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# Combined Project Information Documents / Integrated Safeguards Datasheet (PID/ISDS)

Appraisal Stage | Date Prepared/Updated: 05-Jan-2018 | Report No: PIDISDSA23623



**BASIC INFORMATION**

**A. Basic Project Data**

Country Congo, Democratic Republic of	Project ID P166004	Project Name Health System Strengthening for Better Maternal and Child Health Results AF2	Parent Project ID (if any) P147555
Parent Project Name Health System Strengthening for Better Maternal and Child Health Results Project (PDSS)	Region AFRICA	Estimated Appraisal Date 29-Nov-2017	Estimated Board Date 08-Jan-2018
Practice Area (Lead) Health, Nutrition & Population	Financing Instrument Investment Project Financing	Borrower(s) Ministry of Health	Implementing Agency Ministry of Health, Democratic Republic of Congo, Ministry Of Finances

Proposed Development Objective(s) Parent

The proposed project development objective is to improve utilization and quality of maternal and child health services in targeted areas within the Recipient's Territory.

Components

- Improve Utilization and Quality of Health Services at Health Facilities through PBF
- Improve Governance, Purchasing and Coaching and Strengthen Health Administration Directorates and Services through PBF
- Strengthen Health Sector Performance – Financing and Health Policy Capacities
- Disease Surveillance System Strengthening and Response

Financing (in US\$, millions)

**SUMMARY**

<b>Total Project Cost</b>	10.00
<b>Total Financing</b>	10.00
<b>Financing Gap</b>	0.00

**DETAILS**



Environmental Assessment Category

Partial Assessment (B)

Decision

## **B. Introduction and Context**

### **Country Context**

The Democratic Republic of Congo (DRC) is experiencing significant fiscal stress due to the global economic slowdown and domestic political uncertainty with presidential elections having been postponed by a year till December 2018. The production of oil and mining products during the first half of 2016 has declined by 8.6 percent compared to 2015; the quantities of cement sold declined by 41 percent; and port activity declined by 17.6 percent. The drop in the global demand for raw materials has resulted in decreased commodity prices and lower levels of economic activities, and greater risk of increased fiscal deficits. Already, preliminary public finance figures show revenues dropping by 12.4 percent in 2016. The decline in 2015 revenues led the government to cut the 2016 budget by 22 percent to keep spending under control. The overall economy has also been impacted: GDP growth in 2015 declined to 6.9 percent and 4.2 percent from 9.5 percent in 2014. As a result, the Government had to delay or only partially fulfill health sector expenditure commitments which jeopardizes the fragile gains in health outcomes in recent years.

Public spending on health in DRC is low in absolute terms and by international standards and the recent decline in domestic revenues has further worsened the priority given to the sector. The Ministry of Health's budget dropped from 6.9 percent of the overall budget in 2014 to 4 percent in 2015 and 2016. While public spending on health decreased, the share of the wage bill in total spending on health increased rapidly and reached 78 percent of total health budget in 2015, leaving few resources to pay for other critical inputs. As a result, the Government had to delay or only partially fulfill health sector expenditure commitments, which jeopardizes the fragile gains in health outcomes in recent years. For instance, Bacillus Calmette–Guérin (BCG) coverage declined by 9 percentage points between 2013 and 2015 (from 83 percent in 2013 to 74 percent in 2015) due to lack of Government funding for the vaccines and operational costs. Furthermore, this decline in resources led to the Government's inability to fulfill its co-financing commitment for routine vaccines in 2016 where support from the World Bank on an exceptional basis was sought. Hence, there is a need to work with the Government to not only protect fundamental budget lines in the years to come (for vaccines, salaries, and essential drugs), but also to address key bottlenecks hampering the performance of the system such as quality of human resources and their motivation, public finance management, which currently is highly inefficient, and supply chain strengthening to ensure quality/affordable drugs and improved governance.

Human development is a priority for the current government. Some recent progress has been noted in selected health and education indicators, but considerable challenges remain. DRC ranks 176 (out of 188) on the 2016 Human Development Index and it did not achieve any of its Millennium Development Goals by the end of 2015. Sixty-three percent of the population is estimated to be poor, living on less than US\$1.25 per day. The country poverty is more than monetary; it includes a sense of exclusion, economic instability, and the inability to cope with uncertainties and plan for the future. Poverty is also experienced as the lack of



economic opportunities and physical and psychological insecurity (World Bank Country Assistance Strategy, 2012). While the primary gross enrollment ratio for education has improved considerably, reaching 101.4 percent, retention, the achievement of learning outcomes remains challenging.

