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Report No: 27448-COB

PROJECT APPRAISAL DOCUMENT

ON A

PROPOSED GRANT

IN THE AMOUNT OF SDR 12.8 MILLION (US$19 MILLION EQUIVALENT)

TO THE

REPUBLIC OF CONGO IN SUPPORT OF THE SECOND PHASE OF THE HIV/AIDS AND HEALTH PROJECT (MAP 2 PROGRAM)

March 19, 2004

Human Development Unit 3 (AFTH3)
Africa Regional Office

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CURRENCY EQUIVALENTS

(Exchange Rate Effective January 1, 2004)

Currency Unit = FCFA
FCFA 650 = US$1
US$1 = FCFA 650

FISCAL YEAR
January 1 -- December 31

ABBREVIATIONS AND ACRONYMS

ACCESS	Accelerated Access to HIV/AIDS Care Initiative
AIDS	Acquired Immune Deficiency Syndrome
ARV	Anti-Retroviral medications
CBO	Community-Based Organization
CDHS	Congo Demographic and Health Survey
CDLS	*Comités Départementaux de Lutte contre le VIH/SIDA*
CENAMES	Public agency for purchasing essential pharmaceuticals
CFAA	Country Financial Accountability Assessement
CHU	University Hospital Center
CNLS/SEP	*Conseil National de Lutte Contre le VIH/SIDA Secrétariat Exécutif Permanent*
CNSEE	*Centre National de la Statistique et des Etudes Economiques*
CNTS	National Blood Transfusions Center
CPAR	Country Procurement Assessment Report
CSI	*Centre de Santé Intégré*
CSO	Civil Society Organization
CTA	Ambulatory Treatment Centers
DOTS	Direct Observation Treatment System
ELISA	Enzyme-Linked Immuno-Sorbent Assay
EMP	Environment Management Plan
FAPM	Financial Acounting Procedures Manual
FCFA	*Francs de la Communauté Financière en Afrique Centrale*
FMA	Fiduciary Management Agency
GRET	*Groupe de Recherche et d'Echanges Technologiques*
HIV	Human Immuno-Deficiency Virus
IAD	Internal Audit Department
ICAARV	Congolese Initiative Access to ARV
IEC/BCC	Information, Education and Communication/Behavior Comportment Change
KABP	Knowledge, Attitude Belief and Practice
M&E	Monitoring & Evaluation
MIS	Management Information System
MOHP	Ministry of Health and Population
NGO	Non-Government Organization
OI	Opportunistic Infections
OPALS	The Pan African AIDS Organization
OVC	Orphans & other Vulnerable Children
PHRD	Japanese Policy & Human Resources Development Fund
PLWHA	People Living with HIV-AIDS
PMCT	Prevention Mother-to-Child Transmission
PMRU II	Second Urban Environment Micro-Projects Program
PNLS-Santé	Ministry of Health AIDS Program
POM	Project Operations Manual
PRESIEC	AIDS Prevention in Congo Schools Project
PSO	Public Sector Organization
PURICV	Urban Rehabilitation Project
RENOSI	National NGO Network against HIV/AIDS
SHAU	Sectoral HIVAIDS Unit
STI	Sexually Transmitted Infections
TANGO	Technical Assistance NGO
TB	Tuberculosis
TSS	Transitional Support Strategy
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDB	United Nations Development Business
UNHCR	United Nations High Commissariat for Refugies
UNDP	United Nations Development Program
UNESCO	United Nations Education, Scientific & Cultural Organization
UNFPA	United Nations Fund for Population Assistance
UNGASS	United Nations General Assembly
UNICEF	United Nations International Fund for Children
UNICONGO	Employers' Associations of Congo
VCT	Voluntary Counseling and Testing
WFP	World Food Program
WHO	World Health Organization

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Task Team Leader:	Michele L. Lioy

CONGO, REPUBLIC OF
HIV/AIDS AND HEALTH (MAP PROGRAM)

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MAP(S)
IBRD No. 32895

CONGO, REPUBLIC OF
HIV/AIDS and Health (MAP program)

Project Appraisal Document

Africa Regional Office
AFTH3

Date: March 19, 2004
Sector Manager: Laura Frigenti
Country Director: Emmanuel Mbi
Project ID: P077513
Lending Instrument: Specific Investment Loan (SIL)

Team Leader: Michele L. Lioy
Sector(s): Other social services (65%), Health (35%)
Theme(s): Other communicable diseases (P), Other social protection and risk management (S), Gender (S)

Project Financing Data

[ ] Loan [ ] Credit [X] Grant [ ] Guarantee [ ] Other:

For Loans/Credits/Others:
Amount (US$m): $19.00

Financing Plan (US$m): Source	Local	Foreign	Total
BORROWER/RECIPIENT	2.00	0.00	2.00
IDA GRANT FOR HIV/AIDS	11.00	8.00	19.00
UN CHILDREN'S FUND	0.10	0.00	0.10
UN FUND FOR POPULATION ACTIVITIES	0.00	0.10	0.10
WORLD FOOD PROGRAM	0.00	0.10	0.10
WORLD HEALTH ORGANIZATION	0.02	0.08	0.10
Total:	13.12	8.28	21.40

Borrower/Recipient: REPUBLIC OF CONGO
Responsible agency: NATIONAL AIDS COUNCIL
(Conseil National de Lutte Contre le VIH-SIDA --CNLS)
Address: Brazzaville, Republic of Congo
Contact Person: Dr. Marie-Francke Puruhence, Permanent Executive Secretary- Permanent Executive Secretariat of the CNLS
Tel: (242) 51-85-95 Fax: Email: sep_cnlscongobrazza@yahoo.fr

Estimated Disbursements (Bank FY/US$m):

FY	2005	2006	2007	2008	2009				
Annual	4.90	4.90	4.20	2.60	2.40				
Cumulative	4.90	9.80	14.00	16.60	19.00				

Project implementation period: July 30, 2004 - December 31, 2008
Expected effectiveness date: 07/15/2004 **Expected closing date:** 06/30/2009

A. Project Development Objective

1. Project development objective: (see Annex 1)

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 across several sectors and not just in the health system. (12 sector ministries are involved). 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.

2. Key performance indicators: (see Annex 1)

The sero-prevalence survey of November 2003 was completed, with support from a Japanese Grant, and forms part of the baseline to track the performance of the project. The knowledge, attitudes, beliefs and practices (KABP) and the socio-cultural survey have also been completed. Further studies that will establish baseline data are underway, with support from the Grant. These are studies of the psycho-social impact of HIV-AIDS and an analysis of the condom situation.

It will be difficult to assess the impact on the overall population of project-supported activities in terms of reduction of HIV-AIDS prevalence or increased life expectancy, within the five-year implementation period. Instead, the impact of the Project will be measured among key vulnerable groups, as defined in the outcome indicators. The main indicators are:

(A more extensive list of indicators appears in Annex 1.)
Outcome indicators

- By project end, 60 % of adults 15-49 use a condom during their last sexual contact with a casual partner (baseline: 40 %);
- By project end, 90 % of people aged 15 to 49 report knowledge of vertical transmission (mother to child) (baseline: 60 %) and 90 % mention condoms as a prevention measure (baseline: not known);
- By project end, 70 % of women attending prenatal consultations will accept voluntary testing for HIV;
- By project end, HIV prevalence among 15-24-year-old pregnant women is <2 % and among 14-19

year old men 1.5 % (baseline: 2.4 %, 1.9 % and overall 2.1 %);
- By project end, the prevalence of sexually transmitted infections (STI) among pregnant women decreases to 2 % (baseline data: 3 %)

Output & process indicators
- By project end, 13 sentinel sites are functional (baseline data: 0)
- By project end, 23 health facilities provide quality treatment of STIs in the 5 departments assisted by the project (baseline: 0)
- By project end, more than 80% of pregnant mothers testing positive, receive PMCT packets;
- By project end, less than 20% of sale points will have had shortage of condoms in the last month;
- By project end, all 12 technical ministries are implementing more than 80% of the agreed HIV-AIDS action plan;
- By project end, disbursement for community civil society and private sector initiatives reach at least 70% of the planned levels;
- By project end, 90 % of population are reached through HIV-AIDS IEC/CBC radio/television (baseline: 53.9 %);
- By June of 2005, data for monitoring of outcome and impact indicators are collected regularly.

B. Strategic Context

1. Sector-related Country Assistance Strategy (CAS) goal supported by the project: (see Annex 1)
Document number: 26566-COB **Date of latest CAS discussion:** September 11, 2003

For post-conflict countries such as the Republic of the Congo, the Country Team prepares a Transitional Support Strategy (TSS) rather than a full Country Assistance Strategy (CAS) . A TSS covers about two years and addresses issues of stabilization, reconstruction and the return to development. The most recent TSS was completed on August 8, 2003, and guides operations for FY04 and FY05.

The TSS for the Congo supports the Government's Interim Post-conflict Strategy in five areas: (i) strengthening economic stability and equitable growth and supporting reforms to facilitate the transition to a market-based economy; (ii) reestablishing basic economic and social services; (iii) building capacity of government and civil society; (iv) fighting the growing threat of HIV-AIDS; and (v) providing assistance to war-affected and vulnerable groups.

This Project is the World Bank's main instrument for supporting the Government in the fight against HIV-AIDS (area iv). The Project also contributes to the reestablishment of social services by investing in parts of the health system (area ii). It builds the capacity of Government by investing in the development of the National Aids Council (CNLS), the National Technical HIV-AIDS Commission and its secretariat and by funding HIV-AIDS programs in ministries and it contributes to the capacity of civil society by funding its initiatives (area iii). The Project assists war-affected and vulnerable groups by supporting programs to prevent HIV-AIDS among displaced persons, treatment of rape victims, and programs for orphans and PLWA (area v).

2. Main sector issues and Government strategy:

2.1 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.

The Marxist-inspired state. The Republic of Congo became independent from France on August 15, 1960. In August 1963, a Marxist-inspired regime took power and imposed single party rule. 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 feature for it to lead to lasting peace. Still, sporadic eruptions of violence continue, mainly in the Pool region, particularly after March 2002, with significant impact on economic activity in Brazzaville (since the main transport link to the sea was regularly cut by attacks). Passenger 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 *département* 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 % of agricultural tools were destroyed and 75 % 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 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 twelve *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.

2.2 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 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). Over the past five years, data on the dimensions of the HIV-AIDS epidemic in Congo have become unreliable, partial at best, as the sentinel surveillance system has not been fully operational since the start of the civil war of 1997. However, different sources confirm an alarming spread of HIV infection. A limited survey conducted by the Ministry of Health in 2000, showed that 14.6 % of pregnant women were infected with HIV in Pointe-Noire and 5.4 percent in Brazzaville. In 2001, UNAIDS estimated that 110,000 people live with HIV and that the national sero-prevalence rate is 7.2%. 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.

2.3 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 functional 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 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 civil servants was further reduced by the devaluation of 1994. Lack of opportunities for promotion or for training has also contributed 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, however, many pharmaceuticals, including ARVs, are available in the informal market. At present, there are plans to create a new procurement agency. Because of this situation, the Project will buy pharmaceuticals, including ARVs, through a system similar (or combined) to that the European Union for the regions which they are supporting.

Public financing. Inadequate public financing contributes to the weak situation of the 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).

Difficulty to deliver adequate HIV-AIDS & STI 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 a few health facilities, mostly located in urban areas. In fact, blood banks have trouble 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. Inadequate 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 (four ELISA chains and two Western Blott machines have been provided by the PURICV, but they are not yet functional). 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.

2.4 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 envisages, in collaboration with WHO, adoption of 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, another potential cause of HIV transmission.

Another cultural aspect of HIV-AIDS concerns information. Traditionally, sexual matters are not discussed in the family. Group discussions 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 cults. 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, 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 (the 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. 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 sero-positive. The rate was 7% for recruits aged 18 to 33 over 1999-2000.

2.5 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 Committee 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.

Today. 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-retro-viral (ARV) drugs from the major pharmaceutical companies. ARVs acquired through ACCESS are managed through the Congolese Initiative Access to ARV (ICAARV) which provides some guidelines for patient selection and care. ICAARV intervention is presently financed by a Grant of FCFA 300 millions, from the President of the Republic. When it met on November 16, 2001, the Council of Ministers approved an annual expenditure of CFAF 1 billion as the Government's contribution to the care and treatment of PLWHA, which made it possible to have this amount specified in the 2004 budget. In addition, in the context of the sub-regional fight against HIV-AIDS, the "Rivers Initiative" against HIV-AIDS was initiated with the African Development Bank's financing. 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 companies 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. With the onset of democracy 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.

Partnerships. A partnership between the Government and the French Red Cross 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 European Union 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 socio-economic 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 set up 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.

2.6 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 *départements* over July-November 2002. Elected and appointed officials, representatives of NGOs, PLWHA associations, churches, youth clubs, women's organizations, and private sector participated in these 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.

3. Sector issues to be addressed by the project and strategic choices:

The second phase of the Multi-Country HIV-AIDS Program for the Africa Region (MAP2) provides the framework to prevent the spread of HIV-AIDS and the Congo HIV/AIDS and Health Project follows this framework. The Congo meets the four MAP2 criteria and is therefore eligible for MAP2 for funding: MAP criteria:

- ***Satisfactory evidence of a strategic approach to HIV-AIDS.*** In 2003, Congo developed a comprehensive and broad-based HIV-AIDS strategic plan, including adequate strategies for prevention, and for care and support. Program preparation was intensely participatory. Consultations with representatives of government institutions and civil society took place in all provinces by November 2003. The President of the Republic is strongly involved in the fight against HIV-AIDS, and cabinet members are regularly sensitized on HIV-AIDS issues. The First Lady is involved in the prevention of MCT and is a champion for the fight against HIV-AIDS.

- ***A high-level HIV-AIDS coordinating body.*** A National HIV-AIDS Council (CNLS) was created under the Presidency of the Republic in December 2002. The members were appointed in September 2003 and include representatives of government agencies and civil society organizations. The CNLS is responsible for (i) coordinating HIV-AIDS policy and strategies; (ii) pressing the population and the authorities to become proactive in the fight against HIV-AIDS; and (iii) mobilizing internal and external resources. Regional and Local Committees are being established in line with the forthcoming decentralization process.

- ***Government agreement to use appropriate implementation arrangements.*** The Government has established a Secretariat to coordinate preparation and implementation of the HIV-AIDS program. It has agreed to transfer resources directly to civil society organizations and communities. Experience with ongoing projects supported by other donors point to a good level of local participation in formulating and implementing programs. The Government has agreed to contract out activities when appropriate and to use streamlined procedures.

- ***Government agreement to use and fund multiple implementation agencies.*** The Government has requested key ministries and public enterprises to prepare HIV-AIDS action plans. It has agreed to use part of the grant proceeds to fund activities undertaken by civil society organizations, including religious groups, local associations, and communities and, to a limited extent, by the private sector. It has also agreed to enlist the support of traditional healers by providing them with adequate support.

Other sector issues to be addressed by the project and strategic choices

Weak institutional capacity and limited partnership with civil society. The intensification of the prevention effort and the introduction of care will require significant strengthening and coordination of the concerned institution, services, and systems, notably:

- Systems and procedures for channeling funds more efficiently to the grassroots on a large scale;
- Developing capacity at the department level through accelerated training of health personnel in the areas of Voluntary Counseling and Testing (VCT) - especially for pregnant women, treatment of OIs and STIs, procedures to ensure safe blood supplies and the safe handling of medical waste;
- Partnerships within the civil society to strengthen and develop local capacity to deliver prevention and care;
- Monitoring and evaluation, which becomes more complex as a result of greater grassroots involvement;
- Operational research and dissemination activities and use of research results;
- Procurement of drugs, testing kits, equipment and provision of related services to ensure that *département* (counties) services are supplied efficiently and on time; and
- Training of health personal at all levels.

The Government is conscious of these weaknesses, but lacks the necessary resources to address most of them.

Prevention at the grass roots level. Although there is broad agreement that prevention as a national priority, much work is still to be done:

- Youth, aged 15 to 19 must be educated about the means of transmission of the disease and of protection and encouraged to postpone first sexual contacts. This group must be reached in the last years of primary school, before sexual activity begins.
- Truck drivers, oil and forest workers often carry and spread the disease. Specific activities need to be set up for these personnel.
- Commercial sex workers, who are likely to have a high HIV sero-prevalence, will be provided with peer education, special STI-HIV prevention measures and condoms (free and/or at the least possible cost).
- Men and women in uniform need to be informed about prevention and have condoms available at all times.

Health sector issues. The present health services need significantly increased resources to prevent the system from collapsing. Unfortunately, few partners support development of the sector. However, the European Union is now developing a health project to provide such support, in particular in the pharmaceutical sector. In particular, it intends to strengthen the pharmaceutical sector. The present project will strengthen the services which are needed to support the fight against HIV-AIDS, such as the blood transfusion system and services in health facilities, by providing essential drugs, equipment and expertise. In addition, the project will build capacity and provide in-service training to health workers.

C. Project Description Summary

1. Project components (see Annex 2 for a detailed description and Annex 3 for a detailed cost breakdown):

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. 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. Management and Coordination, 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 selected to measure their progress appear in the logical framework in Annex 1 of this PAD and a more detailed description of the components is presented in Annex 2.

The project preparation 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 population movement) 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 submit a new 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 allow the fight against HIV-AIDS to extend into the remaining *départements* and to strengthen it in the five *départements* of the project.

COMPONENT 1: PUBLIC SECTOR RESPONSE (US $ 4.7 million)

Subcomponent A: Health System Response (US $ 2.6 million)

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, support 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.

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 distributed 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. The Project will also invest in capacity development, condoms, and some equipment.

Reduction of the impact and global care, support 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 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 (see annex 2 for details).

To implement the global care and treatment strategy, the Project invests in the rehabilitation of health units where counselling and voluntary testing as well as diagnosis and treatment of HIV/AIDS/STI will take place, 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 guides 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) and that the MOHP will name and train ARV prescribers. Finally, the project finances drugs for the treatment of STIs and opportunistic diseases and their distribution.

Subcomponent B: Other Sectors' Response (US $ 2.1 million)

The National Strategic Plan for the fight against HIV-AIDS also sets forth the response of ministries other than the MOHP which have under vulnerable groups and at-risk sectors under their jurisdiction. The project supports these ministries. Each of the 12 ministries has set up a sectoral HIV-AIDS unit (SHAU) which includes five members, one of them an accountant. Each of these units have terms of reference describing their responsibilities towards their ministry and their role in the coordination of the interventions to be carried out by their ministry and in their sector. In addition, the terms of reference describe how the unit will coordinate its activities with the Permanent Executive Secretariat. The POM describe the procedures to be used to manage funds which will be allocated by the project and deposited in a bank account. These SHAU will carry out the sectoral plan developed annually. Each plan identifies the mandate of the ministry with regard to priority groups under its jurisdiction and define essential activities both at the central and the decentralized levels. Moreover the sectoral plans fix objectives for coverage of vulnerable groups and present budgets for achieving the objectives. 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 is being 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 the Congo school). The Ministry of Social Affairs is active in the implementation of a pilot project for orphans & other extremely vulnerable children and for PLWHA. Finally, the Ministry of Youth & Sports has started a program of social mobilization for out of school youth. These ministries will assist with the preparation of the different guides in their area of expertise.

COMPONENT 2: CIVIL SOCIETY RESPONSE (US $ 3.5 million)

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 sub-projects by these civil society institutions.

The process of identification of community-based sub-projects began with *départemen*t level workshops, where community groups contributed relevant parts of their programs to the *département* level operational plans. Sub-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 sub-projects also receive training and other capacity building, prior to engaging in the implementation. The Second Program for Urban Micro Projects (PMRU) 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.

