of the Donor meeting which took place in June 2003.

1.6 Government strategy for 2003-2006

The Government has prepared a National Strategic Plan for Combating HIV-AIDS for 2003-2006 (Cadre National de Lutte contre le VIH-SIDA). The plan is based on recommendations made during consultations
and meetings in all regions over July-November 2002. Elected and appointed officials, representatives of NGOs, PLWHA associations, churches, youth clubs, women's organizations, and private sector participated in the meetings. The plan was then ratified through a consensus meeting of these partners as well as the donor community. The meeting was held in Brazzaville in December 2002.

The plan supports interventions that have been demonstrated to be effective, in particular, it supports the:

i. Strengthening of HIV-AIDS prevention through multi-sectoral communication for behavior change activities;
ii. Expansion and promotion of availability of VCT services;
iii. Promotion of condom utilization;
iv. Reinforcement of STI management;
v. Security of blood transfusion;
vi. Prevention of mother-to-child transmission of VIH;
vii. Psycho-social, nutritional and medical support to people living with HIV-AIDS (PLWHA);
viii. Care and support to affected individuals and families, and in particular orphans;
ix. Support to research;
x. Improvement of coordination at all levels; and
xi. Support to human resource development.

These interventions are to be implemented on the basis of sectoral and département level plans that present activities and costs. Moreover, each plan identifies the priority vulnerable groups, the basic packages of activities for each group, the financing requirements and the partnership between government and non-governmental institutions. The département level plans identify interventions and projects of NGOs and community-based organizations (CBOs) as well as institutional support for NGOs & CBOs. The sectoral plans include a strategy to inform and assist the groups they have jurisdiction on (e.g., the Ministry of Defense has a strategy to inform, screen and assist soldiers; the Ministry of Education focuses on students, etc.). They also include interventions for the personnel of the Ministry and their families.

2. Objectives
The Project's specific development objectives are to support actions by the Government of the Congo to:

- Slow the spread of HIV-AIDS and
- Strengthen support and care for people infected or affected by HIV-AIDS.

To reach these objectives, the Project follows the proven approach of supporting action in several sectors and not just in the health system. More precisely, the Project supports actions to:

(i) Support civil society and community initiatives for HIV-AIDS prevention and care;
(ii) Expand access to treatment of opportunistic infections;
(iii) Care and support for people living with HIV-AIDS (PLWHA);
(iv) Care for orphans & other highly vulnerable children; and
(v) Reduce transmission among high risk groups.

The Project objectives and actions are consistent with the Second Multi-Country HIV-AIDS Program (MAP-2 Report No.P7497AFR of December 20, 2001). Most importantly, these actions support the Congo's National Strategic Plan (Plan national stratégique) for 2003-2007. The broad objectives of the National Strategic Plan are to:

- Contain or reduce the level of the epidemic by 2007;
- Mitigate the health and socioeconomic impact of HIV-AIDS at individual, household and community levels; and
- Increase access to prevention services as well as care, treatment and support of those infected and
affected by HIV-AIDS, in particular by developing local responses to the epidemic.

3. Rationale for Bank’s Involvement
Through the country program, the Bank leads the donor community in assisting Congo in rebuilding its economy and society after the three rounds of civil war. Commendable progress has been made since the signature of the Armistice in 2000. This progress will not be sustained, however, if the international community does not help Congo implement its HIV-AIDS program. Donors express interest in supporting the program and believe that Bank involvement is essential for its success. More specifically, IDA’s role is to (i) ensure better coordination among key stakeholders; (ii) prevent duplication of efforts; (iii) exploit the complementary aspects of the different projects currently being financed by IDA; and (iv) encourage other donors to get involved in the fight against the epidemic and in the rehabilitation of the health sector.

Importantly, since, at present, the Congo has not yet benefited from support from the Global Fund and there are no other large-scale donors, it is the main donor in the area.

4. Description
The Project supports the implementation of Congo’s HIV-AIDS National Strategic Plan (2003-2006) through a wide variety of public sector agencies, private and nongovernmental organizations, and community-based organizations. In order to simplify project management, its activities have been grouped in four components:
1. The Public Sector Response, which consists of the response of the Ministry of Health and of other Ministries;
2. The Civil Society Response, which consists of community-level initiatives and support for a limited number of private sector initiatives (in collaboration with UNDP);
3. Investments in Orphans and other Vulnerable Children; and
4. Policy Development, Management, Capacity Building and Monitoring & Evaluation, including a sub-component that finances data collection at the national level (a Congo demographic & health survey.