While DRC has started its demographic transition, the pace is slow and the country is at high risk of not harvesting the demographic dividend. The demographic dividend is characterized by a period in a country's demographic transition when the proportion of the working-age population is higher than the number of dependents. This period corresponds to an extra economic boost through increased savings and private investments. Triggering such a demographic dividend requires two ingredients: (i) a decreased dependency ratio which is made possible only when fertility is declining more rapidly than mortality; and (ii) adequate policies to foster human capital, employment and investments to ensure that the additional working-age population is healthy and can get good jobs. The demographic transition (the shift from high to low mortality and fertility levels) and demographic dividend are central to the discussion on both health and economic growth in DRC.

### **Sectoral and Institutional Context**

Progress in health outcomes remains timid in DRC. The 2013-2014 Demographic and Health Survey (DHS) reported a 30 percent reduction in under-five mortality from 2007. However, chronic malnutrition rates have remained high (43 percent of children under five are stunted) and stagnant. The same survey estimated a maternal mortality ratio of 846 (per 100,000 live births), among the highest in the world. The under-5 mortality rate has decreased from 148 (per 1,000) in 2010 to 104 (per 1,000) in 2014 and the infant mortality rate has also decreased from 92 (per 1,000) to 58 (per 1,000). Despite this decline, greater progress in these rates will require improvements in both the quantity and quality of reproductive, maternal, neonatal, child and adolescent health (RMNCAH) services. While 85 percent of pregnant women receive some professional antenatal care and two-thirds of births take place in a health facility, the high rate of maternal mortality is directly correlated to the low quality of care, inadequate preparedness for obstetric emergencies and ineffective referral systems. These statistics point to an urgent need to strengthen systems that deliver good quality services with a focus on adolescent health.

The adolescent fertility rate is high with 21 percent of adolescent females between 15 and 19 having given birth in 2014. Unmet family planning needs among adolescents has increased from 26.2 percent to 30.8 percent between 2007 and 2013 (DHS 2013-2014). The two biggest barriers preventing adolescent girls and boys from seeking reproductive health services are stigma and cost. The regional disparities are significant: in the East and Far North, respectively, 44.2 percent and 23.4 percent of young women 15 to 19 years of age had already had a child in 2014, while in Kinshasa this rate was only 7.6 percent. Education and poverty are determining factors: 48.8 percent of adolescents aged 15 to 19 without any education were pregnant or already had a child, a rate that is three times higher than among girls with a secondary education (17.9 percent). Similarly, 31.3 percent of young women aged 15 to 19 in the poorest quintiles had begun their reproductive life, whereas only 8.6 percent of young women in the richest quintile had done so.

Modern contraceptive prevalence remains low. Most health facilities do not provide family planning services resulting in the low prevalence rate for modern contraception. According to the Service Availability and Readiness Assessment (SARA) survey (2014) on the availability of services, there is little integration of family planning services in most health areas. Only 33 percent of health zones are covered by functional family planning services. In 2016, as per the baseline survey conducted for the PDSS project, only 30 percent of health facilities surveyed offered family planning services. Only 20 percent of health facilities have all six tracer drugs and the average health facility has only 4 of the 6 essential commodities for the



supply of family planning services. Moreover, the quality of family planning services remains worrying with low availability of a wide range of family planning methods. Additionally, the laws on family planning are troubling, there is still a 1920 law in place banning the use of contraceptive methods, however a revised reproductive health law is currently being discussed in parliament and has yet to be adopted.

The nutritional status of women and children in DRC presents an alarming situation which has severe consequences for current and future generations. DRC suffers from a high prevalence of malnutrition, despite being home to just 1 percent of the world's population; it is one of the five countries which together are responsible for half of all deaths globally among children under five (WHO 2012a). About half of these deaths are caused by malnutrition; chronic malnutrition among children under five is estimated at 43 percent (DHS 2013-2014 not changed since 2007) and almost half of the children under five are moderately or severely anemic (43.7 percent and 4.2 percent respectively). High fertility rates among adolescents is an important determinant of early life stunting. Despite efforts to improve the nutritional status of Congolese children, the prevalence of stunting among children under five has remained practically unchanged – just under 45 percent of children under 5 were stunted – between 2001 and 2014.