The private sector is starting to understand the economic, personal, family, and sectoral impacts of the HIV pandemic on their enterprises. The Project will provide limited support (including training, especially for peer education, and provision of educational materials) to enterprises that request assistance, working in collaboration with the UNDP.

COMPONENT 3: ORPHANS & OTHER EXTREMELY VULNERABLE CHILDREN (US $ 3.5 million)

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 OVC chapter of the MOP). 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 enrollment 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 Affairs, 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: MANAGEMENT AND COORDINATION, CAPACITY BUILDING, AND MONITORING & EVALUATION (US $ 6.3 million)

Subcomponent A: Policy development and Management. This subcomponent strengthens the capacity of the Congo to fight against HIV/AIDS by supporting the CNLS and its Permanent Executive Secretariat. In particular, it supports the management of the project by the Permanent Executive Secretariat of the CNLS. 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 sub-component finances training at different levels and local and international technical assistance. Finally, this part of the component supports the up-dating 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 a plan developed under the Project Preparation Facility. Although this plan is based on the model established by UNAIDS, it was simplified and includes only indicators that easy to measure and which 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, conducted by the national statistical authority (CNSEE) of the Ministry of Plan 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.

Component	Indicative Costs (US$M)	% of Total	Bank-financing (US$M)	% of Bank-financing
1. Public sector response (Health and other ministries)	5.70	26.6	4.70	24.7
2. Civil society response	4.00	18.7	3.50	18.4
3. Orphans & other extremely vulnerable children.	4.00	18.7	3.50	18.4
4. Management and coordination, capacity building, and monitoring & evaluation (including data collection).	6.70	31.3	6.30	33.2
PPF	1.00	4.7	1.00	5.3
Total Project Costs	21.40	100.0	19.00	100.0
Total Financing Required	21.40	100.0	19.00	100.0

2. Key policy and institutional reforms supported by the project:

The National HIV-AIDS Commission (CNLS) is in the Office of the President and is directly under the leadership of the President because HIV-AIDS is a multi-sectoral, development issue meriting maximum inter-ministerial coordination. The Project builds capacity at all levels, and in particular at the ministerial and local community levels, and helps them address their development challenges, including HIV-AIDS. The Project enhances the capacity of local associations, local clubs and other NGOs to prepare and implement projects. The Project also strengthens the capacity of public institutions, including the HIV-AIDS Commission and its secretariat at the national and *département* levels. Moreover, the Project establishes a strong monitoring and evaluation system.

3. Benefits and target population:

Economic Benefits. Unless checked, the rates of adult HIV-AIDS infection in the Congo will lead to a rapid spread of the disease, especially among the population of productive age group, which is also the sexually active population. This could have grave macro-economic consequences, particularly as population's dependency ratio increases rapidly and savings rates decline. The Project should improve production by reducing the frequency of sick-days of both patients and their families. In addition, the Project supports community-based programs that help individuals affected by HIV-AIDS, including PLWHA and orphans and thereby reduce the private costs of caring for HIV-AIDS patients and their families. Project interventions targeted to orphans, widows, women and persons in uniform further mitigate the economic and social impact of HIV-AIDS. Cost savings are also expected from the decrease in future needs for treatment, care and support.

Social Benefits. The Project strengthens the capacity of local communities to provide support to groups affected by HIV-AIDS. It promotes the establishment of a social support system with counseling services, support groups for patients and their families, community clinics and assistance in revenue-generating activities for PLWHA. It assists orphans through education and medical care. This should reduce the economic and social burden on patients and the affected families.

Institutional Benefits. The Project builds the capacity of key stakeholders, including community groups, to coordinate, manage, and implement the proposed interventions. It strengthens civil society: as shown in the Chad Population and AIDS Control Project (closed in 2000). In that project, the training given to small and weak community-based organizations, such as women's and youth groups, empowered them to carry

out HIV-AIDS prevention and care activities and also strengthened their ability to deal with the authorities and to organize. Development of an improved national system for monitoring HIV-AIDS involves exchange of information with sub-regional information systems (such as that of the Congo basin) and should benefit monitoring & evaluation in other countries.

Health Benefits. The Project will contribute to lowering the Congo's burden of disease through prevention, diagnosis and treatment of sexually transmitted infections and tuberculosis and other opportunistic diseases. Reducing the number of HIV-infected newborns will lower the risk of an even higher child mortality rate. The promotion of HIV testing should increase the number of persons who know their HIV status and are able to protect their partners and to take early treatment to slow the progression of the disease.

Target Groups. The entire population of Congo will benefit from the project. Many project interventions address the population in the productive age brackets; prevention efforts in particular target those vulnerable to HIV-AIDS such as pregnant women, commercial sex-workers, persons in uniform, long-distance traders, forestry workers and the young in general. PLWHA will receive improved care and support. This will benefit their immediate families, i.e. more than half a million people. A special component targets orphans and families headed by children.

4. Institutional and implementation arrangements:

Project coordination. The CNLS will supervise implementation of the HIV-AIDS National Strategic Plan and oversee and coordinate actions against HIV-AIDS. Its Permanent Executive Secretariat will carry out the day-to-day work of coordinating implementation. The Secretariat will also assist communities in preparing of plans and budgets. Moreover, the Secretariat will provide over-all policy guidance relating to management of project funds and is responsible for following up on audit findings and recommendations.

In carrying out its work, the Secretariat will follow the Project Operations Manual (POM), which includes chapters on interventions at the community level and interventions for orphans and other vulnerable children. The POM also includes chapters on procurement and on monitoring and evaluation. The Project's financial management procedures are documented in a chapter on Financial and Accounting Procedures.

Financial management. Quick delivery of interventions against HIV-AIDS to a large and varied group of beneficiaries requires an effective financial management system. The financial management assessment stresses several risks and in particular the lack of capacity in the planning system, in line ministries, and at the community level. To mitigate the risks, the Government agreed to outsource financial management and procurement to a Fiduciary Management Agency (FMA) whose objective is to ensure transparent and efficient fiduciary management of IDA funds. To achieve this, the FMA will be a well-established international professional auditing firm and will be selected on a competitive basis.

The FMA will establish a Fiduciary Unit that will operate at all levels, under the authority of the Permanent Executive Secretariat. In addition to managing the financial, accounting and procurement process, the FMA will also be in charge of data collection for monitoring & evaluation.

The FMA will supply the core fiduciary staff to the Permanent Executive Secretariat: these will be a Senior Financial Management Specialist and a Senior Procurement Specialist. The specialists will be familiar with World Bank's procurement procedures as reflected in the terms of reference approved by the Bank. The FMA will also determine the best accounting staffing arrangement for decentralized coordinating units

to enable the FMA to take full responsibility for the fiduciary aspects of the Project.

The Project will commission an annual external financial audit of its transactions and operations and also an annual external technical audit of its operations. To this end, the Project will recruit, on terms of reference acceptable to IDA, professional and independent external auditors to carry out the audits. Furthermore, an international consultant with significant experience and qualifications will lead the internal audit unit.

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

D. Project Rationale

1. Project alternatives considered and reasons for rejection:

The "Multi-Country HIV-AIDS Program (MAP) for the Africa Region Project Memorandum of the President" explains the reasons for selecting the MAP approach (Report No. 20727 AFR, paragraphs 67-69). Given the situation in the Congo, a MAP seems to be the most effective instrument in the fight against HIV-AIDS.

Because the civil conflict worsened the AIDS pandemic, the country team considered inserting a large HIV-AIDS component into one of the projects launched after the end of the civil conflicts. The team did insert a $1.5 million HIV-AIDS information and sensitization component into the Emergency Rehabilitation & Reconstruction Project and a $400,000 component for preparing the national HIV-AIDS strategy and providing equipment into the Transparency & Governance Capacity Building Project. However, the team did not insert a large HIV-AIDS component into any of the post-conflict projects because of the complex, multi-sectoral, nature of the struggle against HIV-AIDS. In addition, the above-mentioned projects were already complex and would not have had the capacity to implement a further component.

An alternative proposal was to include a HIV-AIDS component in the next health project. But given the urgency and magnitude of the HIV-AIDS problem, the country team decided to prepare a stand-alone project under the MAP-2 umbrella. The addition of a robust health component to the MAP will bring the health sector to the standard necessary for the fight against HIV-AIDS.

The Government and project team decided to contract out financial management and procurement to ensure transparency, as the Government is still struggling with financial management and procurement reform. Some of the mechanisms applied in other countries, such as central pharmaceutical procurement agencies, are not functioning in the Congo. Consequently procurement for certain goods such as pharmaceuticals, reagents, and medical consumables will be done through a system similar to (or jointly with) that of the European Union which provides pharmaceuticals in the regions where it intervenes.

2. Major related projects financed by the Bank and/or other development agencies (completed, ongoing and planned).

Sector Issue	Project	Latest Supervision (PSR) Ratings (Bank-financed projects only)	
		Implementation Progress (IP)	Development Objective (DO)
Bank-financed			
Road & rail rehabilitation & employment generation. Includes a HIV-AIDS sensitization component	Emergency Rehabilitation & Reconstruction Project (Republic of Congo)	S	S
Increasing transparency & reducing corruption. The Project includes a $400,000 component for preparation of the national HIV-AIDS program and for equipment	Transparency & Governance Capacity Building Project (Republic of Congo)	S	S
HIV-AIDS - Multisectoral	Multisect. HIV-AIDS Contr. & Orphans (Burundi)	S	S
HIV-AIDS - Multisectoral	Multi-sectoral HIV-AIDS Project (Cameroon)	S	S
HIV-AIDS	HIV/AIDS (Cape Verde)	S	S
HIV-AIDS	HIV-AIDS (Central African Republic)	S	S
HIV-AIDS	HIV-AIDS, Malaria, STD & TB Control (Eritrea)	S	S
HIV-AIDS - Multisectoral	Multisectoral HIV-AIDS (Ethiopia)	S	S
HIV-AIDS	HIV-AIDS Rapid Response (The Gambia)	S	U
HIV-AIDS	AIDS Response Proj. (GARFUND) (Ghana)	S	S
HIV-AIDS - Multisectoral	Multi-Sectoral AIDS Project (MAP) (Guinea)	S	S
HIV-AIDS	HIV-AIDS Disaster Resp. (Umbrella) (Kenya)	S	U

HIV-AIDS - Multisectoral	Multisect. STI/HIV-AIDS Prev. (Madagascar)	S	S
HIV-AIDS - Multisectoral	Multisect. HIV-AIDS Control (Mauritania)	S	S
HIV-AIDS	HIV/AIDS Response Project (Mozambique)	S	S
HIV-AIDS - Multisectoral	Multisect. STI/HIV-AIDS Prog. (Niger)	S	S
HIV-AIDS	HIV-AIDS Prog. Dev. (Nigeria)	U	U
HIV-AIDS - Multisectoral	Multisect. HIV-AIDS (Rwanda)	S	S
HIV-AIDS	HIV-AIDS Prevent. & Control (Senegal)	S	S
HIV-AIDS	HIV-AIDS Response (Sierra Leone)	S	S
HIV-AIDS	HIV-AIDS (Tanzania)	S	S
HIV-AIDS	HIV-AIDS Control (Uganda)	S	S
HIV-AIDS	HIV-AIDS for Abidjan-Lagos Corridor (Five Western African States)	S	S
Other development agencies			
UNICEF and UNDP	Prevention of AIDS in the schools of the Congo		
UNDP/WHO/UNICEF/UNFPA/	Inter-Agency Emergency		
UNESCO/WFP/UNHCR	Initiative to Fight the Spread of HIV-AIDS in the Republic of Congo		
Laboratories Boehringer Ingelheim	Prevention of mother to child HIV Transmission		

IP/DO Ratings: HS (Highly Satisfactory), S (Satisfactory), U (Unsatisfactory), HU (Highly Unsatisfactory)

3. Lessons learned and reflected in the project design:

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 African countries. For example, in Senegal, financial management and procurement were contracted out to avoid delays and to compensate for the limited experience 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:

- ***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 years, 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 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 and information will be collected through knowledge, attitude, belief and practices 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. Project design was also done during preparation of the National Strategic Plan through consultations with line ministries, UNAIDS and UN Agencies, other IDA projects, and other donor agencies. Three consensus workshops were held in the three regions to contribute to the finalization of the National Strategic Plan and in Brazzaville to endorse the plan.

4. Indications of recipient commitment and ownership

The political and religious leadership in Congo have demonstrated increased commitment to the struggle against HIV-AIDS. The country has established the National AIDS Council (CNLS) under the Office of the President and its Permanent Executive Secretariat which has the mandate to implement the National Strategic Plan. An extensive consultation process has been carried out to prepare the National Strategic Plan. A large number of local NGOs have shown considerable interest in supporting the initiative.

5. Value added of Bank support in this project:

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, the Bank is the donor of last resort, since, at present, the Congo has not yet benefited from support from the Global Fund and there are no other large-scale donors. So the Bank is also the main donor in the area.

E. Summary Project Analysis (Detailed assessments are in the project file, see Annex 8)

1. Economic (see Annex 4):

○ Cost benefit NPV=US$ million; ERR = % (see Annex 4)

○ Cost effectiveness

● Other (specify)

The "Memorandum of the President for the Multi-Country HIV-AIDS Program for the Africa Region" sets forth the economic justifications for the Program (Report no. 20727 AFR, paragraphs 76-78). The Memorandum assesses the overall assessment impact of HIV-AIDS and shows how the pandemic affects the economy through reductions in labor's production, domestic savings and economic growth. The MAP report also includes a cost-benefit analysis of HIV-AIDS interventions.

HIV-AIDS extracts a terrible cost in terms of illness and death. The pandemic also imposes immense economic costs on the public health system and on caretakers of the ill, which reduces savings. Moreover HIV-AIDS leads to the loss of skilled workers and of scarce talent, for example, the loss of well trained teachers reduces both the supply and quality of education. In many African countries, the pandemic has reached stage where it has reversed other human development achievements, for example by lowering expected life spans at birth. The pandemic has contributed to the emergence of a cohort of tens of millions of orphans. This burdens grandparents and poses questions about the orphans' integration into their communities and about the financing of their basic health and education.

The Congo is emerging from an era of economic mismanagement and three rounds of a devastating civil war. The HIV-AIDS epidemic, if not curbed, has the potential of being even more destructive in the medium-term.

2. Financial (see Annex 4 and Annex 5):
NPV=US$ million; FRR = % (see Annex 4)
A large amount of resources will be directed to community interventions. The program will largely rely on civil society organizations. The fiscal burden of the program is expected to be low and the recurrent costs will be limited. The recurrent costs will consist mainly of costs related to the coordination of program implementation, financial management, studies and monitoring and evaluation.

Fiscal Impact:

The fiscal impact of the project is likely to be small. It is estimated that less than US$ 4 million will be disbursed annually. As the Congo is in a post-conflict situation, counterpart funds will not be requested. The actual fiscal impact will be even less than implied above since much of the project will be directly channeled to CSOs, NGOs and communities which are required to generate their own counterpart contributions equivalent to 10% of the cost of their proposals.

3. Technical:
The technical design is based on lessons learned from earlier projects. For instance, vulnerable groups will be clearly identified and information messages will be tailored to their audiences. Line ministries will prepare their annual action plans in keeping with national technical standards. Moreover, the technical teams at the national and *département* levels will receive training to help them produce technically sound and cost effective proposals. Most components will include training programs and capacity building activities to ensure that staff involved in implementation have the capacity to deliver the expected services. Finally, the performance of technical assistance will be evaluated taking into account their ability to transfer skills and competence.

The Government is preparing a Project Operations Manual.

To promote effective interventions, a series of technical guides define the nature of interventions and set standards in sectoral areas:

i. Informal peer education about sex;
ii. Psychological counseling for HIV-AIDS voluntary testing;
iii. Medical care for PLWHA;
iv. Social communication methods;
v. Social mobilization; and
vi Socioeconomic support for PLWHA.

4. Institutional:
See section C4 for a detailed description of institutional arrangements.

4.1 Executing agencies:

Ministries and other public agencies as well as civil society organizations and NGOs will implement (execute) the program with support from the national and *département* units of the Permanent Executive Secretariat to the CNLS. The Project Operations Manual will define the roles of each category of executing agency and of other participants in implementation. The Manual will set forth procedures for preparing, reviewing, approving, implementing and supervising community-based intervention proposals, sectoral ministry action plans and OVC interventions.

4.2 Project management:

Section C4 explains project management in detail. The main point of interest is that financial management, procurement, and data collection for monitoring & supervision will be contracted out to a respected international firm.

4.3 Procurement issues:

The World Bank has not carried out a Country Procurement Assessment Report (CPAR) in the Republic of Congo for more than twenty years. The Assessment of the country procurement environment conducted during the appraisal mission reveals the following weaknesses;(i) the national procurement regulation is not applied and is in fact outdated ; (ii) direct contracting for goods and works and sole source selection for consultants are the rule rather than the exception; (iii) when a competitive process is used, the evaluation criteria are rarely clear and most of time ultimately there are not applied; (iv) corruption is a matter of real concern; (v) as there is no tradition of sound procurement practices, qualified procurement specialists are rare.

In order to mitigate the risks assessed, it was agreed with the Government that the Project's procurement activities will be handled by a consultant management agency. The terms of reference for this assignment were reviewed and accepted by IDA during the appraisal mission. The recruitment of the FMA that will be responsible of the procurement function is a **condition of the grant effectiveness**.

The adoption of a Project Operations Manual (POM) is also a **condition of the grant effectiveness** that will contribute to alleviate the procurement risks. The POM will describe among other things: (i) the responsibilities of the different parties involved in the project's procurement activities for each step in the process ; (ii) the procurement method to be used depending on the nature and the contract amount for goods, works and services to be procured; (iii) the standard bidding documents to be used for NCB, national shopping and community-based procurement; (iv) the minimum requirements to set up for a satisfactory procurement filing system.

4.4 Financial management issues:

The outsourcing of the financial management function to an international FMA will establish a financial management system for the Project that satisfies the Bank's minimum requirements under OP/BP10.02. This arrangement will provide, with reasonable assurance, accurate and timely information on the status of the project required by IDA. Once put in place, this arrangement will enable IDA to disburse the Grant on the basis of Financial Monitoring Reports (FMRs) within nine to twelve months after effectiveness, subject to a Financial Management Assessment satisfactory to IDA and the submission of satisfactory FMRs for the preceding months. The Financial Management Action Plan (Paragraph V: of the Annex 6 (B) of the PAD) lists the actions required between now and Grant Effectiveness to facilitate the establishment of this system.

5. Environmental: Environmental Category: B (Partial Assessment)

5.1 Summarize the steps undertaken for environmental assessment and EMP preparation (including consultation and disclosure) and the significant issues and their treatment emerging from this analysis.

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 distributing it in the country.

5.2 What are the main features of the EMP and are they adequate?

The Plan assesses current practices and sets rules for management of clinical waste. The Plan also provides for training on how to safely dispose of contaminated blood and other materials. Health facilities benefiting from proceeds of the credit will be required to demonstrate that they have safe methods of waste disposal and that the training provided to their staff includes precautions in handling sensitive materials. To realize these objectives, this the plan will take the following steps:

i. Create centers for medical waste management in Brazzaville and Pointe Noire, which will serve all health centers of these regions and install appropriate incinerators in the health facilities supported by the Project.
ii. Inform and sensitize the population about HIV-AIDS waste issues through diverse media;
iii. Launch a comprehensive national training program targeting health center administrative staff; doctors, nurses, mid-wives, technicians working in the medical waste management sectors; and
iv. Prepare legislation.

