## PROJECT INFORMATION DOCUMENT (PID)  
**CONCEPT STAGE**

Report No.: PIDC1022

<table>
<thead>
<tr>
<th><strong>Project Name</strong></th>
<th>Health Sector Project (P143849)</th>
</tr>
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<tbody>
<tr>
<td><strong>Region</strong></td>
<td>AFRICA</td>
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<tr>
<td><strong>Country</strong></td>
<td>Congo, Republic of</td>
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<tr>
<td><strong>Theme(s)</strong></td>
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<td><strong>Implementing Agency</strong></td>
<td>Ministry of Health and Population</td>
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### I. Introduction and Context

#### Country Context

The Republic of Congo (ROC) is growing and urbanizing. ROC is a low middle income country with vast oil revenues and a small population, estimated at 4.2 million in 2012. ROC has one of the fastest economic growth rates in Sub-Saharan Africa (average 5.7 percent over 2007-2012) and has the potential to become an emerging economy over the next decade. Sixty two percent of the population lives in urban areas half of which are living in two main urban centers, Brazzaville and Pointe Noire. Nearly forty percent of Congo’s population is under 15, and growing at a rate of 3 percent per year. This trend will lead to a doubling of the population in 25 years.

ROC’s weak institutions delay progress on social and economic growth. Many years of conflict and unstable governments have severely weakened the country’s administration, eroded public accountability, and undercut publicly funded services. This decline is reflected in the inability of the administration to transform its economic growth into better access to basic services and improved
social outcomes for the majority of the population. In addition, policy implementation suffers from low administrative and managerial capacity at the local level. Mindful of the need to modernize public administration and its human resources, the Government of Congo has initiated a civil service reform (including deconcentration) and allocated additional resources to the civil service apparatus. Despite these efforts, public administration remains dysfunctional partly due to outdated laws and regulations, unclear institutional mandates and structures, skills mismatch, low managerial capacity, and inadequate remuneration.

**Sectoral and Institutional Context**

Congo’s progress towards better health outcomes is slow. Despite some improvements in health status, MDG 4, under 5 mortality, and MDG 5, maternal mortality, the respective mortality indicators remain high. Neonatal mortality on the other hand showed a small decrease from 28 to 22 per 1000. Similarly, the adolescent fertility rate for 15–19 year olds remains high at 147 per 1,000 women in the 2011-12 DHS, and HIV-AIDS prevalence among young women (15–24) is more than three times higher than prevalence among males of the same age.

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

The availability and allocation of resources in the health sector is a major concern in ROC. Whereas ROC ranks among the countries with the highest per capita income in Sub-Saharan Africa (rank of 35 out of 45 countries –, its total health expenditure (THE) per capita, at 2.5% of GDP, is the second lowest in the region. Public health expenditure as a share of THE is the 6th lowest regionally and the country's reliance on out-of-pocket health spending out of total health financing, at 64%, is among the highest (rank of 39).

The distribution of human resources is inequitable. The health institutional context is characterized by inadequate capacity for planning, poor motivation of the health worker, and weak health systems, all of which culminate in the poor quality of service delivery. Distribution of health personnel is unequal with higher concentrations of personnel in the two main cities, Brazzaville and Pointe-Noire; 68% of ROC’s population lives in these two cities but 93% of specialized doctors, 73% of general practitioners, 78% of midwives and 85% of pharmacists work in these 2 cities. (HR Census - 2011). Training, recruitment and allocation of health workers are managed by 5 different Ministries without sufficient coordination. Consequently, health workers do not receive adequate in-service training, they are not deployed to health facilities that need their specialized skills, thus rural facilities which need certain specialists have vacant positions and urban facilities which do not need additional specialists have more positions than they require.

In addition, availability of drugs at an accessible cost is uneven across the health facilities in ROC. This is mainly due to the fact that health facilities procure drugs from various sources including the private sector. However, the private pharmaceutical market is not well regulated and the price of the
drugs on the market is relatively high while the quality of the drugs is unknown. Field visits show
that more than half of all drugs and medical consumables present have been procured from the
private market, while about half of all products are generic products from the COMEG (Congolaise
de MédicamentsEssentiels et Génériques).

Access to health care is also an issue of financial barriers to care and poor individuals are at a clear
disadvantage. Disparities in access to health care reflect in part differences in the availability of
health care providers along the national territory – providers tend to be more heavily concentrated in
the larger urban areas of Brazzaville and Pointe Noire. But unequal access also results from
differences in families’ ability to pay for health care.

Over the next 10-15 years the health landscape of ROC’s population will change significantly and
the country needs to be poised to respond. Currently, the country's health system is ill equipped to
meet the challenges ahead in order to improve the health status of the population and tackle the
demands on the health system as urbanization and rural poverty increase.