This prevalence has persisted despite reductions in the prevalence of underweight children under five (dropped from 34 to 23 percent) and wasting of children under 5 which has dropped from 21 to 8 percent. In stark contrast reduction in child stunting has seen declines of just 1 percent over the last four years (DHS 2013-14). High child stunting rates remain one of the most intransigent health issues in the DRC. Investing in nutrition can increase a country's GDP by between 3 and 11 percent annually (Horton and Steckel 2013) and investments in early nutrition have the potential to boost wage rates by 5 to 50 percent, make children 33 percent more likely to escape poverty in the future, and address gender inequities. The Government and the Develop Partners (DPs) recognize the importance of investing in nutrition and are supporting nutrition interventions in PDSS and are looking to support them further through this AF.

Gender inequalities are also prevalent; DRC ranks 148 out of 157 countries on the Gender-related Development Index. However, greater women empowerment will not necessarily translate into greater reproductive choice if women do not have access to needed reproductive health services. It is therefore important to ensure that health systems provide a basic package of RMNCAH services, including family planning, which is one of the key priorities of the Ministry of Public Health (MOPH) as reflected in the new National Health Development Plan for 2016-2021. Provision of these services alone is not sufficient if stigma persists and financial access a barrier.

Women are among the most vulnerable groups in DRC. They face multiple and mutually reinforcing constraints including high levels of violence, inadequate control over their health, limited economic opportunities, and lack of control over resources. The severity of the constraints varies widely across countries. For example, 97 percent of women face one or more of these constraints; 42 percent are affected by both domestic violence and inadequate control over their health, and 25 percent by three key constraints (domestic violence, lack of control over their health, and inadequate control over resources).

Vulnerability is witnessed by the high prevalence of sexual and gender-based violence (SGBV) throughout DRC and not only in the conflict areas (in eastern DRC). Sixty-four percent of women in DRC have been victims of physical violence, and an alarming 71 percent of women have suffered from spousal or partner abuse. DHS 2013-2014 found that nearly 50 percent of victims of SGBV do not seek help from any service provider. In focus groups conducted by Pathfinder International in four former provinces (including one of the PDSS provinces – Maniema), women stated the following reasons for not seeking help: (i) stigma associated with sex; (ii) impunity within the justice system; (iii) fear of divorce or abandonment; (iv) lack of



funds; (v) preference for ‘amicable’ settlement; (vi) lack of information; (vii) lack of appropriate health care services; and (viii) fear of losing one’s job.

Gender norms are at the heart of maternal and child nutritional deficiencies and health outcomes. Traditional male-centered norms and values weigh heavily on women’s access to productive resources and impede their ability to determine their well-being and that of their offspring. This starts in early adolescence and can produce harmful effects throughout different stages of the lifecycle. Therefore, the role of women as child bearers cannot be separated from that of women as providers of food security. Together they highlight a picture of conflicting demands on women’s time and responsibilities and as a result high levels of vulnerability, which become worse during times of economic recession as witnessed in DRC.

The health system was severely weakened during the decades of conflict and continues to be both economically and politically fragile. The government recognizes the need to build strong institutions and systems for effective health, education and social protection services and has made a request to the Bank to scale-up its support in this area. The Government has launched a number of reforms focusing on decentralization and public administration reforms to strengthen the fiduciary and technical aspects of the Government. Health financing and public finance management remain very inefficient. The share of health spending remains at 4 percent of the total Government budget, well below similar countries in sub-Saharan Africa where spending on average is US\$130 per capita per year compared to US\$13 per capita per year for DRC.

A plethora of health workforce exists in DRC, over-staffing of health facilities is common in both rural and urban areas. Adding to this problem is the fact that 70 percent of the health workforce does not receive a salary. To cover the cost of salaries and offset the insufficient Government allocation, health facilities charge high user fees. Various partners have paid salary top-ups and financed training of health workers as a motivation bonus but this has been insufficient to improve results. Important reforms in the health workforce in DRC are required in order to improve the system’s efficiency. A critical aspect of this reform will be to reduce the current workforce numbers to match the needs of the system; additionally, the reform must also focus on addressing the lack of worker motivation while enhancing skills.