The objectives of these components and the indicators or their progress appear in the logical framework in Annex 1 of this PAD.

The project team decided to concentrate project activities, except for blood transfusion, on the départements with the highest population --which also have the highest sero-prevalence rates. In selecting départements, the project team also considered the technical capacity available, indicators of the likelihood of future infection (such as regular population movements) and interventions by other partners. On the basis of these criteria, 5 départements were selected: Brazzaville, Kouilou, Niari, Lékoumou and Sangha. The population of their capitals covers 82% of the Congolese population and, according to the recent national HIV sero-prevalence survey, 91% of HIV infected persons.

The Congo is planning to resubmit its application to the Global Fund for HIV-AIDS, Tuberculosis and Malaria. The project team expects that an application that responds to recommendations of the Fund will be approved. This would fund extension of the fight against HIV-AIDS to the remaining départements.

COMPONENT 1: PUBLIC SECTOR RESPONSE
Subcomponent A: Health System Response.

The objective of sub-component A is to improve the health system so that it can respond to medical aspects of the epidemic and prevent HIV transmission, particularly through safe blood transfusion and better bio-security in general. To that end, the Ministry of Health and Population (MOHP) has prepared a national plan for fighting HIV-AIDS, that complements support from other donors and is based on plans developed at the département level. More specifically, sub-component A supports interventions in two areas: (i) prevention and (ii) reduction of the impact of HIV-AIDS and global care and treatment of PLWHA.

Prevention. The objective is to improve bio-security and voluntary testing services and to build capacity for prevention. To achieve this, the project team has identified a program of rehabilitation of the blood transfusion system, notably in Brazzaville, Pointe Noire, Dolisie and Impfondo. Rehabilitation has already begun, with support from the project preparation facility. Once the transfusion network is fully functional, its centers and posts may assist with voluntary HIV testing.

Furthermore, the MOHP has prepared a strategy for reducing HIV infections through the health system (bio-security). To achieve this, the MOHP will put in place mechanisms and train health workers to avoid infections among patients and workers, as outlined in the medical waste management plan, which is being disseminated in Congo. Furthermore, this subcomponent supports a prevention program, which includes diagnosis, treatment and prevention of sexually transmitted infections, condom purchase and distribution. A study is being carried out to determine the best channels for making condoms available, including social marketing. Then, the Project will invest in capacity development, condoms, and some equipment.

Reduction of the impact and global care and treatment of people living with HIV-AIDS (PLWHA). This provides care and support for PLWHA and others affected by the pandemic. It also supports the expansion and improvement of the program for prevention of mother to child transmission of HIV-AIDS within the context of global care and treatment of PLWHA strategy. At present, the Government and project team are developing such a treatment strategy, which will guide the decision process and identify the various interventions (medical and non medical) offered at each stage, from the time a person is diagnosed as HIV sero-positive until the full development of the disease.

To implement the global care and treatment strategy, the Project invests in the rehabilitation of health units, laboratories at the periphery as well as the central National Laboratory for Public Health (in collaboration with the Coopération Française). It also invests in training of personnel and in preparation of a guide for personnel. Once the national strategy towards ARVs is defined, the subcomponent will assure that the appropriate mechanisms are put in place (selection committee, medical committee, ethical committee, etc.) and that the MOHP name and train people to prescribe ARVs.

Subcomponent B: Other Sectors’ Response.
The National Strategic Plan for the fight against HIV-AIDS also sets forth the response of ministries other than the MOHP. The Strategy was established on a participative basis and sets priorities for each sector. Eleven ministries have prepared sectoral plans for the fight against HIV-AIDS, indicating the high level of commitment in many sectors. Each plan identifies the ministry’s mandate for the priority groups under its jurisdiction and defines essential activities at both the central and decentralized levels. Moreover the sectoral plans fix objectives for coverage of vulnerable groups and present budgets for achieving the objectives. All ministries have appointed focal points and their teams, including an accountant to pursue the plans. Because of their limited experience, the Project will support training for the teams, especially, in communication for behavior change and peer education, but also in project management and basic accounting.