5.3 For Category A and B projects, timeline and status of EA:
Date of receipt of final draft: December 9, 2003.

5.4 How have stakeholders been consulted at the stage of (a) environmental screening and (b) draft EA report on the environmental impacts and proposed environment management plan? Describe mechanisms of consultation that were used and which groups were consulted?

Government ministries, participants in the health system and NGOs were consulted by the consultants who prepared the medical waste management plan for the Government.

5.5 What mechanisms have been established to monitor and evaluate the impact of the project on the environment? Do the indicators reflect the objectives and results of the EMP?

Regular monitoring will be put in place to ensure that the desired standard is maintained. The *Direction Générale de la Santé* will ensure monitoring of the plan and will organize field visits and produce activity reports.

6. Social:

6.1 Summarize key social issues relevant to the project objectives, and specify the project's social development outcomes.

See paragraph 83 of the Multi-country HIV/AIDS Program for the Africa region. The program will empower local communities, associations, and civil society organizations to deal more effectively with the HIV epidemic. The Government has agreed to build up the capacity of local communities, and change attitudes from top-down to bottom-up approaches. The program will contribute to this change, which will have beneficial impact on other development issues.

6.2 Participatory Approach: How are key stakeholders participating in the project?

Stakeholders have been consulted systematically in the preparation of the *département* level and National HIV-AIDS Strategy and in the preparation of action plans. Moreover, meetings were held with representatives of public agencies and private enterprises and with local associations. The draft POM was discussed with representatives of the civil society and adjusted to take into account their comments, if need be. Importantly, all these actors will be participate in implementation of the project.

6.3 How does the project involve consultations or collaboration with NGOs or other civil society organizations?

As described above, NGOs and other civil society organizations were engaged in the formulation of the National HIV-AIDS strategy. In addition, NGOs have already been consulted and are being involved in project design and are expected to play an active role in project implementation. Their involvement will consist primarily of assisting community-based organizations in the design, implementation and monitoring of community-led, community-owned initiatives. Resources will also be provided to NGOs, using simple contractual agreements, to enable them to conduct specific sub-projects on a larger scale and to cover their participation in evaluation and research.

6.4 What institutional arrangements have been provided to ensure the project achieves its social development outcomes?

The participatory approach used in project preparation will be continued during project implementation. Two beneficiary assessments will be conducted, one before project mid-term and another at the end of the project (a KABP conducted during preparation will be used as a baseline). The CNLS will provide regular oversight of the Annual Plan of Action. The Secretariat will review quarterly progress in meeting key indicators.

6.5 How will the project monitor performance in terms of social development outcomes?

Indicators of beneficiary satisfaction are built into the monitoring and evaluation system and will be tracked during project implementation.

7. Safeguard Policies:

7.1 Are any of the following safeguard policies triggered by the project?

Policy	Triggered
Environmental Assessment (OP 4.01, BP 4.01, GP 4.01)	● Yes ○ No
Natural Habitats (OP 4.04, BP 4.04, GP 4.04)	○ Yes ● No
Forestry (OP 4.36, GP 4.36)	○ Yes ● No
Pest Management (OP 4.09)	○ Yes ● No
Cultural Property (OPN 11.03)	○ Yes ● No
Indigenous Peoples (OD 4.20)	○ Yes ● No
Involuntary Resettlement (OP/BP 4.12)	○ Yes ● No
Safety of Dams (OP 4.37, BP 4.37)	○ Yes ● No
Projects in International Waters (OP 7.50, BP 7.50, GP 7.50)	○ Yes ● No
Projects in Disputed Areas (OP 7.60, BP 7.60, GP 7.60)*	○ Yes ● No

7.2 Describe provisions made by the project to ensure compliance with applicable safeguard policies.

The only potential environmental issue relates to medical waste management. A Medical Waste Management Plan has been prepared (along standardized guidelines of other MAP projects) and has been approved by the Government which is disseminating it. Training and equipment have been included in the health sub-component of the project to ensure that health personnel has the means and knowledge necessary to ensure safe management of medical waste.

F. Sustainability and Risks

1. 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 approval by the Government, 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 with year 3 of the project, it will include in its budget an increasing share of the operating costs for 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, at renew, at least in part, the drug supply.

2. Critical Risks (reflecting the failure of critical assumptions found in the fourth column of Annex 1):

Risk Rating – H (High Risk), S (Substantial Risk), M (Modest Risk), N (Negligible or Low Risk)

Risk	Risk Rating	Risk Mitigation Measure
From Outputs to Objective		
Political support is not maintained at all levels of Government to address the problem	S	Consultations with the highest level during project preparation.
Communities are not willing to take up the responsibilities of caring for the ill or dying.	S	Mobilization of communities to develop community action plans to combat HIV-AIDS; training of community members in the basic health care of ill or dying patients, and care for AIDS orphans.
The NGOs and the public sector remains weak.	M	The Project will provide support (financial and technical) both to NGOs and to the line ministries involved in the fight against the spread of HIV-AIDS
Knowledge of safe behavior is not translated into action, especially among younger people.	S	Repeated messages on media, through the education system, and in peer group settings
The "reconciliation policy" of Government is not effective which causes political instability	M	Support is being provided to Government by IDA.
From Components to Outputs		
Health services remain impoverished and weak	H	The project will contribute to improvement of health services necessary to the fight against HIV-AIDS
Data collection is not systematic and representative.	M	International expertise will be brought in to design a simple but effective system which can be implemented, and to conduct intensive training of the users.
Stigma against HIV-AIDS and AIDS victims impede community action.	S	Enlist help of community leaders, including religious leaders.
Overall Risk Rating	S	

The project is rated as a "substantially risky" project because of the social stigma associated with HIV-AIDS, the burden of poverty faced by the majority of the population, the weak condition of the health system and of public entities, the weakness of the NGOs, and political instability. It is also and foremost a substantial-risk project because of the shortage of qualified human resources and the limited capacities available in the Congo. Finally, NGOs and CBOs are weak, and past experiences have been mixed. One way of mitigating this risk has been to put added emphasis on capacity building and strengthening at the start of the project.

3. Possible Controversial Aspects:

Some religious leaders or parent groups may object to condom promotion and sexual education of young people. In order to prevent this, the preparation team met with religious groups. The largest religious group in the Congo, the Catholic Church, which has an educational system (from preschool to university) covering the whole country, has formally requested to be involved in the fight against HIV-AIDS and has prepared an action plan to be financed under the community-intervention component of the project. With regard to the parent groups, the action plan of the Ministry of Education has planned interventions in order to minimize this risk.

G. Main Grant Conditions

1. Effectiveness Condition

1. the Recipient has employed a Fiduciary Management Agency satisfactory to the Association and established an accounting and financial management system for the Project satisfactory to the Association;

2. the Recipient has adopted the Project Operations Manual in form and substance satisfactory to the Association; and

3. The Recipient will have amended the CNLS Decree, and any text enacted for its application, in form and substance satisfactory to the Association.

2. Other [classify according to covenant types used in the Legal Agreements.]

Financial
The Recipient will have recruited an audit firm to carry out the annual financial audit before October 31, 2004.

H. Readiness for Implementation

☐ 1. a) The engineering design documents for the first year's activities are complete and ready for the start of project implementation.
☒ 1. b) Not applicable.

☐ 2. The procurement documents for the first year's activities are complete and ready for the start of project implementation.
☒ 3. The Project Implementation Plan has been appraised and found to be realistic and of satisfactory quality.
☒ 4. The following items are lacking and are discussed under loan conditions (Section G):

Procurement documents will be prepared by the fiduciary firm which is being recruited. The draft procurement plan has been reviewed during the negotiations and the final version will be submitted to the Association before April 15, 2004.

I. Compliance with Bank Policies

☒ 1. This project complies with all applicable Bank policies.
☐ 2. The following exceptions to Bank policies are recommended for approval. The project complies with all other applicable Bank policies.

Michele L. Lioy	for Laura Frigenti	Emmanuel Mbi
Team Leader	**Sector Manager**	**Country Director**

Annex 1: Project Design Summary

CONGO, REPUBLIC OF: HIV/AIDS and Health (MAP program)

Hierarchy of Objectives	Key Performance Indicators	Data Collection Strategy	Critical Assumptions
Sector-related CAS Goal: Improve human development indicators by mitigating the socioeconomic impact of HIV-AIDS epidemic on development and on the level of poverty	**Sector Indicators:** Human Development indicators	**Sector/ country reports:** UNDP annual report	**(from Goal to Bank Mission)** Political commitment to make the HIV-AIDS Committee function
	- HIV new infections - prevalence adolescent population	- Health Statistical Reports - Data from Sentinel sites-Epidemiological surveillance	- Implementation of the National HIV-AIDS Strategic Plan - Political stability
	- STI in pregnant women - TB prevalence in pregnant women		

Hierarchy of Objectives	Key Performance Indicators	Data Collection Strategy	Critical Assumptions
Project Development Objective: To contribute to the change in behavior of the Congolese population in order to contain or reduce the spread of the HIV-AIDS epidemic and to mitigate its impact on infected and affected persons.	**Outcome / Impact Indicators:** At the end of the project phase: 60 % of adults 15-49 used condom during their last sexual contact with a casual partner (baseline 40%)	**Project reports:** KABP studies	**(from Objective to Goal)** Political support maintained at all levels of Government to support the . fight against HIV-AIDS
	90 % of people aged 15 to 49 report knowledge of vertical transmission (mother to child) (baseline 60%) and 90% mention condom use as a preventive measure (baseline to be known when KABP study results are available)	KABP studies	Knowledge of safe behavior is translated into action Continuous political stability
	70% of women attending prenatal consultations accept voluntary testing for HIV (baseline in pilot program PN >90%)	Analysis of services Statistics	The reconciliation policy of the Government is effective Continuous economic growth at 4.8 % pa or more (= projection 2002-206)
	HIV prevalence among 15-24 year-old pregnant women is < 2% and among 14-19 year old men <1.5%; (Baseline men: 2.4% , baseline women: 1.9%)	Prevalence surveys /Sentinel sites	Knowledge of safe behavior is translated into action, especially among young people
	STI prevalence among pregnant women does not exceed 2 % (Baseline data:3%).	Prevalence surveys /Sentinel sites	Empowerment of women

Hierarchy of Objectives	Key Performance Indicators	Data Collection Strategy	Critical Assumptions
Output from each Component: **Response of the Public Sector** **Component 1A: Health Sector Response**	**Output Indicators:**	**Project reports:**	**(from Outputs to Objective)**
- the setting up of the national sentinel surveillance system and sero-prevalence surveys;	13 sentinel sites functional (Baseline 0)	MOH/PNLS data	Health services are available and improving
- the strengthening of the health system for the early detection and treatment of HIV-AIDS, STIs, and opportunistic infections in particular TB;	23 health facilities provide quality treatment of STIs in project areas (Baseline 0%) 90% of PLWA tested for TB	MOH service statistics MOH service statistics	Regions are given resources and authority to use them Drugs are available at affordable cost
- prevention of mother to child transmission	->80 % of pregnant mothers tested positive receive PMCT packet	MOH services statistics	Households' purchasing power improves
- Strengthening of blood security	100% of blood units used for transfusion screened for HIV, HpB ,HpC and syphilis (baseline <100%)	CNLS services statistics	
- Development VTC protocols as well as a significant role in carrying out VCT activities and follow-up;	23 health facilities provide VCT (MoHP) (baseline 4)	Secretariat/project Progress reports	Population is willing to visit centers for VCT
- Capacity Building and Training, which would include on-the-job training for health personnel, advocacy	200 health staff adequately trained to provide care for sexually transmitted infections (STIs) and opportunistic infections by 2007;	Secretariat/project Progress reports	
- the procurement of condoms, and a significant role in their distribution;	<20% of sale points did have shortage of condoms in the last month	Secretariat/project Progress reports	
Component 1B: Multi-sector Responses (other than health) for HIV/AIDS Prevention and Care Sectors have developed HIV/AIDS action Plans and budgets	All 12 ministries that have developed HIV-AIDS action plans are implementing these for >80% 60 civil servants trained as trainers (non-health)	Secretariat/project Progress reports Secretariat/project Progress reports interventions	Strong government commitment to National Strategic Plan continues The line ministries have limited capacities to implement HIV-AIDS

Component 2: Support to community-based initiatives (NGOs, CBOs) and private sector	Disbursement for community, civil society and private sector initiatives will reach at least 70% of planned level;	Secretariat/project Progress Reports	Communities are willing to take up the responsibilities and Government is willing to transfer resources to the Communities
IEC/BCC strengthened	90% of population reached through HIV/AIDS IEC/BCC radio/television programs (baseline 53.9%)	KABP Surveys Secretariat/Project	Capacity of NGOs and local associations improves Strong religious groups commitment to program continues
Mechanisms in place to funnel funds to communities	50% of communities implementing an HIV/AIDS prevention/care action plan	Secretariat/project Progress Reports	Stigma against HIV-AIDS victims does not impede community action
Communities empowered against HIV/AIDS	2000 of community workers trained in prevention and care	Secretariat/project Progress Reports	Government does not object to financing community activities
Capacity Building and Training, which would include advocacy and communication training. National Strategic Plan and Annual Action Plans; and Budgets		Project reports, workplans	
Component 3: Orphans and other vulnerable Children Pilot projects results analyzed and design of project component.	Pilot Project completed Report for pilot project completed and analyzed	Data from the M&E of on-going pilot project Report on Pilot Project	
Delivery of basic health, education, and psychological support services.	Services delivered to least 7,000 OVC in five cities and towns.	Reports from the FMA, annual technical audit, annual in-depth survey of a sub-sample of OVC beneficiaries.	
Component 4: Data Collection Policy Development, capacity Building and Project Management, including monitoring and evaluation			
Sub-component A: Review of Policy orientations Review of annual plans and budgets (sectoral and regional)	National HIV/AIDS Strategic Plan implemented CNLS functioning	CNLS Reports	

Sub-component B: Project coordination, implementation and administration	Coordination mechanisms are in place and function satisfactorily Satisfactory MIS At least 80% of annual plan executed	Beneficiary Assessments at mid-term review	
Sub-component C: Monitoring and evaluation	By 2005, data for monitoring of outcome and impact indicators are collected regularly	Data collection is systematic and representative Documents from cartographers Survey questionnaires	Civil unrest prevent field work either for cartography or data collection
Sub-component D: Data collection : CDHS (EDSC) cartography carried out during project preparation and sample drawn Field work for data collection and in putting of data from questionnaires Analysis of data and report production	List of Census areas drawn and their GPS location Data from surveys (households, women, and men) are available for entering database Demographic and health data available for Congo).	Data provided from survey questionnaires	

Hierarchy of Objectives	Key Performance Indicators	Data Collection Strategy	Critical Assumptions
Project Components / Sub-components:	**Inputs: (budget for each component)**	**Project reports:**	**(from Components to Outputs)**
Component 1: Public Sector Response	4.7million	Semi-Annual project progress Report and FMR External Audit	
Sub-Component 1A: Health Sector response	2.6 million		
Component 1B: Multi-sector Responses (other than health) for HIV/AIDS Prevention and Care	2.1 million	Semi-Annual project progress Report and FMR External Audit	
Component 2: Support to community-based initiatives (NGOs, CBOs) and private sector	3.5 million	Semi-Annual project progress Report and FMR External Audit	
Component 3: Orphans and other vulnerable Children	3.5 million	Semi-Annual project progress Report and FMR External Audit	
Component 4: Policy Development, capacity Building and Project Management, including monitoring and evaluation/ Data Collection	6.3 million	Semi-Annual project progress Report, CDHS financial report, External Audit 6 monthly M&E reports	

Annex 2: Detailed Project Description
CONGO, REPUBLIC OF: HIV/AIDS and Health (MAP program)

The Project supports the implementation of Congo's HIV-AIDS National Strategic Plan (2003-2006) through a wide variety of public sector agencies, nongovernmental and private organizations, and community-based organizations. To simplify project management, the team has grouped project management into four components:

(i) The Public Sector Response, which is divided into a sub-component for activities of the Ministry of Health and a sub-component for other ministries;

(ii) The Civil Society Response, which supports interventions by NGOs and community-based organizations and some limited support to the private sector (in collaboration with UNDP);

(iii) Investments in Orphans and other extremely Vulnerable Children (OVC); and

(iv) Management and Coordination, Capacity Building and Monitoring and Evaluation, which includes a sub-component for data collection at the national level -- including financing for the Congo Demographic and Health Survey (CDHS).

The objectives of these components and the indicators of their progress appear in the logical framework in Annex 1. A more detailed description of Project components is presented in Annex 2.

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

The Congo intends to modify and resubmit its application to the Global Fund for HIV-AIDS, Tuberculosis and Malaria. The team expects that the modified proposal will be accepted so that the Congo can extend the struggle against HIV-AIDS to the remaining *départements* and reinforce activities in the project *départements*.

By Component:

Project Component 1. Public Sector Response - US$4.70 million

Sub-component A: Health - US$2.6 million:

The National HIV-AIDS Strategic Plan assigns a fundamental mission to the Ministry of Health and Population (MOHP) in the national response to HIV-AIDS. To carry out its mission, the MOHP has prepared a national health operational plan. This project sub-component will help the MOHP accomplish the mission described in these plans by strengthening the public health system. To marshal health resources rationally, the component stresses coordination with activities planned by other donors. IDA resources will then flow, through this sub-component, to two types of priority interventions:

i. Prevention, and

ii. HIV-AIDS impact reduction and a global approach to care, support and treatment.

Prevention. Bio-security and voluntary HIV testing are among the most important parts of the health sector response to HIV-AIDS. To establish bio-security, the MOPH and project team identified actions to improve blood transfusion services. The component will rehabilitate equipment and support transfusion networks in the country. This work has already started with financing from the project preparation facility. Moreover, the component invests in institutional capacity and improves the bio-security of health services. Specifically, the component strengthens hygiene and prevention in clinical settings, for instance, through steps to reduce and improve the use of injections in health facilities and the systematic collection of needles. It supports measures to protect health personnel and to provide emergency therapy in case of exposure to blood. Importantly, it also supports the proper elimination of medical waste.

The Project supports a voluntary HIV testing program and supports development of a national policy on voluntary testing. This HIV testing program includes counseling units with personnel specially trained in psycho-social and cultural aspects of HIV-AIDS. There has already been some progress with regard to testing: the Bank-supported PURICV project helped set-up two anonymous voluntary testing centers in Brazzaville. In the future, there are plans to integrate counseling and voluntary testing into selected health facilities (health centers and treatment centers). And, a guide to counseling and voluntary testing is under preparation with support from a Japanese grant.

Furthermore, the component strengthens programs for diagnosis, treatment and prophylaxis of sexually transmitted infections, in collaboration with the WHO, an intervention that has proven efficient in other African countries (e.g., Tanzania). In addition, the component supports the purchase and promotion of condoms and the establishment of a system to distribute condoms, possibly with the aid of social marketing. The basic policies and design for the system will be drawn from the conclusions and recommendations of the study of the condom situation being carried out with financing from the Japanese grant.

HIV-AIDS impact reduction and global care, treatment and support. The Project supports care and treatment for PLWHA and others affected by the pandemic. The Government and the project team are presently developing a global strategy for the care, support and treatment which will guide decision making and identify the various interventions (medical and anon-medical) offered at each stage of HIV-AIDS, from the time a person is diagnosed as HIV sero-positive until the full development of the disease. The Project supports the expansion and improvement of the program for prevention of mother to child transmission of HIV-AIDS within the context of the strategy for the global care and treatment of PLWA.