The aging of human resources in the health sector is a real obstacle to improving the effectiveness and quality of the health system, thus jeopardizing the prospects for achieving the country's development objectives. Human resources statistics show that out of an overall workforce of 250,000 staff eligible for retirement in the DR Congo, 22,000 staff (or 8 percent) are concentrated in the health sector. It should be noted that 27 percent of human resources in the health sector are eligible for retirement. The enormous weight of these human resources negatively affects the quality of health care offered to the population. Furthermore, looking at the wage bill in the health sector, many civil servants still active are either registered but not mechanized or new units, hence benefiting only from the bonus but not salary. While on the other hand, agents who are eligible for retirement are regularly paid despite poor performance. This situation leads to the demotivation of human resource whose performance is still relatively high and which, however, must be remunerated accordingly in view of their performance.

Strengthening key underfunded RMNCAH interventions continues to be the highest priority for the Government. DRC is one of the five pilot countries for the Global Financing Facility (GFF). The country launched the GFF process in a high-profile event in April 2015, demonstrating significant political commitment. A governance structure has been established to oversee the preparation of an investment case for RMNCAH as well as a health financing strategy. The GFF presents considerable opportunities for the country, on several fronts. First, the country’s response to RMNCAH has been fragmented, with separate



analytical work and strategies for various aspects of the RMNCAH continuum. Second, some key technical elements that the GFF emphasizes – such as gender, equity, and efficiency – have been under-addressed in DRC.

### **C. Proposed Development Objective(s)**

#### Original PDO

The proposed project development objective is to improve utilization and quality of maternal and child health services in targeted areas within the Recipient's Territory.

#### Current PDO

The proposed project development objective is to improve utilization and quality of maternal and child health services in targeted areas within the Recipient's Territory.

#### Key Results

At the PDO and PDI level, end-target values have been revised to take into account this AF and the ability to reach more beneficiaries.

### **D. Project Description**

Component 1: Improve Utilization and Quality of Health Services at Health Facilities through Performance-Based Financing. Total original cost, including contingencies, was US\$120 million equivalent, of which US\$115 million from IDA and US\$5 million from HRITF. Revised cost with AF-1 is US\$174 million equivalent, of which US\$154.5 million from IDA, US\$5 million from HRITF, US\$12 million GFF-TF, US\$2.5 million from USAID TF. The proposed revised cost with AF-2 is US\$182 million, including US\$8 million from the Global Fund TF.

This component aims to increase the utilization and quality of health services, with a specific focus on maternal and child health interventions, through PBF in selected health zones. The proposed AF co-finances the existing package of the essential health services so as to increase utilization and ensure effective coverage of these RMNCAH-N services.

Component 2: Improve Governance, Purchasing and Coaching and Strengthen Health Administration Directorates and Services through Performance Based Financing. Total original cost, including contingencies, was US\$67.2 million equivalent, of which US\$63.7 million from IDA and US\$1.5 million from the HRITF. Revised cost with AF-1, is US\$90.7 million equivalent, of which US\$83.2 million from IDA, US\$1.5 million from HRITF, US\$5 million from GFF-TF, US\$1 million from USAID-TF. The proposed revised cost with AF-2 is US\$92.7 million, including US\$2 million from the Global Fund TF.

Performance frameworks will continue to be financed at all levels of the health system which have been introduced as part of the parent project. The proposed AF will co-finance the performance frameworks that have been established at all level of the health system so as to improve the governance and management of the health sector.



Component 3: Strengthen Health Sector Performance – Financing and Health Policy Capacities. No change.

Component 4: Disease Surveillance Strengthening and Response. No change.

## **E. Implementation**

The implementation arrangements for the proposed AF will remain the same. The high-level steering committee will continue to provide oversight and strategic guidance to the project, and the Ministry of Public Health (MOPH) will continue to implement the project through the Planning and Evaluation Directorate (*Direction de la Planification et Evaluation* - DEP).