Relationship to CAS
The FY13-16 Country Strategy's objectives continue to be supporting the country's need to diversify
its economy and improving its social outcomes. The Bank will focus on improving the civil service
and public sector management, playing a catalytic role to leverage the large public investment
program, and targeting niche activities that could serve as policy experiments for the Government to
replicate. The proposed operation will help to strengthen the health sector in the country by
improving the quality and access to health services while laying down the foundation for the
Government to provide subsidies to the poor to reduce their out of pocket expenditures.

II. Proposed Development Objective(s)

Proposed Development Objective(s) (From PCN)
22. The project development objective (PDO) of the proposed operation is to increase the
utilization and quality of maternal and child health services in targeted rural and urban areas of the
Republic of Congo (ROC).

Key Results (From PCN)
23. The proposed PDO key results indicators are as follows: (i) increase in the number of
people with access to a basic package of health services (number of consultations/capita/year in
targeted areas); (ii) increase in the number of children fully immunized under one year of age; (iii)
increase in the number of women of child bearing age using modern family planning methods; (iv)
increase in the number of pregnant women receiving two doses of intermittent preventive treatment
against malaria; (v) increase in the number of postnatal care visits from those that delivered in a
health institution; (vi) increase in the number of pregnant women tested for HIV; (vii) increase the
number of health workers that know the protocol for antenatal care visits; (viii) increase the number
of health workers that know the protocol for assisted deliveries; and (ix) increase in utilization by
the poorest 40% of the population.

III. Preliminary Description

Concept Description
The project will test innovations initially in 6 out of the 12 Departments of ROC (the 6 to be
identified during pre-appraisal) and will scale up those that are proven successful during the life of
the project. The project will comprise the following components.

Component 1: Improvement of access and quality of health services at health facilities through performance-based financing (PBF)

This component would be supported by the Government’s own funds, IDA resources and a grant from the Health Results Innovation Trust Fund (HRITF). It will finance PBF implementation through the contracting of performance-purchasing agencies (PPAs). This support would have the following two dimensions:

Subcomponent 1.1: Performance payments to health facilities

Building on the ongoing experience with PBF, grants will be paid to health facilities based on the: (i) number of maternal and child health (MCH) services delivered to the targeted population; and (ii) the technical quality of those services. Facility payments will be made quarterly after the volume of services and the quality of care have been verified and certified by an independent performance purchasing agency (PPA).

Due to challenges encountered in improving hospital performance, various options to strengthen hospital management will be explored. Such options could include, in addition to PBF, contracting with individual managers or firms, or recruitment of hospital management consultants. For now tertiary hospitals will not be part of this project.

More than half of the population of Congo lives in two large urban centers: Brazzaville and Point Noire. Assessments in urban areas document the widespread availability of both public and private curative services. Both types of providers are underutilized and the coverage of preventive services remains lower than expected. The project will explore various options, including: (i) subsidizing curative and preventive services through PBF (lowering out of pocket costs to clients); (b) contracting with private for profit providers to provide essential services (through PBF); and (c) contracting with non-state actors (Performance-Based Contracting) to increase coverage of preventive and promotive services in specified geographical parts of the cities.

Subcomponent 1.2: Support to PBF implementation and supervision

Given the technical challenges of PBF implementation and the shortage of technical capacity and human resources within the MOH, the project proposes to identify international NGOs with demonstrated experience with PBF to act as the PPAs. This subcomponent will finance activities related to PBF implementation and supervision. The graph below describes the potential institutional and administrative arrangements that will be put in place for the PBF activities.

Component 2: Strengthen Health Care Financing Policies

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

Financial barriers to access services are high in ROC. There is evidence that utilization of basic maternal and child health services is low and this may be attributable in part to the pervasive
presence of user fees in all public facilities.

This sub-component will draw on the experience of the Social Protection Program that is also under preparation, to identify households that will benefit from fee waivers. However, alternative definitions of target groups to tackle observed differences in health status and in effective access to health services may be considered. As is shown in Tables 1 and 2, above, access to some key maternal and child health services is bi-modal, with those in the two or three bottom quintiles exhibiting rather similar and lower access to services, and the top two quintiles exhibiting similar but higher access. The sub-component will also promote the adoption of fee exemptions for selected health services with high externalities and which are under-valued by the population. These exemptions will hold for all patients, and not just for the poor. For example, some preventive services for mothers and children and obstetric services may be included in the list of exempted services.

**Sub-component 2.2 Improving budget allocations**

A preliminary review of budget allocations by the Ministry of Health (MOH) to the departments suggests that certain inequalities would be overcome if the MOH adopted an explicit budget allocation formula. An allocation formula or criterion could consider the department’s population, the per capita cost of the minimum and complementary benefit packages, the degree of remoteness, poverty, and other variables. The project will support the assessment of resource allocation, carry out fiscal space analysis.