The medical aspects of support begin with identifying persons living with HIV and with actions to prevent and treat opportunistic diseases, including tuberculosis. Mothers and their children form a special category of persons living with HIV-AIDS and the strategy is intended to identify specific actions for their benefit. Furthermore, health structures supported by the Project care for victims of sexual violence and the strategy will identify the services they will receive.

The strategy will describe the medical procedures (algorithms) for the treatment of opportunist infections and for the use of anti-retroviral medications. It will set rules for selecting patients and setting pharmaceutical prices in agreement with the patients' means, it will also define a system for prescription and delivery of ARVs and for delivering the non-medical aspects of support to these patients. Once the strategy is defined, the Government may revisit the mechanisms in place for the management of treatment and care (selection, medical, and ethical committees) and identify staff to be trained to prescribe ARV (before the ARV can be financed by IDA funds).

Under the strategy, the component supports investments that strengthen reference laboratories at the national and the peripheral levels and health facilities responsible for HIV testing, and diagnoses and

treatment of opportunistic infections. Moreover, the component supports training of health personnel and preparation of guides for health personnel (sexually transmitted infection diagnosis and treatment and global treatment and support strategy guides as well as for counselling of PLWHA). Under these conditions, the Project supports the supply and the distribution of drugs for STIs, OIs and HIV.

Sub-component B: Other sectors response (excluding Health) - US$2.1 million: The National HIV-AIDS Strategy calls for actions by ministries -- other than the MOPH -- that are responsible for vulnerable groups and for sectors at risk. These ministries will receive priority support from the Project. Each of these 12 ministries has put in place a 5-member sectoral team (HIV-AIDS Unit - SHAU) including a focal point and an accountant. Each of these SHAUs has terms of reference describing their responsibilities towards their ministry and their role in the coordination of interventions to be carried out by their ministry and in their sector. Moreover, the terms of reference describe how the SHAUs will coordinate its activities with the Permanent Executive Secretariat. The POM specifies the procedures to be used for the management of funds which will be allocated by the project and deposited in a Bank account.

A Ministry's sectoral plan explains its general responsibilities, or 'mandate', toward vulnerable groups under its jurisdiction and identifies the actions it plans to take to benefit the vulnerable group directly (its 'essential' actions), both at the central and *département* level. The sectoral plans also identify 'supporting actions', such as training, transport, etc., necessary to carry out 'the essential activities. These teams will need support and training as soon as July 2004, since most have limited field experience in areas such as communication for behavior change and peer education, but also in project management and accounting. Each plan goes on to identify the ministry's main partners among governmental, nongovernmental and private sector institutions. Turning to operational detail activities, the plans lay down objectives for coverage of vulnerable groups (receipt of benefits from the essential actions) over the five-year length of the Project.

During the first year, support to these ministries concentrates mostly on social communication and advocacy activities aimed at the vulnerable groups under their jurisdiction. However, the *Ministère de la Force publique* (Defense and Interior) will receive additional support to mitigate the impact of the HIV-AIDS on PLWHA. The Ministry of Justice and the Ministry for the Promotion of Women will define the legal framework for the protection of human rights, in particular for the victims of sexual violence and of other discrimination, in addition to their communication and advocacy activities. In addition, they are planning to set up an observatory of women's and girls' vulnerability to HIV-AIDS. Furthermore, the Ministry of Social Affairs is one of the partners in the implementation of the component which will provide a package of services to the most vulnerable children. Finally, the Ministry of Communication will implement the communication strategy developed by the Permanent Executive Secretariat to support the implementation of the National Strategic Plan. The Ministry will play a critical role in promoting services, and disseminating educational messages.

To carry out these sectoral responsibilities, the Government is preparing six national guides for essential activities with support from the Japan Grant. These are: (i) informal sexual education by peers; (ii) counseling and psychological support for persons diagnosed with HIV-AIDS; (iii) medical care for persons living with HIV-AIDS; (iv) social communication; (v) social mobilization and (vi) the socioeconomic guide for people affected by HIV-AIDS. The guides will be tested and finalized before the Project is launched.

Several ministries have demonstrated what they can achieve in their sectors. For example, the Ministry of Primary and Secondary Education delivers formal and informal peer education on HIV-AIDS. In a further example, the Ministry of Youth and Sports has a special role in social mobilization. These ministries bear broad responsibilities for guiding the development of the guides in their areas of experience, setting

standards and assuring quality control.

Project Component 2. Civil Society Response - US$3.50 million

Sub-component A: Community-based interventions. The objective of the component is to support efforts of civil society in the fight against HIV-AIDS and the protection of groups rendered vulnerable by HIV-AIDS. For this purpose, civil society is defined as national NGOs, unions, the private sector and community-based organizations such as churches, parent-teacher associations, traditional leaders and clubs dedicated to the fight against AIDS. To reach the objective, the component channels financing to civil society for several types of interventions. Most importantly, the component supports implementation of qualifying micro-projects by national NGOs and community-based organizations. Furthermore, the component delivers technical support to these national NGOs and community-based organizations through national or international NGOs (which are known, in French, as *ONG d'encadrement* and in English as technical assistance NGOs - TANGO). The TANGOs help communities conduct rapid participative assessments, identify their priorities, formulate their micro-projects, set up their own associations or organizations, train personnel to implement micro-projects and assess the quality of their activities. The TANGOs will themselves receive some institutional support through training, coaching and capacity transfer. The objective of this support is to ensure that, at the end of the project, most of the community micro-projects are implemented by community-based organizations and not by NGOs, who will instead have an increasing responsibility in training and supervision.

Congolese communities, with the assistance of the Permanent Executive secretariat, have already begun to prepare a program of micro-projects for financing. The first step was the mobilization of civil society at *département* level programming workshops, where participants contributed their proposals to *département* level operational plans. Once the Project becomes effective, micro-projects that appear in the plan can be processed and selected for financing by a independent committee. This committee will include representatives of sectors, civil society, and donors. During the first year, the project will finance 42 community micro-projects, in the 5 *départements* covered by the project, targeted to and in collaboration with vulnerable groups, i.e., young people and in particular young women and some rural populations such as the Ba Twa (Pygmies) and forestry industry communities, who are exposed to commercial sex and to sexual violence. The selection, financing and control processes for the micro-projects will not depend on government ministries. Instead, an autonomous committee that includes representatives of civil society, of the sectors and the donors will select micro-projects from the portfolio assembled at the annual *department* level workshops. Two officials of the Permanent Executive Secretariat of the CNLS will administer the process and monitor the micro-projects.

A consultant has already produced the first draft of the Chapter of the POM concerning the Procedures for Community Micro-Projects. It lists the criteria for eligibility and the procedural steps for funding. Adequate quality control depends on use of national reference guides for each type of essential activity. Thus, there will be one guide per essential activity, which will include information for instructors and for quality control.

The Community Intervention Specialist of the Permanent Executive Secretariat of the CNLS are identifying the technical support NGOs on a geographic (one per *département*) and on a thematic basis (one technical support NGO per type of essential activity). These NGOs will deliver a cycle of training, including institutional development and project management skills, to civil society organizations, before the launch of their micro-projects. The Second Urban Environment Micro-Projects Program (PMRU II), the only entity in Congo with experience in community intervention management, will conduct training that will benefit NGOs support by the component; it had been agreed that the Permanent Executive Secretariat of the CNLS and the PMRU II should negotiate on a sole source basis a two-year service contract for collaboration with

regard to training.

Sub-component B: Private Sector Response: The employer's associations, UNICONGO, has been working closely with UNDP and the Permanent Executive Secretariat to raise awareness of HIV-AIDS among the private sector employers. The *Union des Employeurs de transports en commun*, another private sector association, has been working with the Permanent Executive Secretariat to identify areas of cooperation. Following these contacts, it appears that the initiatives promoted by UNDP with the private sector has led to a demand for assistance for training and the provision of educational materials. The private sector is starting to understand the economic, personal, family, and sectoral impacts of the HIV pandemic on their enterprises. The Project will provide limited support (including training, especially for peer education, and provision of educational materials) to enterprises that request assistance, working in collaboration with the UNDP.

Project Component 3. Investments in Orphans and other Vulnerable Children - US$ 3.50 million

Evidence for several African countries demonstrates that orphans and children separated from their parents (such as street children) are more vulnerable than their peers: they are more exposed to malnutrition, morbidity, lack of basic education and abuse. This is not an exclusively humanitarian issue. Because the children may not grow up in families, they may not internalize traditional values and may fail to establish social bonds within their community. This can sometimes lead to negative and even criminal behaviors, and these outcomes justify intervention on social grounds. Without adequate health care and education, these children often grow into adults with lower productivity than their peers, and these outcomes justify intervention on economic grounds.

Objectives. The Congo's National HIV-AIDS Strategy calls for actions to assist orphans and other vulnerable children (OVC). The OVC component responds to this Strategy, its objectives are to:

- Reduce the vulnerability of OVC to HIV, poor health, and loss of education relative to other Congolese children;
- Improve the integration of OVC into families and communities.

Pilot phase. In July 2003, the Ministry of Social Affairs and the Bank pre-appraisal mission decided to launch a pilot project to gain practical knowledge in assisting OVC and to inform preparation of a larger-scale component. The pilot project serves, at present, about 500 orphans in the poor Brazzaville quarter of Moungali. It is being implemented by the local NGO 'African Doctors' (*Médecins d'Afrique*) with support from the project preparation facility. In addition, the UNICEF supplies some basic medicines and the World Food Program supplies food packages. Ministry of Social Welfare participates in monitoring and evaluation of the pilot project. The Brazzaville office of the UNICEF manages the funds and helps supervise the pilot.

Principles of design of the component. The design of the component follows from principles established by consensus in the Congo:

i. Nondiscrimination regarding HIV status,
ii. Targeting of the most vulnerable,
iii. Delivery of a small but integrated package of services.

There is a broad consensus against discrimination between orphans from HIV-AIDS and orphans from other diseases and from war. Furthermore, the Ministry of Social Affairs and the mission agreed to extend coverage beyond orphans to children separated from their parents (whether they are in displaced persons or refugee camps or are street children), to handicapped children and to albinos. The manual of procedures for the OVC component specifies the groups covered and the system for rating vulnerability.

Moreover, the component targets support to the most vulnerable children because it is however impossible to intervene with all OVC despite the moral, social and economic justifications. First, the funds available limit the number that can receive support. Second, the limited number of personnel with the skills needed to assist OVC imposes an important constraint. Finally and following the design of the pilot, the component invests in the health, education and psychological and economic well being of the most vulnerable orphans and other extremely vulnerable children.

Planning and budgeting. The Permanent Executive Secretariat of the CNLS prepares a draft annual plan and budget for the component. It then presents the draft plan and budget to the National Commission for OVC, which includes representatives of the Ministry of Education and of Health and of civil society and is chaired by a representative of the Ministry of Social Action. The Commission then approves or modifies the annual plan and budget. The Commission also selects the technical assistance organizations and the local execution organizations, based on criteria that appear in the OVC section of the Project Operations Manual.

Identification of beneficiaries. The first step in implementation of the design is identification of the beneficiaries. A technical assistance organization, usually an NGO with experience in assisting children, identifies the most vulnerable children through a household survey, conducted with a community group, in each urban *quartier*. The children are classified according to indicators of their health, psychological and economic condition. The technical assistance organization then computes an index of vulnerability to identify the most vulnerable children on an objective basis. The children with the highest index numbers for vulnerability are covered up to a limit determined in the plan and budget envelope for each urban *quartier*. This methodology has been tested successfully by the NGO *Médecins d'Afrique* and by the UNICEF.

Services to OVC. One of the TANGOs trains a local execution organization in each *quartier*. The local execution organization can be national NGOs, faith-based organizations or other community-based organizations. These execution organizations deliver services to each child, according to their need as determined by their index of vulnerability.

All children receive a health care card (financed by the Project) that provides for visits to health centers and for medications. Moreover, all children receive psychological support through participation in-group meetings (*groupe de paroles*). The Project enrolls all children of school age (about 75% of the OVC) in primary school or the first cycle of secondary school. Adolescent orphan heads of households receive skills training. Some caretakers receive support in grant for starting revenue-generating projects.

Supervision. The Social Action Department of the Ministry of Social Affairs supervises the technical support organizations. The regional offices of the Ministry (*Circonscriptions d'actions sociales*) supervise the execution organizations. The execution organizations collect basic information on the conditions of the children they assist. The forms for use in collection of this basic information appear in the annexes to the section of the POM on OVC procedures.

Monitoring. The *Circonscriptions d'actions sociales* collect and verify basic information on the condition of the children. They then prepare aggregate tables and send the information to the fiduciary agency, with copies to the Social Action Department of the Ministry of Social Affairs and the Permanent Executive Secretariat of the CNLS. The fiduciary agency compiles the information into analytical tables and a quarterly report and forwards their report to the National Commission on OVC, with copies to the Ministry of Social Affairs, the Executive Permanent Secretariat of the CNLS and the World Bank.

Partnership with UNICEF. The UNICEF is a partner in implementation in many ways: it supported development of the design of the component, participated in financial management of the pilot phase, and is a member of the National Commission on OVC. Moreover, the mission remains interested in supporting part of UNICEF's program for protection of children and women and is exploring the possibility of an agreement.

Project Component 4. Management and Coordination, Capacity Building and Monitoring & Evaluation - US$6.30 million

This component will strengthen the Congo's capacity to fight the spread of HIV/AIDS, and, specifically, will support:

i. Project coordination and other responsibilities of the CNLS and its Permanent Executive Secretariat, including
updating of the National HIV-AIDS Plan and preparation of the annual action plans for regions, sectors and
for the Project;

ii. Capacity building of public, private and nongovernmental institutions;

iii. Monitoring and Evaluation; and

iv. Data collection at the national level (CDHS).

Sub-component A: Management and Coordination The staff of the Permanent Executive Secretariat of the CNLS prepared much of the Project. The Government has recruited most of the technical staff of the Secretariat. The management unit of the urban rehabilitation project (PURICV) manages the funding from the project preparation facilities and manages procurement for the Permanent Executive Secretariat. The PURICV is recruiting an administrator-accountant (financed under the MAP PPF) to assist them with this work. Moreover, the PURICV is also advertising the technical assistance positions internationally. Their terms of reference have been discussed with the Permanent Executive Secretariat and are satisfactory to IDA. The Permanent Executive Secretariat is working closely with UNAIDS and with its thematic group. A consultant has prepared the draft Administrative, Financial, and Accounting Procedures Section of the POM. The Sections of the POM concerning, respectively Community Sub-projects and Orphans' intervention, are also being finalized. A simple guide for M&E is being prepared.

This sub-component strengthens the capacity of the Congo to fight against HIV-AIDS by supporting the CNLS and its Permanent Executive Secretariat. In particular, it supports the management of the project by the Permanent Executive Secretariat of the CNLS. 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 sub-component finances training at different levels and local and international technical assistance. Finally, this part of the component supports up dating of the National Strategic Plan and preparation of action plans.

The Permanent Executive Secretariat of the CNLS will be responsible for coordination of implementation of the Project, for the realization of annual plans and budgets, and for contacts with the Government and with IDA.

Role of the international fiduciary management agency. The Government, in consultation with IDA, has decided to delegate financial management, procurement, and data collection for monitoring & evaluation to an internationally respected fiduciary agency that will be selected on the basis of a short-list of firms. A list of qualified international firms is being established on the basis of their expressions of interest; and they

will be invited to submit technical and financial proposals. The firm selected will arrange for audits, accounting services and business management. The firm will also prepare the procurement documents, at the request of the Permanent Executive Secretariat, which will furnish the technical specifications. A draft procurement plan that will form a basis for scheduling and following up on bids was reviewed during negotiations and will be submitted to the Association before April 15, 2004. Finally, the international fiduciary firm will assist with data collection for Monitoring and Evaluation. The firm will put in place a management information system that has already been tested in similar projects. It will report to the Permanent Executive Secretariat to the CNLS. The responsibilities of the firm are discussed in detail in Annex 6-B of this document.

Sub-component B: Building capacity to administer and implement the Project at the central and peripheral levels. The scarcity of skilled human resources could significantly constrain the success of the Project. The limited number of qualified staff slows work and harms quality in several departments of the MOHP. That is why the MOHP was the last ministry to complete its action plan, which was of mixed quality.

To address this, the mission and the Government agreed that this component will strengthen the Permanent Executive Secretariat to the CNLS by recruiting staff funded through the Project on a competitive basis; moreover, these staff will receive one-year contracts, renewable on the basis of performance. Furthermore, the CNLS will recruit two international technical assistants, a facilitator and a social communication expert, to provide training and support during repeated quarterly short-term visits. The terms of reference for the international technical assistants, now in advanced drafts, require them to transfer knowledge to nationals. Therefore each technical assistant will have an official counterpart named or recruited by the Congolese authorities. This sub-component 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. The component may also support several study tours as part of this training for selected members of the CNLS and its Permanent Executive Secretariat. Separately, the CNLS will recruit several short-term experts for specialized tasks such as training in counseling or in prescriptions of ARV.

Training of NGOs and Ministries in financial management. The mission found that many NGOs active in health and in the fight against HIV-AIDS have poorly organized accounts. The POM defines the criteria for selection of these NGOs and training sessions will be organized to reinforce their capacity (see the description of Component 2 above). Training sessions will also be organized for SHAUs of technical ministries and *département* offices on the basis of the findings of the capacity assessment that is to be carried-out before Project launch.

Each participating technical ministry will manage its own advance of project funds, deposited in a bank account, through a qualified accountant who will work closely with the international fiduciary firm. The POM sets the mechanisms for financing and the ceilings for the amount of funds the ministries can manage.

Sub-component C: Monitoring & evaluation. The Guide to Monitoring & Evaluation follows the UNAIDS model guide. The project guide is detailed and comprehensive and should be considered a tool kit that the Permanent Executive Secretariat and ministries can draw upon. However, the monitoring & evaluation process for the Congo is simplified as follows:

i. At the first level: monitoring of UNGASS indicators;
ii. At the second level: monitoring of indicators proposed for the Project at the national level, complemented by a surveillance plan that includes sentinel groups, behavior surveys, and biological studies; and
iii. At the third level: the monitoring & evaluation system for sub-projects, using indicators specially defined for each activity. (Several key indicators of sub-projects will be selected for use as indicator of the project at the national level).

The indicators at the first level and second level have been identified.

To put the monitoring & evaluation system into practice, the mission developed an algorithm showing the circulation of information. The Permanent Executive Secretariat will promote feed back by creating a data bank that will be easily accessible to all participants. A simplified guide, in preparation, will describe the data collection and distribution system in detail.

The CNLS will constitute a committee of experts to oversee development of the monitoring & evaluation system. Once the system is developed, this committee could continue to assist with improving the monitoring & evaluation system. The evaluation expert at the Permanent Executive Secretariat will coordinate with the committee of experts on monitoring & evaluation, which will include representatives of the WHO and the UNICEF. Monitoring of these three levels of indicators will essentially be the responsibility of the monitoring & evaluation specialist of the Permanent Executive Secretary. However, an agent of the international fiduciary firm will be responsible for collection of information on project activities and on project finances and for control of their quality. The agent will not be responsible for in-depth analysis of project activities but rather for entering information on the activities into electronic data banks.

Surveillance of the pandemic and monitoring & evaluation of the Health sub-component. Until now, surveillance of the pandemic has not been done in a systematic manner. Therefore a surveillance system should be put in place as soon as possible. Several studies have been or being carried out in order to provide base line data. On the basis of these data, a comprehensive surveillance plan is being developed for the period of the project.