As part of the original project, a unique and innovative partnership has been put in place to provide funding for the PBF program. The Global Fund, UNICEF, World Bank, GAVI, UNFPA and USAID have signed a memorandum of understanding (MOU) to partner with the government to better align and harmonize their interventions to increase access to essential maternal and child health services. This collaboration has enabled financial and technical resources to be pooled together to deliver a basic package of health services to the entire population in all eleven provinces in which the PDSS is currently being implemented. These donors work synergistically to complement each other and utilize their comparative advantage to maximize effectiveness, avoid duplication and improve efficient use of resources.

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## **F. Project location and Salient physical characteristics relevant to the safeguard analysis (if known)**

The original project covers 140 health zones which translates into eleven Provinces out of the 26 newly created Provinces. All of the health zones in the formerly known Provinces of Equateur and Bandundu are covered, 8 health zones out of 18 in Maniema are covered and in the former Katanga the following newly created Provinces are covered: Haut-Katanga (8 health zones), Haut Lomami (8 health zones), and Lualaba (6 health zones). The first AF increased coverage to the remainder 8 health zones in Lualaba and in Haut Lomami to achieve full coverage of these two Provincial Health Directorate (*Direction Provinciale de la Santé – DPS*). A total of 16 new health zones were added in the first AF, resulting in the total number of health zones being targeted at 156, or 30 percent of the population. The second AF will not add anything health zones nor new activities.

## **G. Environmental and Social Safeguards Specialists on the Team**

Lucienne M. M'Baipor, Social Safeguards Specialist  
Claude Lina Lobo, Environmental Safeguards Specialist





**SAFEGUARD POLICIES THAT MIGHT APPLY**

Safeguard Policies	Triggered?	Explanation (Optional)
Environmental Assessment OP/BP 4.01	Yes	
Natural Habitats OP/BP 4.04	No	
Forests OP/BP 4.36	No	
Pest Management OP 4.09	No	
Physical Cultural Resources OP/BP 4.11	No	
Indigenous Peoples OP/BP 4.10	Yes	
Involuntary Resettlement OP/BP 4.12	No	
Safety of Dams OP/BP 4.37	No	
Projects on International Waterways OP/BP 7.50	No	
Projects in Disputed Areas OP/BP 7.60	No	

**KEY SAFEGUARD POLICY ISSUES AND THEIR MANAGEMENT**

**A. Summary of Key Safeguard Issues**

1. Describe any safeguard issues and impacts associated with the proposed project. Identify and describe any potential large scale, significant and/or irreversible impacts:

The original project covers 140 health zones, which translates into eleven provinces out of the 26 newly created provinces. All of the health zones in the formerly known provinces of Equateur and Bandundu are covered, 8 health zones out of 18 in Maniema are covered, and in the former Katanga the following newly created provinces are covered: Haut-Katanga (8 health zones), Haut Lomami (8 health zones), and Lualaba (6 health zones). The first AF increased coverage to the remaining 8 health zones in Lualaba and Haut Lolami to achieve full coverage of these two provincial health directorates (Direction Provinciale de la Santé – DPS). A total of 16 new health zones were added in the first AF, resulting in a total of 156 health zones being targeted, i.e., 30 percent of the population. The proposed second AF will not add new health zones or new activities.

Institutional capacity building at the national and health zone level is the focus of the project. Particular attention is given to some of the most “foundational” system building blocks in the health sector. No civil works will be undertaken and no adverse environmental or social impacts are expected. The project does not require any land acquisition leading to involuntary resettlement and/or restrictions of access to resources and livelihood. The project is expected to have a positive impact for all beneficiaries including vulnerable groups such as children, women and the poor who are the main target beneficiaries of the project.

This project will cover 11 provinces and hence part of the population targeted will include Indigenous Peoples (IPs).



The expected impacts are positive as the IPs do not have access to quality care and hence the project will ensure that quality free care is provided to them to ensure a better health outcome. An Indigenous Peoples Plan Framework (IPPF) has been prepared and disclosed as part of the parent project in October 2016, and was redisclosed in April 2017 as part of the first additional financing. The IPP will be updated and redisclosed as part of the proposed AF2.

2. Describe any potential indirect and/or long term impacts due to anticipated future activities in the project area: Both the parent project and two additional financings are not expected to have large scale, significant, or irreversible environmental or social impacts. Project activities are focused on delivery of an integrated package of health services both at the community and health facility level, as well as providing high impact maternal and reproductive health services.