This sub-component will also include a debate with government officials and other stakeholders about the appropriateness of the government’s current budget allocation to the health sector, the potential need to expand it, and the sources of any such expansion (the question of fiscal space arises in this context). As part of this sub-component, is the preparation stage the project will support a critical review of the existing primary and complementary benefit packages, help revise their contents and cost out the packages. The review and revisions of the primary benefit package will be aim at ensuring that the services that are selected include those with the highest potential for accelerating the country’s achievement of MDGs 1, 4, 5 and 6.

**Sub-Component 2.3: Assessment of health insurance options.**

The government of ROC has embarked on the path to reach universal coverage through health insurance. A report written by Congolese policy-makers who visited Rwanda and Ghana, describes health insurance in these countries and makes recommendations about how health insurance should be structured in ROC. A second document takes the recommendations from that report to propose in draft form a law for the establishment of universal health insurance in ROC. This sub-component will provide technical assistance to the government of ROC to further refine the draft law while discussing the feasibility of such a reform, looking at different options, and a timeline for implementation. A health insurance experiment in one department of the country may be considered and will be addressed during appraisal.

**Component 3: Strengthen the Governance of the national Health System and support the**
Implementation of the project

Performance frameworks will be introduced at the health district (Circonscriptions Socio Sanitaire - CSS) level, at the department (Direction Départementale de Santé, DDS) level, and in selected Ministry of Health departments at the central level. This component will also include technical assistance to strengthen specific functions such as the Health Management Information System (HMIS) and Monitoring and Evaluation (M&E) capacity. Furthermore, this component will also include the creation of a PBF technical unit which will be merged with the project implementation unit at the MOH. Finally, this component contains the third party firm which will carry out surveys and counter-verify PBF performance. An impact evaluation, financed through the HRITF will be used to test the effectiveness of the innovations.

Sub-component 3.1: Health Management Information System (HMIS) Strengthening

Shortcomings in ROCs health information system do not allow for proper monitoring and evaluation (M&E) of health sector performance. Inaccurate and incomplete HMIS data combined with infrequent household surveys and the absences of health facility survey data to assess quality of care, mean that policy makers do not have the information they need to make evidence based decisions. This sub-component will strengthen the HMIS system, support the conduct of two demographic and health surveys, and finance two rounds of health facility surveys (using the Service Delivery Indicators approach pioneered by the Bank). This will be accomplished by a contract with an External Evaluation Agency (EEA). The EEA will also include (a) monitoring and evaluation of Component 1; (b) strengthening of the recipient’s capacity to carry out data collection and analysis; and (c) help carry out the impact evaluation.

Sub component 3.2 Capacity Building and Technical Assistance to strengthen health sector

This sub-component support the development and implementation of a capacity building program in ROC aimed at high and medium-level policy-makers from the central MOH, other ministries (such as Finance, Planning, and Economy), senior staff from the health departments. The training will adopts the form and methods of WBI’s Flagship Program on Health Systems Strengthening, with a thematic emphasis on the most pressing policy issues in the country, such as pharmaceutical policy, human resource policies, PBF, benefit packages, and universal health coverage, . Management training for facility managers and senior level technical staff would include training on how to implement PBF (performance frameworks, verification, contract management etc.), human resource policies, financial management, pharmaceuticals management and distribution, and monitoring and evaluation among others. In addition to management training, it will be imperative to train staff at all levels on clinical protocols; this training will include doctors, nurses, auxiliary workers, midwives and traditional providers (as necessary). This training would be based on updated protocols.

Since PBF is a new approach being utilized in ROC, sufficient attention will be paid to ensuring that health sector staff at all levels are well versed in the topic and that they have the requisite skills to implement this project. This area of capacity building will include training on contract management and verification, performance frameworks, information and communication technology and evaluation among others.
Finally, this sub-component will develop activities and interventions that would help address the issue of availability, quality, and costs of drugs in health facilities.

Sub-component 3.3: Technical and Management Support to the implementation of the project.

At the central level a national technical PBF unit, will guide PBF implementation to draw lessons and policy implications for the health sector. It should be chaired by the Director of Cabinet of the MOH and includes key directorates of the MOH, the Ministry of Planning and Economy, the Ministry of Finance, and representatives from the donor community. The PBF technical unit will oversee the implementation of PBF, document the lessons learned from various initiatives of PBF in the country, provide guidance to the PIU and PPA, and generate policy direction for the institutionalization of PBF in ROC.

The National Technical PBF Unit will be in charge of: (i), supporting the regulatory function that the Ministry has to assume in PBF implementation, (ii) monitoring the progress of PBF implementation in the field, and promoting ownership of PBF by the Ministry, and (iii) exploring ways and mechanisms to institutionalizing PBF as a national policy in ROC and to scaling up PBF beyond the 6 initial departments. Finally, the PBF unit will also support the coordination, implementation and management of the project.

IV. Safeguard Policies that might apply

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