The capacities of national agencies that should contribute the studies and monitoring & evaluation systems are insufficient. Consequently, the Project will strengthen the capacity of the National Public Health Laboratory, as well as those of the Studies & Planning Division *(Direction des Etudes et de la Planification)* of the MOHP, and of the National Statistical and Economic Studies Center of the Ministry of Plan, by providing equipment, in-service training of their personnel in qualitative and quantitative research. In order that research on HIV-AIDS not be interrupted, it will be necessary to pay particular attention to bio-medical equipment maintenance.

The Project will build up a simple system for monitoring and evaluation of activities carried out by the HIV-AIDS program of the MOHP. This system will attempt to compensate for weaknesses of the Studies and Planning Direction. Monitoring depends on a well-functioning epidemiological surveillance system. To improve this system, the sub-component will invest in the actual network of sentinel sites, in collaboration

with WHO. The health component will also strengthen the network of peripheral laboratories and the capacities of the National Public Health Laboratory, complementing expected support from the French Cooperation Agency. In addition, it will support specific research studies.

Sub-component D: Data collection at the national level: Financing of the Congo Demographic and Health Survey (CDHS)

The Government has not collected systematic, nation-wide and reliable information on the population and on health for about 10 years because of recurrent conflict and instability. 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), to be conducted by the national statistical authority (*Centre National de la Statistique et des Études Économiques,* CNSEE) of the Ministry of Plan in collaboration with the MOHP, the Permanent Executive Secretariat of the CNLS, and with the support of WHO, UNICEF and UNFPA.

Responsibilities for implementation. The CNSEE will collaborate, at each stage of the survey, with national and international institutions engaged in population and health issues, and in particular, the Ministry of Health and Population, the Permanent Executive Secretariat of the CNLS, the World Health Organization, the UNFPA and the UNICEF. These organizations will convene in a consultative committee, chaired by the CNSEE. The committee will meet regularly during the preparation, collection and processing of the demographic and health survey. Its duties will be to review updates on progress of the survey and also to respond to technical questions and propose solutions to logistics problems.

The CNSEE and its partners have already begun preparations for the survey. A planning mission visited the Congo with support from the first project preparation facility. The second facility supports mapping and selection of the sample so that data collection can begin as soon as the Project becomes effective.

Parts of the DHS survey. The survey will consist of the two basic questionnaires: a household survey and a women's survey, as well as a male survey questionnaire:

Household survey. The household survey part of the DHS will collect the list of household members and information on their socio-demographic characteristics. This part of the survey will also collect information on housing that will permit calculation of the poverty index, using the methods developed for the World Bank by ORC Macro. Moreover, the household survey will collect information through tests and measures. First, the interviewers will determine the nutritional condition of women aged 15 to 19 and of children under 5 through anthropometric measurement of height and weight. Second, the interviewers will test the salt used in order to estimate the proportion of women and children living in households that use sufficiently iodized salt.

Women's survey. The women's survey part of the DHS will cover women aged 15 to 49. It collects basic information on women's social and demographic characteristics. With regard to maternal health, the women's survey will collect information on reproduction, family planning and pre- and post-natal care, childbirth and breast-feeding. It will also collect information on marriage and sexual activity and preferences for fertility. The survey will collect information on vaccination and infant and child health. Finally it will collect information on the characteristics of husbands, professional activities of the interviewed women and on HIV-AIDS and other sexually transmitted diseases.

Once this information is collected it will be possible to estimate basic indicators of human development, in particular, all indicators based on general population data and defined by UNAIDS and UNGASS.

These include fertility rates, infant and child mortality rates and the statistical determinants of fertility. The women's survey should also reveal contraceptive use levels, attitudes and practices that influence the spread of HIV-AIDS such as rates of condom use and knowledge about HIV-AIDS and other sexually transmitted infections. Finally, the data will yield information for an assessment of women and children's health, and nutrition and breast-feeding practices.

HIV-AIDS survey of men. There will be an individual HIV-AIDS survey of men aged 15 to 59. This will require interviews with only half the men in households in the sample. The proposed questionnaire is a shortened version of the women's questionnaire. It includes only 5 sections: on social and demographic characteristics; reproduction questions and in particular questions about the number of children desired; marriage and sexual activity; adult and maternal morality; and HIV-AIDS and sexually transmitted infections.

Possible additional questionnaires. If sufficient funds are available, the consultative committee may add additional questionnaires. For example, the test for anemia could be added to the household survey. In the questionnaire for individual women, the committee could add the module on malaria and on adult and maternal mortality. However the survey will not include a test for HIV-AIDS for each person interviewed because an HIV-AIDS sero-prevalence study for the general population is now under way, with support from the Japanese Grant.

Annex 3: Estimated Project Costs

CONGO, REPUBLIC OF: HIV/AIDS and Health (MAP program)

Project Cost By Component	Local US $million	Foreign US $million	Total US $million
Public Sector Response	3.41	0.71	4.12
Civil Society Response	2.85	0.50	3.35
Orphans & Other Vulnerable Children	2.90	0.50	3.40
Policy Development, Capacity Building, Project Management and Monitoring & Evaluation	0.84	5.13	5.97
PPF	0.00	1.00	1.00
Total Baseline Cost	10.00	7.84	17.84
Physical Contingencies	0.44	0.14	0.58
Price Contingencies	0.44	0.14	0.58
Total Project Costs[1]	10.88	8.12	19.00
Total Financing Required	10.88	8.12	19.00

The Letter 0426/MEFB-CAB from the Minister of Economy, Finance and Budget of the Recipient dated March 5, 2004 provides for an exemption of taxes and custom duties levied in the territory of the Recipient on works, goods and services for this Project. In the event of any change made to said letter which has the effect of levying taxes or customs duties on such works, goods and services, the percentages referred to above shall be decreased in accordance with the provisions of Section 5.08 of the General Conditions.

[1] Identifiable taxes and duties are 0 (US$m) and the total project cost, net of taxes, is 21.4 (US$m). Therefore, the project cost sharing ratio is 88.79% of total project cost net of taxes.

Annex 4: Supervision Framework
CONGO, REPUBLIC OF: HIV/AIDS and Health (MAP program)

The project will require intensive supervision, given its multisectoral and multi-agency nature, and large span of activities. Moreover, some of the actors to be involved (i.e. associations of PLWHA, local NGOs, and CBOs) have relatively limited experience with Bank operations and have limited management capacities in general.

Some of the skills required for supervision will be needed on a regular basis while others will be required on an ad-hoc basis. Therefore, a core supervision team will be established, to be complemented by other technical specialists, as agreed upon with the Beneficiary. The core team would carry out annually, on average, 2 three-week supervision missions comprised of approximately 5 or 6 staff. Other technical experts would provide support periodically, as required. During the first year, a heavier supervision program would be expected, with 3 missions, tapering down over subsequent years.

IDA's supervision task will be facilitated by the continuous monitoring of the Fiduciary Management Agency, which will be responsible for financial and procurement management, the regular mission of the technical assistants (international Public Health Specialist and the Social Communication Specialist) who will visit the Congo quarterly.

The core team would be comprised of the following experts from headquarters and from the Burundi and DRC country offices: (i) a task team leader with experience in health projects, with particular focus on HIV-AIDS operations (HQ); (ii) an economist in charge of the OVC component (HQ); (iii) a financial management specialist who would review adherence to Bank procedures with regard to fiduciary responsibilities (DRC CO); and (iv) a procurement/implementation specialist who would be responsible for the procurement, implementation, and institutional issues (Burundi CO). In addition, a consultant-specialist in community-based and multi-sectoral intervention would be part of the team.

The core team would be complemented with other technical experts in the following areas: (a) an M&E Specialist (2 visits the first year, one in the subsequent years unless there are major problems with M&E); (b) sector specialists (e.g., environmental specialist, rural development, education, transport), when necessary to review progress in the respective sector; (c) a communications specialist to review BCC/social communication interventions; (d) social scientists to explore the social aspects of HIV/AIDS; and/or (e) economists to assist in priority setting and in monitoring the impact of the epidemic on households.

The core team could also include representatives from development partners active in the control of HIV-AIDS-STI and tuberculosis and present in the Congo, e.g., UNICEF, WHO, UNDP, and WFP. As with project preparation, partners from the extended UNAIDS Thematic Group would be invited to participate in supervision missions to ensure complementarity of interventions, build strong partnerships, and facilitate a cross-fertilization of experiences. During preparation, WHO, UNICEF, UNDP, and the French Cooperation were involved in project preparation, while all other at-large UNAIDS partners were involved in specific discussions as well as during regular mission briefings and debriefings.

The core team will be primarily responsible for the review of: (i) quality of project management and implementation, and adherence to the Project Implementation Manual (PIM); (ii) monitoring and

evaluation; (iii) financial management, including FMR (after 0 or 12 months), performance, procurement procedures, environmental safeguards, and review of technical and financial audits; (iv) spot-check quality and relevance of sub-projects financed under the Community Fund component; and (v) progress on the development and implementation of sectoral plans.

The whole core team would visit the country at least twice the first year, and once in subsequent years, either by themselves or accompanied by other specialists. In addition, some of the members of the country team may visit the Congo one additional time to ensure a good start for the project. For the first year, a total of 42 staff weeks are planned, of which 15 headquarter staff, 10 for country office staff . 17 weeks will be for consultants.

The team has proposed the following breakdown of staff weeks:

Supervision Planning

Staff/Consultants	Consultant Staff **Travel** for **First** Year	Number of Staff/Weeks for the **First** Year	Estimated Total Labor Budget for **first** Year (US$)
Task Team Leader HQ	3 trips x 2 wks	8	32,000
Economist – OVC Component	3 trips x 2 wks	7	26,000
Financial Management Specialist DRC CO	2 trips x 2 wks	5	3,000
Procurement Specialist Burundi CO	2 trips x 2 wks	5	2,500
Community-based and multi-sectoral Intervention Specialist	3 trips x 2 wks	6	20,000
Public Health /HIV/AIDS Specialist	3 trips x 2 wks	6	16,000
M&E Specialist	2 trips x 2 wks	5	20,000
Total	About **$150,000**	42	**119,500**

The total supervision budget for the first year would be about US$269,500. It should be noted that M&E may be financed from the Gamet budget as it was during preparation. In that case the budget for supervision would be about $40,000 lower. The TTL will also try to obtain Trust Fund funds to finance some of the consultants.

Expected yearly supervision missions for the other years:

- End-of-year progress review mission to take stock of what has been accomplished and to decide on next year's action plan (annual review). These missions should be led by the government and held jointly with other donors.
- About six months after the end-of-year progress review mission, a regular supervision mission.
- A mid-term review will be carried out about 30 months after effectiveness.

Project progress reviews will be held annually at the end of the calendar year to assess the performance of the project and its contribution to the national effort to reduce the spread and impact of HIV-AIDS. They will be held jointly with the UNAIDS Thematic Group. Monitoring and Evaluation information and

conclusions of site visits conducted by the supervision team will form the basis of the discussions.

Progress reviews would include a presentation by the Permanent Executive Secretariat on progress attained, problems encountered, and future steps. A progress report will be prepared for annual review attendees to be distributed at least one week prior to the meeting. The presentation will employ data derived from the project M&E system and observations made during site visits. Other information available at the time, including studies conducted by the project or other donors, will be used to complement M&E data. Progress reviews will culminate in stakeholder meetings that will form a basis for planning for the next year. These meetings will be used to share information on trends and best practices and to provide general technical information.

Regular supervision mission will be concluded by a debriefing to which all the stakeholders will be invited. The mid-term review will be preceded by a beneficiary assessment and an evaluation of the project performance done by an outside consultant.

Annex 5: Financial Summary

CONGO, REPUBLIC OF: HIV/AIDS and Health (MAP program)

Years Ending
June 30

	IMPLEMENTATION PERIOD						
	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7
Total Financing Required							
Project Costs							
Investment Costs	2.7	4.3	4.2	3.8	2.5	0.0	0.0
Recurrent Costs	0.8	0.7	1.0	0.8	0.6	0.0	0.0
Total Project Costs	3.5	5.0	5.2	4.6	3.1	0.0	0.0
Total Financing	3.5	5.0	5.2	4.6	3.1	0.0	0.0
Financing							
IBRD/IDA	2.9	4.4	4.7	4.2	2.8	0.0	0.0
Government	0.5	0.5	0.4	0.3	0.3	0.0	0.0
Central	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Provincial	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Co-financiers	0.1	0.1	0.1	0.1	0.0	0.0	0.0
User Fees/Beneficiaries	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Other	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Project Financing	3.5	5.0	5.2	4.6	3.1	0.0	0.0

Main assumptions:

Annex 6(A): Procurement Arrangements
CONGO, REPUBLIC OF: HIV/AIDS and Health (MAP program)

Procurement

General. The World Bank has not carried out a Country Procurement Assessment Report in the Republic of Congo for more than twenty years. The appraisal mission assessed the country procurement environment and found the following major weaknesses:

i. National procurement regulations are not applied and are outdated;
ii. Direct contracting for goods and works and sole source selection for consultants are the rule rather than the exception;
iii. When a competitive process is used, the evaluation criteria are rarely clear and are usually not applied;
iv. As there is no tradition of sound procurement practices, qualified procurement specialists are rare on the labor market; and
v. Corruption is a matter for concern.

The absence of a modern procurement code is one of the main weaknesses of the Congo's legal and institutional framework. Early in 2001, the Government started, on its own initiative, to review and amend the procurement code. The Government solicited and obtained comments and guidance from the World Bank about the first version of the revised procurement code. However, it seems that this reform is blocked since there has been no evidence of progress over the last twelve months. The dialogue with authorities on this subject still continues. The Government can receive assistance to pursue and complete the revision of the procurement code through the Transparency and Governance Capacity Building Project (Cr. 3600 Cob) since this activity meets the objectives of the Project.

Guidelines. Procurement of goods and works required for the Project and to be financed from the proceeds of the grant shall be governed by the *Guidelines for Procurement under IBRD Loans and IDA Credits*, published in January 1995 and revised in January and August 1996, September 1997 and January 1999. National Competitive Bidding will be carried out in accordance with the procedures to be spelled out in the Project Operations Manual (POM) acceptable to IDA. The procurement procedures in the manual will ensure economy, efficiency transparency and fair participation. More specifically these procedures will be ensure that: (i) bids will be advertised in national newspapers with wide circulation; (ii) the bid document clearly explains the bid evaluation and award criteria; (iii) bidders are given adequate response time (minimum four weeks) to prepare and submit bids: (iv) bids will be awarded to the lowest evaluated bidder and not arbitrarily; (vi) eligible bidders, including foreign bidders, will not be precluded from participation and; (vii) no domestic preference margins are applicable to domestic manufactures and suppliers.

Consultant services contracts financed by IDA will be procured in accordance with the Bank's *Guidelines for the Selection of Consultants by World Bank Borrowers* (January 1997, revised in September 1997, January 1999 and May 2002). The World Bank's Standard Request For Proposals will be used and forms of contracts as needed (lump sum, time-based and/or simplified contract for short-term assignment and individual consultants) as well as the sample evaluation report for the selection of consultants.

Procurement for community based sub-projects will conform to paragraph 3.15 of the bank's procurement guidelines (Community Participation in Procurement) and the Bank's G*uidelines for Simplified Procurement and Disbursement for Community-Based Investments* (February 1998). The POM will describe the specific procurement arrangement of the community-based component.

Advertising. A General Procurement Notice will be prepared and issued upon board approval in the United Nations Development Business and in the Development Gateway Market, listing all goods contracts above US$150,000 equivalent and contracts for consultant services above US$ 100,000 equivalent to obtain expressions of interest and to identify solid candidate firms from which to compile a short list. Sufficient time, not less than fourteen days, will be allowed before preparing the short-list. The general procurement notice will be updated on a yearly basis as long as International Competitive Bidding (ICB) for goods contracts and consultant contracts exceeding the above-mentioned amount are foreseen in the annual procurement plan. Specific Procurement Notices will be required for all goods contracts procured by ICB and National Competitive Bidding (NCB). Specific Procurement Notices will be published in national newspapers of wide circulation and in the UNBD online and the Development Gateway Market Portal (dgmarket.com) for large contracts (ICB).

Procurement capacity. The assessment of the procurement environment conducted during project preparation indicates that this is a high-risk project. In order to mitigate the risks, a consulting firm, which will be referred to hereafter as the Fiduciary Management Agency (FMA) will handle the Project's procurement, disbursement and financial management functions. The recruitment process of the FMA is under way. The selection process is expected to be completed by the end of June 2004.

At this stage no procurement capacity assessment of the implementing agency can be done since the FMA is not in place. The short listed firms for this assignment are being evaluated, among other things, on their relevant experience and on the proven records of their key staff in procurement. Therefore, the project team anticipates that the FMA eventually selected at the end of the process will be fully equipped to carry out this assignment. A complete procurement capacity assessment of the FMA will be carried out within six months after the Project's effectiveness.

The second main measure aimed at reducing the procurement risk is the adoption of a satisfactory POM. The procurement sections of this document will present the following: (i) the responsibilities of the different parties involved in the Project's procurement activities for each step of the process; (ii) the procurement methods to be used depending on the nature and the contract amount for goods, works and services to be procured; (iii) the standard bidding documents to be used for NCB, national shopping and community based procurement (iv) the minimum requirements to set up for a satisfactory procurement filing system.

In addition to the above-mentioned measures, procurement training activities will be conducted through realization of the Project. Thus, the FMA will define a procurement-training program and will carry out a two-day procurement training session for the *département* level NGOs that will provide support and guidance to community-based organizations. Regional procurement experts that are recruited on a competitive basis and financed by the Project, will conduct subsequent training activities. During implementation, support mission procurement clinics will be organized. The topics of the clinics will be derived from the findings of post procurement reviews and the findings of the annual technical audit.

Procurement Plan. The Borrower prepared a draft procurement plan which was reviewed during Negotiations; the plan will be finalized by April 15, 2004. By November 1 of each year, a procurement plan for the next year will be submitted by the CNLS for IDA prior review. The procurement plan will be updated at least once a year and the progress report forwarded to IDA.

This plan excludes sub-projects to be implemented by NGOs, civil society organizations and private sector entities. Their demand-driven nature makes it difficult to plan the activities of this component. However, the appraisal document of each approved sub-project will include a procurement schedule for completing the sub-project.

Procurement implementation arrangements. The overall coordination of procurement will be handled by the Permanent Executive Secretariat of the CNLS in close collaboration with line ministries at national and *département* levels and two nongovernmental organizations - one for HIV-AIDS community-based activities and one for the Orphans & Other Vulnerable Children component - that will be recruited in each one of the five *départements* of the country covered by the project, i.e. ten Technical Assistance NGOs (TANGOs) in total. As already stated a FMA will handle the Project's procurement activities for the Permanent Executive Secretariat.

For the public sector response and in particular its health component, the Permanent Executive Secretariat, through the FMA, will procure all the goods and works required under the various procurement methods foreseen in the development grant agreement. Line ministries will conduct very few procurement activities, either at the national or regional levels. Instead, the Permanent Executive Secretariat will procure all the items contained in their annual work program that can be grouped and purchased in bulk. Goods and various items that cannot be grouped in packages should not exceed US$ 5,000 per annual work program: these will consist of per diems and transportation costs when applicable, as well as small office supplies. The POM will indicate the procurement procedures to be used: mainly local shopping and all the requirements concerning the documentation.