Some ministries are already active in the fight against HIV-AIDS and their experience will be used to assist the other ministries in preparing their interventions. The Ministry of Primary and Secondary Education has been implementing an out-of school program in peer education about sex through the project known as PRESIEC (prevention of AIDS in Congo schools). The Ministry of Social Affairs is active in the preparation of programs for orphans & other extremely vulnerable children and for PLWHA. The Ministry of Communication is responsible for information and social communication. Finally, the Ministry of Youth & Sports has started a program of social mobilization for out of school Youth.

COMPONENT 2: CIVIL SOCIETY RESPONSE

This component supports efforts that emerge from civil society to prevent the spread and to reduce the impact of HIV-AIDS. These efforts may come from local institutions such as NGOs, community-based organizations including faith-based organizations and parent-teacher associations, as well as trade unions, and to a degree, the private sector. The component supports implementation of micro-projects by these civil society institutions.

The process of identification of community-based micro-projects began with département level workshops, where community groups contributed relevant parts of their programs to the département level operational plans. Micro-projects are selected for financing by an independent commission attached to the Permanent Executive Secretariat of the CNLS. The commission consists of representatives of the sector ministries, civil society, and donors.

As civil society is weak in the Congo, local NGOs and community-based organizations receive assistance in identifying their priorities, and in mobilizing their communities. To provide financing for these activities, the component includes a Community Response Support Fund. NGOs and community-based organizations selected to implement micro-projects also receive training and other capacity building, prior to engaging in the implementation. The Second Program for Urban Micro Projects is the only entity in Congo able to manage such capacity building and therefore the Permanent Executive Secretariat is negotiating an arrangement with this program to capitalize on their positive experience.

COMPONENT 3: ORPHANS & OTHER EXTREMELY VULNERABLE CHILDREN
HIV-AIDS, civil conflict, and the decline of the public health system all contributed to the emergence of a large and growing cohort of orphans and other extremely vulnerable children (OVC) in the Congo. This component addresses the OVC issue at a meaningful scale by investing in the health, education and overall well-being of these children.

To achieve this, NGOs with practical experience in serving OVC, such as the national NGO Médecins d’Afrique, conduct household surveys to identify the most vulnerable children using objective indicators of their vulnerability in terms of health, education and economic conditions (these are defined in the manual of procedures for the component). Then, local NGOs, faith-based organizations or other community-based organizations deliver basic services to about 8,000 children in five cities and towns. The basic package consists of a medical insurance card that provides for visits to health centers and pharmaceuticals, fees for enrolment in primary school and the first cycle of secondary school, along with school uniforms and textbooks, and psychological support groups. Some older children will receive skills training and some caretakers of OVC will receive help in starting revenue-generating projects. These organizations will receive training and technical support from more experienced NGOs.

The National Commission on OVC, chaired by a representative of the Ministry of Social Affaires, selects the organizations that implement the component, according to criteria spelled out in the manual of procedures. The same Commission approves the annual plan and budget for the component. The Ministry of Social Affairs is responsible for monitoring and supervision of implementation.

COMPONENT 4: POLICY DEVELOPMENT, MANAGEMENT, CAPACITY BUILDING, AND MONITORING & EVALUATION.

Subcomponent A: Policy Development and Management. This subcomponent supports management of the Project by the Permanent Executive Secretariat of the CNLS. Moreover, it supports both local and international technical assistance. Importantly, the Government receives assistance, through this part of the component, for contracting out financial management, procurement and data collection for monitoring & evaluation to a well-respected international fiduciary firm, which is being recruited through a competitive process. Furthermore, this part of the component supports updating of the National Strategic Plan and preparation of action plans.

Subcomponent B: Capacity Building. This subcomponent supports capacity strengthening and training (and supply of related equipment and materials) in the CNLS and its Permanent Executive Secretariat, in Government ministries, and in civil society. This program underlies the Government and civil society response to HIV-AIDS as well as activities supported under the OVC component.

Subcomponent C: Monitoring & Evaluation. This subcomponent follows the plan prepared with support from the project preparation facility. Although this plan is based on the model established by UNAIDS, it is simplified and includes only indicators that are easy to measure and provide useful information for all levels, not only for the central level.
**Subcomponent D. Data collection at the national level:** Because of instability and civil conflict, no one has collected systematic health and demographic data for the past 10 years. These data are necessary for rational planning of investments in health and in the fight against HIV-AIDS and for monitoring & evaluation. Therefore this component will support a Congo demographic and health survey (CDHS), conducted by the national statistical authority (CNSEE) in collaboration with the MOHP, the Permanent Executive Secretariat of the CNLS, and with the support of WHO, UNICEF and UNFPA. Work on planning of the demographic & health survey is already under way, with support from the project preparation facility.