Project activities that could potentially cause an adverse impact that will need to be minimized, mitigated and managed include: (i) During the operation of the health facilities the generation of additional quantities of medical waste will increase slightly over the current baseline. (ii) In addition, the health facilities will receive an investment bonus at the beginning of each year, which they can use to do some minor rehabilitation such as painting, opening a window, fixing the roof etc. These activities may cause noise, vibrations and emissions from vehicles and machinery, generate construction waste and involve potential risks regarding workplace and community health and safety. However, the anticipated impact of these activities will be temporary, site specific and localized, and limited in scope.

3. Describe any project alternatives (if relevant) considered to help avoid or minimize adverse impacts.

Not applicable.

4. Describe measures taken by the borrower to address safeguard policy issues. Provide an assessment of borrower capacity to plan and implement the measures described.

At the national level, the DRC has a legislative and regulatory framework which is conducive to good environmental management. In addition, the DRC has signed several international treaties and conventions. However, implementation capacity is weak. Environmental policies and their compliance are governed by the Ministère de l'Environnement, de la Conservation de la Nature et du Développement Durable (MECNDD) – (Ministry of Environment, Conservation and Sustainable Development). The MECNDD has three departments in charge of environmental monitoring and management : i) the national agency ACE (Agence Congolaise de l'Environnement), the former GEEC (Groupe d'études environnementales du Congo); ii) le Centre National d'Information sur l'Environnement (CNIE); and iii) La Cellule Réglementation et Contentieux Environnementaux (CRCE). The ACE is responsible for safeguards compliance of all projects in the country.

Under the parent project, two safeguard policies have been triggered: 1) OP/BP 4.01 Environmental Assessment because of the potential negative environmental and social impacts related to the handling and the disposal of medical and health waste (such as placentas, syringes, and material used for delivery of pregnant women) in health facilities covered by the project area. However, health care waste to be generated by the project is expected to be site-specific, small scale and easily manageable; and 2) OP/PB 4.10 on Indigenous People. The IPP prepared for the parent project and AF1 will be updated and redisclosed for the proposed AF2.

To manage properly health care waste in accordance with OP/PB 4.01, the existing Health Care Waste Management Plan (HCWMP) disclosed by the PDSS in April 2017 will be updated and redisclosed for this second AF. The project team has recruited environmental and social specialists to ensure implementation of the instruments.



5. Identify the key stakeholders and describe the mechanisms for consultation and disclosure on safeguard policies, with an emphasis on potentially affected people.

The AF2 will continue to rely on the consultation process being used under the parent project and first AF, which includes consultations with government officials at relevant levels, provincial officials, donor community, implementation partners, community and civil society groups, and direct beneficiaries of the project.

**B. Disclosure Requirements (N.B. The sections below appear only if corresponding safeguard policy is triggered)**

**Environmental Assessment/Audit/Management Plan/Other**

Date of receipt by the Bank	Date of submission for disclosure	For category A projects, date of distributing the Executive Summary of the EA to the Executive Directors
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"In country" Disclosure

**Indigenous Peoples Development Plan/Framework**

Date of receipt by the Bank	Date of submission for disclosure
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"In country" Disclosure

**C. Compliance Monitoring Indicators at the Corporate Level (to be filled in when the ISDS is finalized by the project decision meeting) (N.B. The sections below appear only if corresponding safeguard policy is triggered)**



## CONTACT POINT

### **World Bank**

Hadia Nazem Samaha  
Senior Operations Officer

### **Borrower/Client/Recipient**

Ministry of Health

### **Implementing Agencies**

Ministry of Health  
Alain Iyeti  
Director  
alainiyeti@yahoo.fr

Democratic Republic of Congo  
Dr. Oly Ilunga  
Minister of Health  
ministre@sante.gouv.cd

Ministry Of Finances  
Honore Tshiyoyo  
Cellule des Coordination des projets



**FOR MORE INFORMATION CONTACT**

The World Bank  
1818 H Street, NW  
Washington, D.C. 20433  
Telephone: (202) 473-1000  
Web: <http://www.worldbank.org/projects>

**APPROVAL**

Task Team Leader(s):	Hadia Nazem Samaha
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**Approved By**

Safeguards Advisor:	Maman-Sani Issa	08-Jan-2018
Practice Manager/Manager:	Trina S. Haque	09-Jan-2018
Country Director:	Yisgedullish Amde	09-Jan-2018