For the civil society response, the procurement activities to be conducted by the NGOs at the *département* level should be very limited. The equipment required for the ten TANGOs that will cover the five *départements* of the country assisted by the Project will be grouped into a bulk order and procured by the Permanent Executive Secretariat. Goods and various items that cannot be grouped into packages will be procured by the TANGOs themselves following the procurement procedures spelled out in the POM, mainly local shopping and direct contracting. The total value of the items to be procured by TANGO themselves should not exceed US$ 5,000 per year per NGO. In the same way procurement for community-based organizations for commonly used goods and items like condoms, printed and other materials for information and education activities will be made available by the Permanent Executive Secretariat. The remaining goods and items derived from their sub-project that cannot be grouped into packages will be procured by the community-based organization themselves. The total annual value of the items to be procured by each community-based organization should not exceed US$ 2,500. The POM will indicate the procurement procedures to be used mainly local shopping and all the requirements concerning the documentation.

Procurement Methods. Civil works. There will be very few civil works contracts and the value of the contracts will be relatively low. Hence, no ICB and no NCB are foreseen but this event cannot be excluded. ICB procedures will be applied for procurement of civil works estimated to cost more than the equivalent of US$ 250,000. Civil works estimated to cost between $US 30,000 and $US 500,000 may be awarded by NCB in accordance with the provisions of paragraphs 3.3 and 3.4 of the Guidelines.

The number of small civil works will also be limited: the total cost of civil works is estimated at US $ 60,000; these will consist of rehabilitation and small extensions of existing infrastructure such as health centers, youth facilities or community meeting facilities. These small works, estimated to cost less than US$ 30,000 equivalent per contract, will be procured on the basis of quotations obtained from at least three qualified contractors in response to a written invitation. The written invitation will include a description of the works, basic technical specifications, the completion date and if necessary the plan of the works. The contract shall be awarded to the contractor who offers the lowest quotation provided that the bid is substantially responsive to the conditions specified in the written invitation. A simple format of the invitation to quote with all the subsequent documents (instruction to bidders, model of contract etc.) will

appear in the POM.

Goods. The total cost of goods contracts is estimated at US$ 6.39 million equivalent for the Project. It will include items such as pharmaceutical products, HIV test kits and other reagents, condoms, laboratory equipment, vehicles, computers, office equipment, furniture, information, education & communication materials and accessories. To the extent practicable, non-medical items will be grouped into packages estimated to cost US$ 150,000 equivalent or more and will be procured through *International Competitive Bidding* procedures, using IDA Standard Bidding Documents.
Contracts for drugs, reagents, medical and laboratory equipment estimated to cost less than US$ 100,000 equivalent may be procured through International Shopping procedures as described in paragraph 3.5 and 3.6 of the Guidelines and June 8, 2000 Memorandum-"Guidance Procurement Note on Handling Procurement under Shopping Method"- issued by the Bank. This method will be used in the cases where there are only a few known suppliers and provided that use of the method is indicated in the annual procurement plan reviewed by the Bank.

Goods apart from medical items estimated to cost less than US$ 150,000 equivalent will be procured through *National Competitive Bidding (NCB)* using procedures acceptable to IDA. Apart from medical items, procurement for readily available off-the-shelf goods that cannot be grouped or standard specification commodities for individual contracts estimated to cost less than US$ 30,000 equivalent, will be procured under *National Shopping or International Shopping* procedures as described in paragraph 3.5 and 3.6 of the Guidelines and June 8, 2000 Memorandum "Guidance Procurement Note on Handling Procurement under Shopping Method" issued by the Bank.

Goods, including drugs and medical supplies may be procured through *United Nations Agencies (IAPSO, UNICEF, UNFPA, WHO)* in accordance with the provisions of paragraph 3.9 of the Guidelines.

Goods which must be purchased from the original supplier to be compatible with existing equipment or, are of a proprietary nature may, with IDA's prior agreement, be procured by direct contracting in accordance with the *provisions of paragraph 3.7 of the Guidelines.*

Community based procurement. The type of sub-projects to be financed under component 2 is defined in the POM. However it is not possible to determine the exact mix of goods, small works, and services to be procured under these activities due to their demand-driven nature. Funding for these activities will be in the form of grants. The contract will be procured following simplified procurement procedures as described in the POM. The tools and procedures to be used for community-based procurement will be based on the Bank Guidelines for Simplified Procurement and Disbursement for Community-Based Investments (February 1998).

Consulting Services and training. Consulting services financed under the credit will be for HIV-AIDS training, information, education and communication, applied research, financial management, monitoring and evaluation, information dissemination, accounting; and strengthening of the institutional and technical capacities. Contracts estimated to cost the equivalent of US$ 100,000 or more, will be procured through *Quality-and Cost-Based Selection (QCBS).* The contracts for services estimated to cost less than the equivalent of US$ 100,000 per contract may be procured under contracts based on *Consultants' Qualifications* in accordance with the provisions of paragraphs 3.1 and 3.7 of the Consultant Guidelines. Financial and technical audits estimated to cost less than the equivalent of US$ 100,000 may be procured under *Least Cost Selection (LCS)* in accordance with the provisions of 3.1 and 3.6 of the Consultant Guidelines

Short-lists for contracts estimated to cost less than the equivalent of US$ 100,000 equivalent may be comprised entirely of national consultants (in accordance with the provisions of paragraph 2.7 of the Consultant Guidelines), provided that a sufficient number of qualified individuals or firms (at least three) are available at competitive costs.

Consultants for services meeting the requirements of section V of the consultant guidelines, may be selected under the provisions for the *Selection of Individual Consultants*, i.e. in essence through the comparison of the curriculum vitae of at least 3 qualified individuals. No civil servant can be hired as consultant.

Single source selection may be used exceptionally for (i) the training and technical assistance. Training of NGOs to reinforce their capacity may be done through a contract with the international NGO 'GRET' up to a maximum amount of US$ 300,000; and (ii) technical assistance for the Demographic and Health Survey may be procured through a sole source contract with Macro International up to a maximum amount of the equivalent of US$ 400,000.

Training, workshops, conference attendance and study tours will be carried out on the basis of approved annual work programs that identify the general framework of training or similar activities for the year, including the nature of the activity, the number of participants, and the estimate cost.

Incremental operating costs will be financed under the Project. This includes salaries for limited staff of the Permanent Executive Secretariat, that will have been recruited on a competitive basis, fuel, office supplies, office rental, communications and insurance costs, utilities for rented office, costs of the maintenance of vehicles and office equipment, and costs incurred on account of the supervision of the Project including per diems while on mission.

Prior Review Thresholds. Works. Contracts estimated to cost the equivalent of US$ 250,000 or more will be subject to IDA prior review. In addition, the first three contracts of works estimated to cost less than the equivalent of US$ 250,000 will be subject to IDA prior review.

Goods. Contracts estimated to cost the equivalent of US$ 250,000 or more and the first three contracts below the below the equivalent of US$ 150,000 will be subject to IDA prior review.

Consultant services. Contracts estimated to cost US$ 50,000 equivalent or more for individuals and US$ 100,000 equivalent or more for firms will be subject to IDA prior review procedures.

Contracts under community based procurement estimated to cost the equivalent of US$ 50,000 or more will be subject to IDA prior review. However such contracts are unlikely since the amount allocated to a single community based sub-project should not exceed the equivalent of US$ 20,000.

All other goods, civil works, services contracts and community based sub-project will be subject to post review by IDA during implementation support missions and by auditors during the technical and financial audits.

At least once every six months, supervision missions will be carried out. During these missions, a selective post review of contracts awarded below the threshold will be conducted. The Project activities will be subject to annual technical audits carried out separately from financial audits.

Procurement methods (Table A)

Table A: Project Costs by Procurement Arrangements
(US$ million equivalent)

Expenditure Category	Procurement Method[1]				Total Cost
	ICB	NCB	Other[2]	N.B.F.	
1. Works	0.00	0.00	0.06	0.00	0.06
Small rehabilitation and extensions	(0.00)	(0.00)	(0.06)	(0.00)	(0.06)
2. Goods	2.63	1.00	2.76	0.00	6.39
Vehicles, equipment, drugs	(2.63)	(1.00)	(2.76)	(0.00)	(6.39)
3. Services	0.00	0.00	5.37	0.10	5.47
consultants' services, audit, training	(0.00)	(0.00)	(5.37)	(0.00)	(5.37)
4. Pilot project	0.00	0.00	0.09	0.00	0.09
OVC component	(0.00)	(0.00)	(0.09)	(0.00)	(0.09)
5. Community Grants and TANGO contracts	0.00	0.00	3.50	0.00	3.50
	(0.00)	(0.00)	(3.50)	(0.00)	(3.50)
6. Operating costs	0.00	0.00	3.59	2.30	5.89
	(0.00)	(0.00)	(3.59)	(0.00)	(3.59)
Total	2.63	1.00	15.37	2.40	21.40
	(2.63)	(1.00)	(15.37)	(0.00)	(19.00)

[1/] Figures in parentheses are the amounts to be financed by the Bank Grant. All costs include contingencies.

[2/] Includes civil works and goods to be procured through national shopping, consulting services, services of contracted staff of the project management office, training, technical assistance services, and incremental operating costs related to (i) managing the project, and (ii) re-lending project funds to local government units.

Prior review thresholds (Table B)

Table B: Thresholds for Procurement Methods and Prior Review[1]

Expenditure Category	Contract Value Threshold (US$ thousands)	Procurement Method	Contracts Subject to Prior Review (US$ millions)
1. Works	>250 >30 <30	ICB NCB Three Quotations	All The first 3 contracts Post Review
2. Goods	>150 >30 <30	ICB NCB Shopping	Contract > 250 The first 3 contracts and afterwards post review Post Review
3. Services Consultants Firms Individuals	 >100 < 100 > 50 < 50 Sole Source	 QCBS QCBS, LCS, CQ See Section V of Guidelines See Section V of Guidelines	 All The first 3 contract and afterwards post review All (TOR, contract, CV) Post review All
4. Community sub-project	All values	Community based procurement	Post review
5. Training	All values	Government procedures acceptable to IDA and described in the POM	Post review apart from training abroad, annual training plans to be prior reviewed by IDA
6. Miscellaneous			

Total value of contracts subject to prior review: US $ 7.25 million
Overall Procurement Risk Assessment: **Average**
Frequency of procurement supervision missions proposed: One every 6 months
(includes special procurement supervision for post-review/audits)

[1] Thresholds generally differ by country and project. Consult "Assessment of Agency's Capacity to Implement Procurement" and contact the Regional Procurement Adviser for guidance.

Annex 6(B): Financial Management and Disbursement Arrangements
CONGO, REPUBLIC OF: HIV/AIDS and Health (MAP program)

Financial Management

1. Summary of the Financial Management Assessment

Conutry issues. The Republic of the Congo is gradually emerging from a decade of political instability, conflict, and mismanagement. The country's institutions and economy are weak. Structural reforms have been launched in the areas of economic governance, public expenditure management, and transparency. The Transparency and Governance Project financed by the World Bank is helping the country to strengthen capacity in public administration and to tackle corruption and mismanagement.

However, there are no recent diagnostic studies that contain a definitive evaluation of the country's financial management environment. The CFAA exercise will take place in FY05 as scheduled in the latest Transitional Strategy. The report of the recent mission of the IMF and the audit report of KPMG, which outlined several weaknesses in the management of oil resources, provides insight into the status of the country's public sector management. These lead to an unsatisfactory rating of the control environment in Congo Brazzaville, considering the weak institutions for economic, financial and administrative affairs.

Because of this unsatisfactory rating and due to the lack of capacity in the Ministry of Health and Population (MOHP), the project team and the Government decided to contract out financial management, procurement and data collection for monitoring and evaluation. The Fiduciary Management Agency (FMA) for the Project will work in close collaboration with the Permanent Executive Secretariat, in particular the Coordinator-Administrator and the Accountant.

Institutional and Implementation Arrangements. The Project's institutional arrangements are summarized in Section C4 of the PAD and are detailed in the Project Implementation Plan. They include: a National HIV-AIDS Council (CNLS or *Conseil National de Lutte contre le SIDA*), the decision making institution chaired by the President of the Republic which supervises implementation of the HIV-AIDS National Strategic Plan, coordinates HIV-AIDS interventions at the national level, and guides the Project. It includes representatives of civil society, such as PLWHAs and women groups, and of the private sector, as well as representatives of each of the ministries that have developed action plans to fight HIV-AIDS. The CNLS meets as least once a year to review progress reports, annual plans and budgets and to make broad policy towards HIV-AIDS.

A Permanent Executive Secretariat to the CNLS is responsible for day-to-day technical management and coordination of HIV-AIDS interventions and, in particular, of the Project. The Permanent Executive Secretariat includes a Permanent Executive Secretary, a Coordinator-Administrative Specialist, a Sectoral Response Specialist, a Community-Intervention Specialist, a Monitoring and Evaluation Specialist, a Social Communication Specialist, and an Accountant. All of these were recruited on a competitive basis, except the Permanent Executive Secretary and the Accountant, who are civil servants and not paid by the Grant. Moreover, the CNLS is recruiting, on a competitive basis, a Public Health Specialist, to supervise the health component, an internal auditor (international consultant), to assist with disbursement at the community level, and data base management specialist, to assist with the monitoring and evaluation sub-component. Project activities will be implemented by three categories of entities at the national level and in five *départements*: (i) beneficiaries who may be at the National or local levels, and may be community groups or NGOs, (ii) executing agencies who may be public or nongovernmental sector organizations with a legal existence, credibility and acceptability in their area of operation (criteria will be specified in the POM), and (iii) consultant firms or individuals.

A *département* level coordinator, who will be assisted by an accountant and two community development agents, will head the département level offices. The Coordinator and the accountant will be recruited on a competitive basis and paid by the grant. The *département* level offices (HIV-AIDS *Département* Committees - CDLS) will work with the local communities and associations, and with the technical ministries to help them establish their priorities and identify their proposals. Proposals will only be financed in a *département* once the *département* coordinator and the accountant are in place to supervise and monitor implementation. The accountant will coordinate with the central level internal auditor. It is expected that by grant effectiveness, each CDLS will have recruited such personnel, and if not, the recruitment of such personnel, satisfactory to IDA, will be **a condition of disbursement** for the CDLS.

Review groups, selected according to established procedures, will be established to approve proposals made by public sector entities and civil sector organizations. These groups will include representatives of the public sector and of the civil society to ensure complementarity and partnership. The National Commission on OVC will approve or modify the plan and budget for assistance to OVC, following rules established in the manual of procedures for the OVC component (see Annex 2 for details).

Three special bank accounts will be opened in commercial banks, acceptable to IDA, and implementing agencies with decentralized *département* units will maintain separate second generation bank accounts to received funds transferred by the FMA with the approval of the Permanent Executive Secretariat.

Finally, the Project will recruit, on the basis of terms of reference acceptable to IDA, professional and independent external auditors to carry out financial and technical audits on an annual basis. Moreover, the internal auditor will be an International Consultant with significant experience and qualification. The Recipient agreed to **recruit this auditor before October 31, 2004**. 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.

Summary risk analysis.

This part of the assessment was performed using the business risk approach to auditing based on the threat that an event or action will adversely affect the Project's ability to achieve its ongoing objective.

The overall project risk is rated as High. An effective financial management system will be vital for the Project because of the need to deliver services to target groups quickly, over a large geographic area. The objectives of the Project's financial management system will be: to ensure that project funds are used only for their intended purposes in an efficient and economical way; to enable the rapid disbursement of project funds to implementing agencies and beneficiaries; to ascertain that funds are properly managed and flow smoothly, adequately, regularly and predictably to implementing agencies; to enable the preparation of accurate and timely financial reports; to build the capacity of the beneficiaries in terms of financial management; to stimulate accountability through a strong flow of information on project activities; to enable project management to monitor the efficient implementation of the Project; and to safeguard the project assets and resources. The table below identifies the key risks that management may face in achieving these objectives and provides a basis for determining how management will address these risks.

Risk:	***Rating***	***Mitigation:***
The project management team lacks sufficient financial management capacity to perform the necessary financial management functions	H	--A FMA will be recruited to undertake financial management functions, including accounting, disbursement, procurement and monitoring & evaluation data collection. It will also provide assistance and capacity building support (seminar and workshops) to implementing agencies. --A percentage of funds intended for activities at each level are being set aside for capacity building.
The sector ministries may lack qualified staff in specific areas of the Project such as planning and accounting, leading to delay in implementing activities.	S	--Assessment of the sector ministries to determine their capacity in implementing HIV/AIDS activities and managing the funds. --The FMA may help recruit and train accountants for each sector ministry and the *département* coordinating committees of the Permanent Executive Secretariat as required.
Funds, especially in community sub-projects, may not be used in an efficient and economical way and exclusively for purposes intended due to the large number of parties and transactions involved, the small value and multiplicity of contracts, and the scattered locations of the sub-projects may impede ex-ante controls on sub-projects.	H	--Accountability will be built into the project coordination mechanisms at the decentralized levels using participatory approaches in identification, implementation and monitoring --Communities will be provided with easily understood financial and physical information in order to involve them in monitoring. --Financial management supervision at the community level will be integrated with monitoring and evaluation to ensure a close link between physical progress and financial reporting. There will be a qualified accountant in each Permanent Executive Secretariat *département* level office. --Independent external financial and technical audits of the Project's transactions and activities will be carried out on an annual basis --An internal auditor will be recruited to carry out regular audit mission and supervise the *département* accountants to ensure that funds are used properly in an economic, efficient, and effective manner. --The Project's financial management procedures will be specified in detail in the Financial and Accounting Procedures chapter of the POM. --The CNLS will provide overall policy guidance relating to management of project funds, and will ensure the follow up of audit findings and recommendations.
Given the weak financial and banking sector, there may not exist satisfactory means through which to make timely disbursement of funds to implementing agencies and beneficiaries.	M	--Other fund transfer networks and mechanisms in addition to the regular bank system will be explored and used, provided their legal and functional integrity is beyond reasonable doubt and costs. --The release of donor funds will follow an agreed schedule as documented in Memoranda of Understanding signed with Ministries. --Funds will be released to implementing agencies (NGOs, Private Sector entities, Association in accordance with agreed contractual arrangements [services contracts, performance based contracts, sub-project agreements]).

Mechanisms used to identify community needs may leave communities out of the decision-making processes	H	--The annual participatory planning approaches will assist the communities in planning and budgeting of project funds --The Project will use a two-tier system (with strong NGOs (TANGOs) being contracted to assist weaker one) to assist communities in the preparation of community plans and proposals --A chapter of the POM on Community Initiatives includes detailed simple guidance on planning aspects and budgetary control.

Risk Rating – H (High Risk), S (Substantial Risk), M (Modest Risk), N (Negligible Risk)

Other Financial Arrangements.

a. The Fiduciary Management Agency. A FMA is being recruited by the Permanent Executive Secretariat to carry out contracting, procurement, disbursement, and financial management functions and data collection for M&E. Detailed terms of reference spell out the specific responsibilities of the FMA and form the basis of invitations for expressions of interest, bids and later, the contract signed with the successful candidate. This contract will specify the nature, level, mix, and standards of services to be delivered by the FMA. In situations where the contractor fails to perform, it will be liable for any resulting delays or damages, and this could lead to the termination of the contract. This will help enhance the control of the Permanent Executive Secretariat over the management and control of program resources. The FMA will supply a Senior Financial Management Specialist and a Senior Procurement Specialist to the Permanent Executive Secretariat:

The FMA will support the Permanent Executive Secretariat in all aspects of financial management (at the national and *département* levels), accounting, contracting and procurement related to the Project. The FMA will also be responsible for the collection of data for the monitoring and evaluation system required under the Project in accordance with standard and accepted guidelines of the donor agencies supporting this program. In particular, the agency will be responsible for designing and establishing a computerized financial management system, disbursement of funds, maintaining the Secretariat's bank accounts, maintaining up-to-date accounting records and ledgers, and recording financial transactions, financial reporting, and ensuring that a proper internal control system is in place to achieve accountability at all levels.