1. Public sector response (Health and other ministries)
2. Civil society response
3. Orphans & other extremely vulnerable children.
4. Policy development, management, capacity building, and monitoring & evaluation (including data collection).

PPF

**5. Financing**

*Source (Total (US$m))*

- BORROWER/RECIPIENT ($2.00)
- IDA GRANT FOR HIV/AIDS ($19.00)
- UN CHILDREN'S FUND ($0.10)
- UN FUND FOR POPULATION ACTIVITIES ($0.10)
- WORLD FOOD PROGRAM ($0.10)
- WORLD HEALTH ORGANIZATION ($0.10)

**Total Project Cost:** $21.40

**6. Implementation**

The National HIV-AIDS Commission (CNLS) supervises implementation of the HIV-AIDS National Strategic Plan and coordinates HIV-AIDS interventions. Quick delivery of services to a large and varied group of beneficiaries requires an effective financial management system. The financial management assessment outlined several risks and in particular the lack of capacity at lines ministries, at the community level, and in the planning system. The outsourcing of the financial management and procurement functions mitigates these risks. Therefore, the procurement and financial functions will be outsourced to a Fiduciary Management Agency (FMA) in order to ensure transparent and efficient fiduciary management of IDA funds. The FMA will be an internationally well-established professional auditing firm. It will be selected on a competitive basis.

The Fiduciary Management Agency (FMA) will establish a Fiduciary Unit that will operate at all levels, under the authority of the Permanent Executive Secretary. In addition to managing the financial, accounting and procurement process, the FMA will be also in charge of data collection for Monitoring & Evaluation activities.

The FMA will supply the core fiduciary staff of the Permanent Executive Secretariat, comprising a Senior Financial Management Specialist and a Senior Procurement Specialist. These specialists will be familiar with World Bank’s procurement procedures as reflected in the terms of reference
approved by the Bank. The firm will also determine the best accounting staffing arrangement for decentralized coordinating units in order to enable the FMA to take full responsibility of the fiduciary aspects of the Project.

The Project’s financial management procedures will be documented in the Project Implementation Manual (sections on Financial and Accounting Procedures). Two independent external audits of the Project’s transactions and operations will be carried out on an annual basis. To this end, the Project will recruit, on terms of reference acceptable to IDA, professional and independent external auditors to carry out financial and technical auditing on an annual basis. Furthermore, an international consultant with significant experience and qualification will lead the internal audit unit.

The Permanent Executive Secretariat will provide overall policy guidance relating to management of project funds, and will ensure the follow up of audit findings and recommendations. The Project Implementation Manual will include, in addition to the sections on accounting, financial and procurement procedures, sections describing procedures respectively for community and OEV interventions. The Project will assist communities in the preparation of plans and budgets.

Three special bank accounts will be opened in commercial banks acceptable to IDA and implementing agencies with decentralized coordination units will maintain separate bank accounts to received funds transferred by the Permanent Executive Secretariat.

7. Sustainability
The sustainability of the program will depend on the degree to which the strategy and activities become fully owned by the various partners at the national, département and local levels. It will hinge on improved capacity, at all levels, to develop and implement action plans and proposals that are effective in changing behaviors and providing care and support to affected groups. The mobilization of local communities around a common threat, regardless of the affiliations of its members, should reinforce the reconciliation efforts undertaken by the Government and enhance the sustainability of project interventions. It has been agreed with the Government that starting year 3 of the proejct, it will include in its budget an increasing share of the operating costs of the Blood transfusion System, the National Public Health Laboratory and of the PNLS. Finally, some cost recovery mechanisms will be put in place for treatment and the funds collected will be used to order new drugs.

8. Lessons learned from past operations in the country/sector
The project team was guided by experience and lessons learned under the first phase of the Multi-Country HIV-AIDS Program for the Africa Region (MAP-1). These lessons are summarized in the Memorandum and Recommendation of the President for MAP-2 (Report No. P 7497 AFR of December 20, 2001). In addition, the team drew upon experience from other African countries. For example, in Senegal, financial management and procurement were contracted out to avoid delays and to compensate for the limited experience and skills of the local staff. The experience of Chad held lessons for design of the community-based and sectoral interventions, to ensure that the program is truly multi-sectoral and focuses on the empowerment of communities in the fight against HIV-AIDS. Key lessons learned from the MAP1 experience are the following:

- **Importance of political leadership and commitment.** Strong commitment from political and religious leadership in the country is important for the success of HIV/AIDS efforts. In recent months, the
President of the Republic and the Government have demonstrated their support for the fight against HIV.