The Manager of the FMA will be under the supervision of Permanent Executive Secretary and report to the Permanent Executive Secretariat's Coordinator-Administrator with regard to day-to-day transactions. The FMA's first two tasks will be to put in place an integrated financial management system, satisfactory to IDA, and to prepare the format and content of the FMR which will reflect the project components, and the source and use of funds. At least two sets of financial reports will be prepared by the FMA: the quarterly Financial Monitoring Reports (FMRs) and the Program's financial statements. In addition, donors and the Permanent Executive Secretariat may request ad hoc reports as reasonable. A senior manager with suitable qualifications and experience in public administration or in the private sector, accounting, or project management will manage the FM and will receive support from professional staff as necessary to assist with accounting, disbursement and expenditure review.

The Terms of Reference for the FMA will indicate the staffing resources required, but the FMA will have the discretion to determine the structure and staff required. These specialists will be familiar with World Bank's procurement procedures as reflected in the terms of reference approved by the Bank. The FMA will also determine the best structure to put in place at the region, *département* and lower levels in order to

enable the FMA to fulfill its obligations. This may be through the hiring of staff, or through supervising personnel that already exist in those locations.

b. Administrative, Financial and Accounting Procedures Section of the POM. The accounting systems, policies and procedures employed by the FMA in accounting and managing for Project funds will be documented in the Section of the POM on Financial and Accounting Procedures. This will be used by staff as a reference manual, by IDA and other donors, to assess the acceptability of the project accounting, reporting and control systems, and by the auditors to assess project accounting systems and controls and to design specific project audit procedures. Specific procedures will be documented for each significant accounting function. They will define document and transaction flows, and will cover the flow of funds, record keeping and maintenance, the chart of accounts, formats of records and books of account, authorization procedures for transactions, planning and budgeting, financial reports (including formats, linkages with Chart of Accounts and procedures for reviewing these); and auditing arrangements.

In addition, the Project Implementation Plan will document the arrangements that have been made for recording project impacts, outcomes, outputs, and inputs that are required to assess progress toward the achievement of project objectives. A team of consultants will be recruited to prepare the Plan. It will be revised, in the first instance after the appointment of the FMA, and regularly thereafter.

The Section on Community Initiatives and the Section on the OVC component will include detailed guidance on planning aspects. It is planned to hire one training and supervision NGO per *département* to assist communities in the preparation of plans and budgets. Finally, there will be a short monitoring & evaluation guide, specifying data collection mechanisms and uses of the data. Advanced drafts of this Section of the POM were reviewed during project appraisal. The POM will be finalized before the project becomes effective.

c. Planning and Budgeting. Each sector and level of administration will prepare a strategy for combating HIV-AIDS, taking into account the views of relevant stakeholders. The strategy will identify the activities to be undertaken, the role of different parties. Sector ministries will have their strategies, their annual action plans and budgets approved by the CNLS.

Sector and administrative level strategies will be converted into work plans and budgets. Work plans for each *département* will be a consolidation of the districts under its area of jurisdiction, which in turn will be prepared using participatory approaches.

The Permanent Executive Secretariat will consolidate annual sectoral and *département* level work plans into a single document and this will be submitted to the CNLS for approval. The consolidation will be done after the Permanent Executive Secretariat ensures, through its technical committee, that the plans meet eligibility criteria.

A project budget and a disbursement schedule has been drawn up and is included in the Project Appraisal Document and the Project Implementation Plan. It is from this disbursement schedule (as may be subsequently revised on the basis of the annual consultations, the mid-term review and/or the beneficiary assessment) that annual budgets will be drawn.

The Permanent Executive Secretariat and the CDLS will be responsible for the review and approval of proposals submitted by implementing organizations.

Each ministry will prepare an annual work plan and a budget for its sector of responsibility in collaboration

nongovernmental partners active in that sector, following the annual consultation meetings. These will indicate the planned activities and related costs, and will form the basis for financial management report-based disbursements.

Every year, community organizations will come together at the *département* level and determine their priority initiatives in a participatory manner. The initiatives they determine will form the basis for the preparation of sub-projects. These will be submitted for approval to the nearest level of project coordination (at either the community or district level). They will be consolidated into the annual work plans for that level of coordination. The Section on Community Initiatives includes more guidance on these aspects.

d. Staffing. Staffing requirements relating to the FMA have been addressed above. Ministries and other implementing agencies will retain staffing resources that are adequate with their level of activities (as mentioned previously, each ministry will need to have a qualified accountant in its HIV-AIDS Sector Unit) and are sufficient to maintain accounting records relating to project financed transactions, and to provide the FMA with the financial reports and returns that are necessary to maintain the Project's overall accounting records.

An evaluation of the accounting capacity of Ministries and of the CDLSs is being carried out. It will identify the number of staff available to carry out these functions at that level. It is envisaged that the FMA will help the Permanent Executive Secretariat hire such staff as are necessary to fill any gaps at *département* level. Training and capacity building plans will also be designed to ensure that the relevant functions are transferred to ministries. Sufficient funds in each work plan will be dedicated to capacity building activities aimed at reinforcing planning and budgeting, implementation and monitoring and evaluation capacity of the implementing agency.

e. Record keeping and maintenance. At the national level, the FMA will be responsible for maintaining the Project's records. For the various implementing agencies including sector ministries and *département* coordination, accounting source documents will be kept at their premises and made available for the purpose of verifying project expenditure incurred and for internal and external auditing.

f. Financial Reporting. Financial reports will be designed to provide high quality and timely information to project management, implementing agencies, and various stakeholders on project performance. Formats of the various periodic financial management reports to be generated, 9 or 12 months after effectiveness, from the financial management system will be developed using the World Bank's *Guidelines for Borrowers on Financial Monitoring Reports*. These will include financial statements (e.g. sources and use of funds; expenditure classified by project components, disbursement categories, expenditure of the Permanent Executive Secretariat and implementing agencies, and comparisons with budgets variance analysis). Additional information required by the World Bank Loan Department for disbursement purposes will also be included (see below).

Annual Financial Statements will include: a Statement of Sources and Use of Funds showing all the sources of project funds, expenditures analyzed by project component and credit category; notes in respect of significant accounting policies and accounting standards adopted by management and any supplementary information required to enhance analysis; a Special Account Activity Statement; an Implementation Report containing a narrative summary of the implementation progress for the Project; and a Summary of Withdrawals using financial management reports, listing individual withdrawal applications by reference number, date and amount, and information on contracts above and below the prior review threshold. The format of the reports will be developed as soon as the FMA will be recruited.

At the community level, simplicity will be the primary objective in designing records that are maintained to account for sub-project transactions. Physical progress reports and financial reports from the sub-project level will be submitted to the FMA in accordance with agreed simplified reporting formats specified in a simple two-page agreement (see the Section on Community-based Interventions). The timing for submission of the reports for sector ministries will also be specified in the Memorandum of Understanding. At this level, the form and content of the reports could include one or more of, *inter alia,* progress and completion reports, technical inspection certificates, minutes of community meetings, memoranda of receipts and expenses, etc., as appropriate for each set of circumstances. These reports will be available for review during regular supervision missions and for audit purposes. For small sub-projects of a short duration, a single report issued at the end of the sub-project period may be sufficient. Other implementing agencies will be required to submit reports in accordance with terms agreed between the Project and the agency.

2. Audit Arrangements

There will be two parallel auditing processes:

Internal Auditing. As mentioned previously, the Project will recruit an international consultant to serve as Internal Auditor within the Permanent Executive Secretariat. The Internal Auditor's task will be to ensure respect for the Project's financial procedures and regulations relating to the management of project resources. To achieve this, the Internal Auditor will inspect the accounting procedures used by the FMA to ensure that they conform to the established procedures and guidelines.

The Internal Auditor will supervise the various implementing agencies, such as the sector ministries and NGOs to assure the effectiveness of the Project's accounting and internal control systems.

At the département levels of project implementation, the Internal Auditor will design and carry out a simple and inexpensive ex-post audit of community sub-projects. These audits will be linked to the overall monitoring and evaluation of the community sub-projects. This will enable the Permanent Executive Secretariat to confirm that sub-project funds are spent on the intended purposes and that the community has received value for money.

The POM will contain a description of the roles and responsibilities of the Internal Auditor and a description of the line of reporting that guarantees adequate independence.

External Financial Auditing. The Permanent Executive Secretariat will contract with a firm of reputable auditors for an audit of the Project's financial statements on an annual basis. The selection of the successful firm will be based on terms of reference that set forth the scope of the audit and that are acceptable to IDA. The audited financial statements together with the Financial Auditor's report and management letter covering identified internal control and accounting system weaknesses will be submitted to IDA within six months after the end of each financial year (as of December 31). The Financial Auditor will issue a single audit opinion on project income and expenditures, special accounts and FMRs. It will issue a further audit opinion on specific controls such as compliance with procurement procedures and FMR requirements. Any firm of auditors subcontracted to carry out the audit must meet the IDA's requirements in terms of independence, qualifications and experience. The Recipient agreed that this Auditor will be recruited at the latest by October 31, 2004.

External Technical Auditing. The Permanent Executive Secretariat will contract, on a competitive basis, with a firm of technical auditors who will review procurement, statements of expenditures, and stocks as well as verifying the physical existence of goods and equipment and verifying the delivery services acquired

through the Project. This audit will be conducted on an annual basis as of June 30 of every year. The selection of the successful firm will be based on terms of reference that set forth the scope of the technical audit and are acceptable to IDA. The audited documents together with the auditor's report will be submitted to IDA within four months of the end of the review. It is expected that the Technical Auditor will be recruited within six months of effectiveness.

Closing the accountability cycle: following up on audit queries. The CNLS is responsible for the review of audited financial statements and of internal and external audit findings. When the audits find weaknesses in the financial management system or incidences of noncompliance with procedures, the CNLS will require corrective action to be taken by the Permanent Executive Secretariat and the FMA. Moreover, the Permanent Executive Secretariat will use the results of the audits in monitoring the performance of the FMA and of other implementing agencies. This arrangement will ensure the satisfactory follow-up of audit findings.

The successful internal control and financial management of the Project will require that beneficiaries and other stakeholders be kept well informed at all times and at all levels about their entitlements, rights, obligations, and the Project's costs and benefits. This information will be provided in a manner understandable to all interested parties and its availability will facilitate the involvement of the beneficiary community in the fiduciary management of the Project. It will also enable them to demand accountability from their leaders or from community organizations that are responsible for the implementation of sub-projects. In furtherance of this objective, summaries of local project expenditures and procurement information will be posted in a public place within the communities.

Conclusion of the Financial Management Assessment. The out-sourcing of the financial management functions to an international FMA will enable the establishment of a financial management system for the project that satisfies the Bank's minimum requirements under OP/BP10.02 and are adequate to provide, with reasonable assurance, accurate and timely information on the status of the Project required by IDA. The arrangements, once put in place, will enable the disbursement of the IDA Grant to be done on the basis of Financial Monitoring Reports (FMRs) nine to twelve months after effectiveness subject to a Financial Management Assessment satisfactory to IDA as well as the submission of satisfactory FMRs in the preceding months. The actions that are required to facilitate the establishment of this system are listed in the Financial Management Action Plan below.

Financial Management Action Plan.

Issue	Remedial Action Recommended	Due Date
Fiduciary management of the Project : FMA	The recruitment of the FMA is completed and the contract signed by the Permanent Executive Secretariat.	Condition of effectiveness
Information System including accounting and M&E software	Same as above.	By three months after effectiveness
Section of the POM on administrative and financial procedures	Manual finalized and agreed	Condition of effectiveness
External Auditing (Financial and Technical)	Selection of the External Financial Auditor completed and agreed by the Bank	By Oct. 31, 2004 (financial) By January 31, 2005 (technical)
Internal Auditing	· Recruitment of the International Internal Auditor completed and agreed by the Bank	Three months after effectiveness
Capacity of Line Ministries	Assessment of ministries completed and reports finalized	Condition of disbursement
Capacity of CDLS of the CNLS/PES	· Assessment of the capacity of CDLS	Condition of disbursement

Supervision Plan. A supervision mission will be conducted at least every six months. The mission's objectives will include that of ensuring that strong financial management systems are maintained for the Project throughout its life. A review will be carried out regularly to ensure that expenditures incurred by the Project remain eligible for IDA funding. The Project Status Report (PSR) will include a financial management rating for the component done by the Country Office Financial Management Specialist after an appropriate review.

3. Disbursement Arrangements

The Permanent Executive Secretariat will open three Special Accounts in commercial banks, on terms and conditions acceptable to IDA (See below for details, section on Special Accounts). The accounts will receive disbursements from IDA for use in implementing the Project and will be denominated in CFA Francs. The FMA will manage the Special Accounts in conjunction with the Permanent Executive Secretariat.

Disbursement of IDA Funds to the Project. After 9 to 12 months of project implementation and subject to a satisfactory FM assessment and regular submission of FMRs, disbursements of IDA funds to the project will be based on Financial Monitoring Reports (FMRs) that integrate project accounting, procurement, contract management, disbursement and audit with indicators of the progress of project implementation.

After the Project becomes effective, IDA will deposit funds into each of the Special Accounts at the request of the Recipient. The initial deposit will cover project expenditures for the first 6 months of implementation, as indicated in the initial six-month cash flow forecast. Once FMR-based disbursement has been approved, the Project will submit FMRs after every subsequent quarter, including a forecast of cash flow for the following 6-month period. The request for cash at the reporting date should be calculated

as the amount required for the forecast period as shown in the approved FMRs, less the balance in the concerned Special Account at the end of the quarter. Subsequent disbursements of the IDA funds will be made in respect of this request. Meanwhile, IDA will replenish the Special Accounts on the basis of a summary of expenditures. Details of payments will be provided in accordance with performance-based contracts, services contracts, sub-project agreements and financing agreements for micro-projects.

Funds will also be disbursed through direct payments from IDA on contracts above 20% of the Special Account authorized allocation. Withdrawal applications for such payments must be accompanied by relevant supporting documents (i.e. copies of the contract, contractors' invoices and appropriate certifications).

Disbursement of funds from the project to implementing agencies and suppliers & consultants.
The FMA will make disbursements to implementing agencies or suppliers, after technical review by the Permanent Executive Secretariat, based on appropriate contractual arrangements (i.e. services contracts, performance-based contracts, sub-project agreements and financing agreements for micro-projects). The submission of accounts for payments of tranches under contracts will not be a condition for making disbursements. However, appropriate corrective action will be sought from implementing agencies where irregularities are identified as a result of exercises carried out by the Permanent Executive Secretariat to verify expenditures.

Sector Ministries. The Permanent Executive Secretariat will sign a Memorandum of Understanding with each of the ministries. Each Memorandum of Understanding will specify the expected results that can be monitored and conditions of implementation. Each ministry will then open an account in a commercial bank satisfactory to IDA to receive an advance for implementation of the activities, which appear in its approved work plan. The Memorandum will contain a schedule of payments that reflects the nature of the activities to be implemented. (Other implementation agencies would be financed based on service contracts, as indicated above).

The Ministries will submit requests for payment to the FMA in accordance with the agreed schedule. The FMA will seek approval for payment from the Permanent Executive Secretariat if the request is in compliance with the Memorandum of Understanding, the approved work plan, and the documentation justifying the use if the funds. Once the Secretariat gives its permission, the cash will be disbursed into the Ministry's bank account. *(FMR-based disbursements for Ministries can begin as approved by AFTFM).*

Approval of new Action Plans will depend on the results of overall performance as measured by the agreed-indicators. Misguided activities could result in the suspension of financing for a given entity.

The Project will also be able to sign a Management Services Contract with United Nations Agencies for the purpose of scaling-up and implementing their HIV-AIDS activities that are included in the National Strategic Plan. These Agencies will receive funds from the Project on the basis of detailed annual budgets and agreed-upon results that can be monitored, as described in the contract payment modalities.

Disbursements for decentralized implementation (including community sub projects). The decentralized entities may sign a contract, a sub-project agreement or a financing agreement for a micro-project, depending on the nature of the services to be rendered., as specified in the POM. Project funds to finance activities in the targeted *départements* will be transferred to second generation accounts opened in these *départements* for the CDLS. The amount to be held in these accounts will not exceed FCFA 50.000.000. When necessary, alternative channels for funds transfers will be used to transmit payments to beneficiaries in remote locations. The contract with the concerned implementing agencies will stipulate tranche payments

and suitable disbursement triggers.

Allocation of grant proceeds (Table C)

Table C: Allocation of Grant Proceeds

Expenditure Category	Amount in US$million	Financing Percentage
Works (small rehabilitation and expansions)	0.06	100
Goods (Vehicles, equipment, furniture)	4.00	100
Pharmaceuticals (drugs, reagents and medical consumables)	0.83	100
Services		
a. Consultants' services, audit for Part A and D1, D2 and D3 of the Project	2.38	100
b. Consultants' services for part D4 of the Project	0.38	100
Training	1.40	100
Civil Society Response		
a. Micro-grants for micro-projects	2.49	100
b. Contracts with TANGOs	0.25	
Incremental recurrent costs		
a. For Component 1, 3, 4A, 4B and 4C of the Project	3.32	100
b. For Component 4C of the Project	0.42	100
PPF	1.00	
Non allocated	2.47	
Total Project Costs with Bank Financing	19.00	
Total	19.00	

Use of statements of expenditures (SOEs):

Disbursements for all expenditures would be made against full documentation, except for items of expenditures under contracts for: (a) consulting firms in an amount inferior to $100,000 equivalent, (b) individual consultants in an amount inferior to $50,000 equivalent, (c) works and goods, in an amount inferior to $250,000, and (d) community sub-projects, multi-sectoral plans or work programs, training and operating costs, which would be claimed on the basis of Statement of Expenditures (SOEs). All supporting documentation for SOEs would be retained at a suitable location at the FMA, the province and/or the community level and made readily accessible for review by periodic IDA supervision missions and internal and external auditors.

Special account:

To facilitate project implementation and reduce the volume of withdrawal applications, the FMA would open three Special Accounts in FCFA in a commercial bank on terms and conditions acceptable to IDA.

- Special Account A: Disbursements to this account finance the Public Sector Response to HIV-AIDS (Component 1) Management and Coordination, Capacity Building, and Monitoring & Evaluation (Component 4A, 4B and 4C);
- Special Account B: Disbursements to this account finance the Civil Society Response to HIV-AIDS (Component 2) and Investments in Orphans & other Vulnerable Children (Component 3); some funds will be channeled from Special Account B to second-generation accounts opened in the targeted *départements*. Special account B will be open in a bank which has offices in the *départements*;
- Special Account C: Disbursements to this account finance data collection (sub-component 4D) to be implemented by the CNSEE, following their annual work program and under the supervision of the FMA.

The authorized allocation would be FCFA 800,000,000 for Special Account A, 350,000,000 FCFA for Special Account B and FCFA 70,000,000 for Special Account C and would cover about six months of eligible expenditures. The Special Account would be used for all payments inferior to twenty percent of the authorized allocation and replenishment applications would be submitted monthly. Further deposits by IDA into the Special Accounts would be made against withdrawal applications supported by appropriate documents.