- **Need for a multi-sectoral approach.** HIV-AIDS control activities typically start in the health sector, but need to be rapidly expanded to other sectors. However, past experience has demonstrated difficulties in implementing projects across multiple ministries. The risks of institutional conflict will be mitigated by coordination by the CNLS, which includes representatives of the line ministries and is under the Office of the President.

- **Need for community participation.** Local communities can play a key role in the prevention of HIV-AIDS, in the care of infected people, and the support to affected groups such as PLWHA and orphans. An HIV-AIDS project must establish mechanisms to promote and support community participation.

- **MAP projects tend to lose momentum after Board approval.** Particular attention is needed to secure the quality of financial and procurement management and community ownership necessary for rapid disbursement of funds. To this end, staff of implementing agencies can benefit from early training in disbursement and procurement procedures. Funds available under a project preparation facility are being used to sensitize representatives of public sector and civil society organizations, to establish program coordination and implementation mechanisms, and to train community development agents.

- **Importance of monitoring and evaluation.** The design of the monitoring and evaluation system should focus on the practical needs of decision makers at the département and central levels. Baseline data are essential for proper monitoring; consequently, the project will contribute to the financing of a demographic & health survey. Planning for this survey has already started. In addition, sentinel sites will be established (for HIV and syphilis) and information will be collected through knowledge, attitude, belief and practices (KABP) surveys.

- **Stakeholder Consultation.** Key stakeholders, particularly those with an important role in implementation, should be involved as early in the process as possible. Project identification has been done in consultation with NGOs and community-based organizations throughout the country during preparation of the département level plans. Information collected during preparation of the National Strategic Plan, through consultations with line ministries, UNAIDS and UN Agencies, other IDA projects, and other donor agencies also contributed to project design. Three consensus workshops were held in the three regions to contribute to the finalization of the National Strategic Plan and one in Brazzaville to endorse the plan.

9. Environment Aspects (including any public consultation)

   **Issues**: The HIV-AIDS program does not appear to have any major environmental impacts. The only significant issue is the handling and disposal of HIV-AIDS-infected materials. To address this, the Government of the Congo prepared a Medical Waste Management Plan and submitted it to the Bank in mid-December 2003. The Plan has been cleared by the safeguards unit (ASPEN) and approved by the Government which is now disseminating it.

10. List of factual technical documents:
- Reports dated September 2003 prepared with the assistance of Consultant CRIDES - In French:

  Tome I: Volume 1: Analyse actualisée de la situation et de la réponse nationale
  Tome I: Volume 2: Orphelins et autres enfants vulnérables - Proposition du Projet pilote sur l’arrondissement de Mounjali à Brazzaville et Analyse de la situation et propositions
Tome I: Volume 3: Analyse institutionnelle des ONG
Tome I: Volume 4: Renforcement du plateau technique des laboratoires et du réseau national de transfusion sanguine

Tome II: Plan d'action national multisectoriel 2003-2005 de lutte contre le VIH/SIDA et les IST - Résumé exécutif
Tome II: Volume 1: Plan d'action national multisectoriel 2003-2005 de lutte contre le VIH/SIDA et les IST - Classement par objectif général, objectifs spécifiques, stratégies et activités
Tome II: Volume 2: Plan d'action national multisectoriel 2003-2005 de lutte contre le VIH/SIDA et les IST - Classement par secteur opérateur
Tome II: Volume 3: Plan d'action national multisectoriel 2003-2005 de lutte contre le VIH/SIDA et les IST - Classement par département bénéficiaire

Tome III: Suivi & Evaluation - Manuel des indicateurs
Tome III: Suivi & Evaluation - Manuel des indicateurs - Annexes

Tome IV: Manuel des procédures - Manuel pour les initiatives communautaires
Tome IV: Projet de Manuel des procédures - Manuel des opérations: Sections sur les Procédures administratives, financières et comptables ainsi que le détail des procédures de passation des marchés

- Medical Waste Management Plan - In French - Prepared by Consultant Djibril Doucouré - November 2003

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12. For information on other project related documents contact:
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Note: This is information on an evolving project. Certain components may not be necessarily included in the final project.