Annex 7: Project Processing Schedule
CONGO, REPUBLIC OF: HIV/AIDS and Health (MAP program)

Project Schedule	Planned	Actual
Time taken to prepare the project (months)	12	12
First Bank mission (identification)	04/01/2002	04/01/2002
Appraisal mission departure	01/26/2004	01/26/2004
Negotiations	03/03/2004	03/03/2004
Planned Date of Effectiveness	07/15/2004	07/15/2004

Prepared by:
National AIDS Commission (CNLS)

Preparation assistance:
Japanese PHRD grant No. TF051891: $628,575 (approved April 11, 2003)
Project Preparation Facility (PPF) : $1 million (1st PPF of $600,000 approved in January 2003 and second PPF of $400,000 approved in November 2003)

Bank staff who worked on the project included:

Name	Speciality
Michele Lioy	Task Team Leader/Sr. Population Specialist
Menahem Prywes	Sr. Economist
David Blankhart	Monitoring and Evaluation Specialist
Myrina McCullough	Operations Analyst
Jean-Charles Amon Kra	Financial Management Specialist
Prosper Nindorera	Procurement Specialist
Mohsen Farza	Community-led initiatives Specialist
Mohamed Ali Kamil	Public Health Specialist
Monthe Bienvenu Biyoudi	Research Analyst
Jonathan Brown	Operations Adviser
Albert Sales	Public Health Specialist
Malonga Miatudila	Sr. Public Health Specialist
Astania Kamau	Language Program Assistant
Anne Anglio	Language Program Assistant

Annex 8: Documents in the Project File*
CONGO, REPUBLIC OF: HIV/AIDS and Health (MAP program)

A. Project Implementation Plan

B. Bank Staff Assessments

- Aide-memoire - Identification mission - April 2-19, 2002
- Aide-memoire - Preparation mission - November 18-28, 2002
- Aide-memoire - Preparation mission - January 27 - February 10, 2003
- Aide-memoire - Pre-evaluation mission - June 23 - July 3, 2003
- Aide-memoire - Evaluation mission - January 23 - February 12, 2004

C. Other

- Reports dated September 2003 prepared by Consultant CREDES - 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 Moungali 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: Manuel des procédures - Manuel des opérations: 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

*Including electronic files

Annex 9: Statement of Loans and Credits

CONGO, REPUBLIC OF: HIV/AIDS and Health (MAP program)

27-Oct-2003

Project ID	FY	Purpose	Original Amount in US$ Millions IBRD	IDA	Cancel.	Undisb.	Difference between expected and actual disbursements* Orig	Frm Rev'd
P081924	2003	Emergency Recovery/Community Project	0.00	28.00	0.00	41.52	-1.17	0.00
P073507	2002	Transparency and Governance Capacity Bui	0.00	7.00	0.00	6.77	-0.45	0.00
P074006	2002	EMERGENCY REHABILITATION, RECONSTRUC	0.00	40.00	0.00	41.86	4.54	0.00
P074639	2002	Emergency Demob. & Reinteg. Project	0.00	5.00	0.00	1.94	0.26	0.00
		Total:	0.00	80.00	0.00	92.09	3.18	0.00

CONGO, REPUBLIC OF
STATEMENT OF IFC's
Held and Disbursed Portfolio
June 30 - 2003
In Millions US Dollars

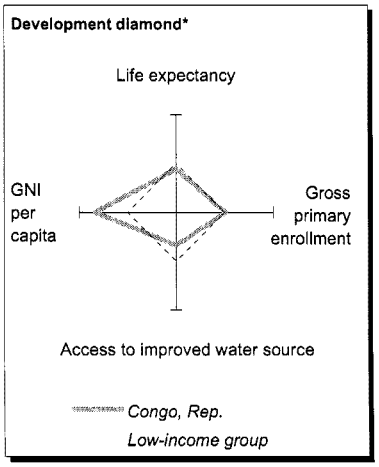
		Committed				Disbursed			
		IFC				IFC			
FY Approval	Company	Loan	Equity	Quasi	Partic	Loan	Equity	Quasi	Partic
	Total Portfolio:	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

		Approvals Pending Commitment			
FY Approval	Company	Loan	Equity	Quasi	Partic
	Total Pending Commitment:	0.00	0.00	0.00	0.00

Annex 10: Country at a Glance

CONGO, REPUBLIC OF: HIV/AIDS and Health (MAP program)

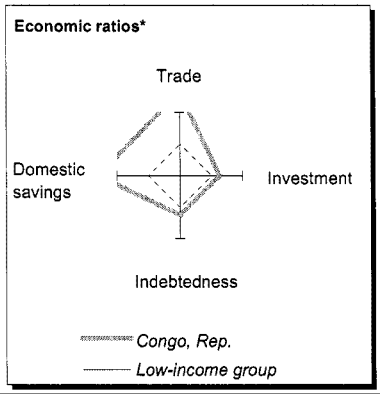
POVERTY and SOCIAL	Congo, Rep.	Sub-Saharan Africa	Low-income
2002			
Population, mid-year *(millions)*	3.2	688	2,495
GNI per capita *(Atlas method, US$)*	720	450	430
GNI *(Atlas method, US$ billions)*	2.3	306	1,072
Average annual growth, 1996-02			
Population *(%)*	2.9	2.4	1.9
Labor force *(%)*	2.9	2.5	2.3
Most recent estimate (latest year available, 1996-02)			
Poverty *(% of population below national poverty line)*	..	..	..
Urban population *(% of total population)*	67	33	30
Life expectancy at birth *(years)*	52	46	59
Infant mortality *(per 1,000 live births)*	75	105	81
Child malnutrition *(% of children under 5)*	..	..	..
Access to an improved water source *(% of population)*	51	58	76
Illiteracy *(% of population age 15+)*	17	37	37
Gross primary enrollment *(% of school-age population)*	97	86	95
Male	101	92	103
Female	93	80	87



KEY ECONOMIC RATIOS and LONG-TERM TRENDS

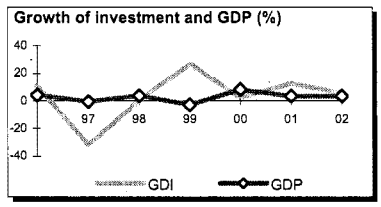
	1982	1992	2001	2002
GDP *(US$ billions)*	2.2	2.9	2.8	3.0
Gross domestic investment/GDP	59.7	21.6	26.8	26.3
Exports of goods and services/GDP	55.3	42.9	83.1	76.6
Gross domestic savings/GDP	46.5	24.4	60.3	52.7
Gross national savings/GDP	..	10.9	30.5	25.7
Current account balance/GDP	-15.3	-10.8	..	..
Interest payments/GDP	4.4	1.0	0.9	0.1
Total debt/GDP	91.8	162.6	161.1	170.9
Total debt service/exports	20.0	12.9	4.0	1.1
Present value of debt/GDP	..	..	151.8	..
Present value of debt/exports	..	..	182.6	..

	1982-92	1992-02	2001	2002	2002-06
(average annual growth)					
GDP	0.8	1.9	3.6	3.5	4.8
GDP per capita	-2.1	-1.1	0.8	0.7	2.0

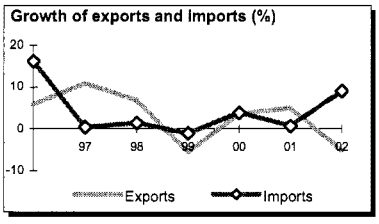


STRUCTURE of the ECONOMY

	1982	1992	2001	2002
(% of GDP)				
Agriculture	7.9	11.5	5.9	6.1
Industry	52.6	35.5	65.2	65.6
Manufacturing	4.8	7.9	4.1	5.2
Services	39.6	53.0	28.9	28.4
Private consumption	40.0	54.5	29.1	34.9
General government consumption	13.5	21.1	10.5	12.4
Imports of goods and services	68.5	40.1	49.6	50.2



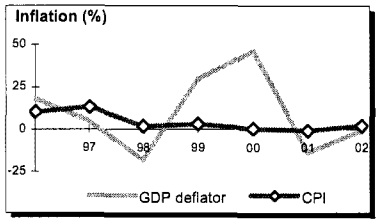
	1982-92	1992-02	2001	2002
(average annual growth)				
Agriculture	2.7	2.1	7.7	4.4
Industry	2.2	3.2	-1.9	1.4
Manufacturing	3.6	0.2	18.5	9.0
Services	-0.6	0.7	8.5	5.3
Private consumption	-2.0	2.1	-2.5	11.9
General government consumption	3.9	-1.6	-0.4	18.9
Gross domestic investment	-12.9	-0.2	12.4	5.7
Imports of goods and services	-7.8	2.6	0.7	9.0



* The diamonds show four key indicators in the country (in bold) compared with its income-group average. If data are missing, the diamond will be incomplete.

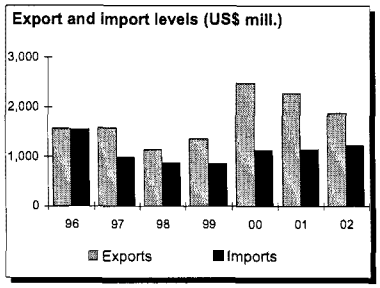
PRICES and GOVERNMENT FINANCE

	1982	1992	2001	2002
Domestic prices				
(% change)				
Consumer prices	12.7	-3.9	-0.9	2.0
Implicit GDP deflator	6.0	-1.6	-14.0	-0.7
Government finance				
(% of GDP, includes current grants)				
Current revenue	..	22.5	30.9	27.7
Current budget balance	..	-12.4	9.4	-0.2
Overall surplus/deficit	..	-14.1	-0.7	-8.8



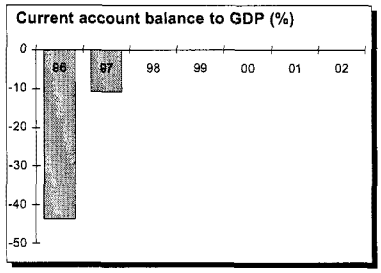
TRADE

	1982	1992	2001	2002
(US$ millions)				
Total exports (fob)	..	1,206	2,285	1,880
Crude oil	..	966	1,295	1,512
Wood	..	142	166	177
Manufactures	..	25	12	13
Total imports (cif)	..	499	1,153	1,234
Food	..	34	24	26
Fuel and energy	..	104	237	246
Capital goods	..	188	496	528
Export price index *(1995=100)*	..	115	133	134
Import price index *(1995=100)*	..	101	109	107
Terms of trade *(1995=100)*	..	114	122	125



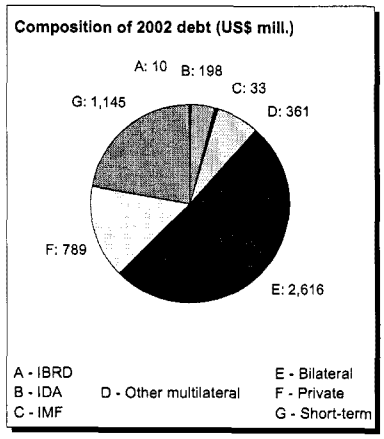
BALANCE of PAYMENTS

	1982	1992	2001	2002
(US$ millions)				
Exports of goods and services	1,186	1,257	2,317	2,255
Imports of goods and services	1,361	1,176	1,382	1,477
Resource balance	-175	82	935	778
Net income	-138	-378	-834	-781
Net current transfers	-55	-19	3	4
Current account balance	-332	-317	..	..
Financing items (net)	251	290	..	..
Changes in net reserves	81	27	142	-57
Memo:				
Reserves including gold *(US$ millions)*	..	..	73	123
Conversion rate *(DEC, local/US$)*	328.6	264.7	733.0	697.0



EXTERNAL DEBT and RESOURCE FLOWS

	1982	1992	2001	2002
(US$ millions)				
Total debt outstanding and disbursed	1,982	4,770	4,491	5,152
IBRD	42	160	16	10
IDA	49	74	187	198
Total debt service	241	162	92	24
IBRD	5	0	70	8
IDA	0	0	10	4
Composition of net resource flows				
Official grants	23	36	35	0
Official creditors	113	16	-17	-7
Private creditors	402	17	0	0
Foreign direct investment	35	4	59	0
Portfolio equity	0	0	0	0
World Bank program				
Commitments	16	0	43	40
Disbursements	15	0	38	2
Principal repayments	2	0	54	9
Net flows	13	0	-16	-7
Interest payments	4	0	26	3
Net transfers	10	0	-42	-10



Note: This table was produced from the Development Economics central database. 8/29/03

Additional Annex 11: Medical Waste Management Plan - Executive Summary
CONGO, REPUBLIC OF: HIV/AIDS and Health (MAP program)

The Republic of Congo, located in Central Africa, has approximately three million inhabitants spread over an area of 342,000 km2. Different strategies are being used to curb the spread of HIV/AIDS infection, the incidence of which is alarming. One of these strategies involves biomedical waste management. The main producers of this waste are public and private heath facilities. The country has one CHU [University Hospital Center], four regional hospitals, thirty-five district hospitals, fifteen integrated health centers delivering the minimum package of activities (MPA), one hundred and fifty-five non-streamlined integrated health centers, and four hundred other facilities. The private sector is expanding rapidly, particularly in Brazzaville and Pointe Noire. Minimum production estimates of hospitals and MPA health facilities alone stand at 341 tons of medical waste per year or 934 kg per day.

Based on observations, biomedical waste management poses a real problem in both the public health and environmental spheres. For one thing, general sanitation conditions in health facilities are disturbing, despite the existence of hospital sanitation services, where shortages exist in terms of both resources and personnel.

Selective sorting of infectious waste is rare. Most often, sorting involves the placement of needles in different receptacles, which end up in the same place as waste that was never sorted at the source level. From a storage standpoint, the number of waste receptacles is very inadequate to facilitate sorting at the source level, and there are no specific locations for intermediate or final storage. Health care personnel are asked to perform collection and removal tasks, owing to the shortage of hospital cleaning staff.

Outside of hospital facilities, private entities transport waste (hand carts, NGOs, businesses). This service is sometimes provided by the local authorities. Waste ends up in illegal rubbish dumps, where adults, and possibly, children, scavenge. Within health facilities, processing includes incineration, burying, and even the unauthorized dumping of biomedical waste. Placentas are buried, incinerated, or given back to parents.

Legislation, in effect in Congo, very briefly alludes to the subject of biomedical waste, without explicitly mentioning it, when it addresses the impact of certain types of equipment, in particular incinerators (Ministry of the Environment).

As a result of this situation, the plan of action focuses on: providing the biomedical waste disposal system with a structure and equipment, developing and strengthening its institutional, legislative, and regulatory framework, conducting an information and awareness-building campaign, and implementing a training program with the general and specific objectives indicated below:

General objective: Provide healthy living and working conditions and safeguard public health through a sustainable system for the collection, removal, and processing of biomedical waste in Congo.

General objective No. 1: Improve significantly the management of biomedical waste in health facilities in Congo.
Specific objectives: Provide health facilities with equipment for the collection and disposal of biomedical waste; formulate plans for the management of biomedical waste in health facilities.

General objective No. 2: Develop a sustainable and secure partnership to manage biomedical waste by putting in place a more efficient management system as well as a sustainable system of financing.

General objective No. 3: Through IEC, build awareness among the different players with respect to the problem of biomedical waste management.
Specific objectives: Provide more information to persons directly and indirectly involved in this process, point out to persons directly and indirectly involved in the process the dangers associated with poor management of biomedical waste and the risks posed by certain attitudes and practices.

General objective No. 4: Strengthen and develop the capacity of persons involved in this activity through targeted training programs.
Specific objectives: Improve attitudes of the different actors, change practices, and provide more information on biomedical waste.

General objective No. 5: Strengthen the institutional, legislative, and regulatory framework.
Specific objectives: Prepare specific regulations for Congo on biomedical waste, design a plan for implementation, monitoring and evaluation.

In terms of the collection, transportation, and internal storage component of the management system, health facilities should be provided with collection equipment in order to encourage sorting at the source level, final storage locations should be set-up, personnel should be provided with protective gear, and all health facilities should draft a management plan following national training sessions. In addition, laundries will be outfitted with equipment to halt the spread of nosocomial infections and sterilization equipment will be purchased and distributed.

An analysis of available equipment for waste processing, taking into consideration efficacity, scope of waste processing, cost and environmental factors, led to the selection of small capacity incinerators for regional hospitals, and Turbo 2000 incinerators for district hospitals and integrated health centers (this choice was made because of their relatively low cost, and easy maintenance). Montfort type incinerators will be built in isolated health centers.

The Government of Congo still has to select, among the several proposals, how bio-medical waste will be collected and treated.

Five basic strategies have been proposed:

1. The centralization of biomedical waste in health facilities that have disposal equipment, with different options for transportation (fee-based).
2. Use of a *société de patrimoine*, with the participation of public hospitals, municipalities, clinics, and other private health facilities, which would buy processing units. This agencies could be operated by a designated private management company that could be assigned responsibility for transportation.
3. Investment in and operation of systems for biomedical waste processing/disposal by municipalities having contracts with health structures that produce biomedical waste.
4. Investment in and operation by private agents with the appropriate expertise and financing capacities.
5. Internal processing and disposal by means of incineration or burial after decontamination.

The following proposal represents a blend of the above-mentioned strategies:

- A "centralized" system could be adopted for Brazzaville and Pointe Noire, on a contractual basis. The transportation system could be managed by the private sector that would serve all health facilities in

exchange for a transportation fee. The municipalities could provide assistance for pick up at intermediate points. These health facilities will also contribute to the operation of the incinerator, which will be owned by the hospital.
- All facilities in remote areas will have access to the centralized system.

A national training program, will be developed. It will include modules that focus on each stage of the waste management system, good practices, the preparation of management plans to be implemented by each facility, health (in particular HIV infection) and environmental risks, and the use and maintenance of incineration equipment. Target audiences for training include:

- Administrative personnel, particularly those persons responsible for the application of regulations (administrators, hospital directors, heads of clinics);
- Doctors, nurses, and midwives;
- Individuals responsible for biomedical waste management within the framework of the management plan, municipal staff assigned to this task (cleaning staff, persons responsible for waste management);
- Organizations involved in the awareness-building program (NGOs, community organizations).

In preparing targeted awareness-building programs, emphasis will be placed on the link between HIV-AIDS and biomedical waste. The media (all forms), NGOs, and community organizations will be used to conduct the awareness-building campaign. Radio and television spots will be produced, skits will be performed by drama groups, musical programs will be aired, and a documentary on biomedical waste management will be shown at community gatherings and on television. Posters will also be designed, as well as T-shirt with a logo that could be chosen through a national school competition.

With respect to legislation on biomedical waste management, a legislative working group, assisted by a consultant, could propose specific and detailed regulatory texts that cover all aspects of bio-medical waste management.
Several entities will be involved in the implementation of this plan: the Ministry of Health and its departments and facilities, the Ministry of the Environment, the private sector, Educational entities, NGOs, community organizations, the media, multilateral and bilateral cooperation agencies, and the implementation agencies and the monitoring and evaluation system.

Activities included in the waste management plan include:

- A six-month preparatory phase: launch seminar, donors meeting, preparation of bidding documents, etc., consensus meetings, finalization of plans, and establishment of an implementation committee;
- The five-year execution phase will include the ordering, delivery, and distribution of material and equipment, the installation of incinerators and the construction of Montfort-type incinerators in selected sites, the implementation of the "centralized" strategy (see above page 3), as well as training and awareness-building. During this phase, a legislative working group will be established to prepare a law concerning bio-medical waste management and facilitating its submission for adoption;
- Overall monitoring will be provided by the implementation committee and the Direction Generale of the MOHP. It will include periodic on-site visits, activity reports, and discussions with the beneficiaries. All implementation agencies will contribute to monitoring and will be assigned follow up tasks.
- Two evaluations will be done: one internal mid-term evaluation and one external evaluation during the month following completion of the project. Each will last for one month.

MAP SECTION