Project Information Document (PID)

Concept Stage | Date Prepared/Updated: 27-May-2020 | Report No: PIDC28508

BASIC INFORMATION

A. Basic Project Data

Country	Project ID	Parent Project ID (if any)	Project Name
Chad	P172504		Health System Performance Strengthening Project (P172504)
Region	**Estimated Appraisal Date**	**Estimated Board Date**	**Practice Area (Lead)**
AFRICA WEST	Oct 22, 2020	Dec 03, 2020	Health, Nutrition & Population
Financing Instrument	**Borrower(s)**	**Implementing Agency**	
Investment Project Financing	Ministre de l`Economie et de la Planification du Developement	Ministry of Health	

Proposed Development Objective(s)

The Project Development Objective is to improve the service delivery of essential health services in project-supported areas

PROJECT FINANCING DATA (US$, Millions)

SUMMARY

Total Project Cost	65.00
Total Financing	65.00
of which IBRD/IDA	50.00
Financing Gap	0.00

DETAILS

World Bank Group Financing

International Development Association (IDA)	50.00
IDA Grant	50.00

Non-World Bank Group Financing

Trust Funds	15.00

Global Financing Facility	15.00

Environmental and Social Risk Classification	Concept Review Decision
Moderate	Track II-The review did authorize the preparation to continue

Other Decision (as needed)

B. Introduction and Context

Country Context

1. **Chad is a low-income country with a real GDP per capita of US$823 (2018).** Economic growth in Chad has been volatile over the last decade and its economy has been highly impacted by the changes in oil prices of 2014 and 2015. Chad's economy has historically been based on agriculture up to 2003 when the oil sector started to play a major role. After 2003, the Chadian economy became heavily dependent on oil. During the period 2005–2011, oil revenues contributed on average 30 percent of total GDP, compared to 25 percent generated by agriculture and livestock; 15 percent by trade; and 30 percent by all other sectors. Since mid-2014, the country has faced an unprecedented economic, fiscal, and social crisis, due to the drastic fall in oil prices, limited diversification of the national economy, and a limited ability to mobilize fiscal resources.

2. **Chad is a large fragile and sparsely populated country. It is a large (1 284 000 square kilometers) landlocked Central** African country. Its population is estimated to be 16 million in 2020. The Country is currently affected by a tenuous security situation resulting from conflicts and terrorist attacks by Boko Haram within and across its borders in Nigeria, the Central African Republic, Sudan, and Libya. Fragility is exacerbated by violence and tensions between communities, political and national identity conflicts, climate change and the scarcity of natural resources. The country is highly vulnerable to climate change, particularly rainfall modifications, increased desertification of arable land, droughts, and other phenomena related to extreme weather conditions. The population density is low, around 10 inhabitants per square kilometer and 47 percent of the population live in 10 percent of the country. The northern part of the country is desert, with less than 0.2 inhabitant per square kilometer and the population are mainly nomadic. The population of Chad is very young, with more than 50 percent under 15 years old with an average household size of 5.8. Sixty percent of women and 44 percent men have no education (DHS-MICS 2014-2015). The median age of marriage is 16.1 years for women against 22.8 years for men. Twenty two percent of the population live in the urban area and 78 percent in the rural area, including 3.4 percent of nomadic population. Nearly half of the population (47 percent) lives below the poverty line (World Bank, 2020) and most of the poor are in rural areas where access to services is problematic.

3. **Chad has the lowest Human Capital Index (HCI) in the world.** A child born in Chad today will be 29 percent as productive when he grows up as he could be if he enjoyed full health and complete education (World Bank, 2018). For an average country at the same income level as Chad, the Human Capital Index should be about 30 percent higher than it is presently. This weak performance is driven largely by high infant mortality rates and poor quality of health and education. An underlying driver of Chad's Human Capital (and broader development) challenges is its high population growth, weakness of its health and education systems. With a Total Fertility Rate (TFR) of 6.4 Chad is among the fastest population growing countries in the world (DHS 2014/15). Nutrition outcomes, in turn, are very poor with 32 percent of children under five being stunted (UNICEF SMART, 2019). Further, while Human Capital outcomes are poor for both boys and girls, girls are particularly vulnerable and perform lower on the HCI, particularly in terms of expected years of schooling and survival rates.

4. **Chad has one of the highest population growth rates in the world. Fertility rates are high in almost all the regions,** and most of the regions have high unmet needs for contraceptives. The share of women with satisfied contraceptive needs is much lower for women in rural areas (4.3 percent) than for women in urban areas (11.2 percent). The TFR is estimated at 6.4 children, higher in rural than in urban areas (6.8 vs. 5.4). Over one-third of adolescent girls aged 15-19-year old (36 percent) have already started her reproductive life.

5. **Civil registration and vital statistics are very weak in Chad**. Chad has one of the lowest birth registration rates in Africa. Only 12% of under-5 children were registered and only 9 % had birth certificate (DHS 2015). There are no differences in birth registration by sex, but large differences are observed by place of residence (36% in urban areas against 6% in rural areas), level of wealth (6% of children in the poorest households registered against 39% of those in the richest households) and regions (56% in N'Djamena, below 10% in eleven of the 23 provinces). There is no information on the registration of deaths and the registration of marriages. Vital statistics are not produced from the civil registration system. The registration of vital events is done on paper. There is no centralized archive of civil status documents, which are dispersed throughout the country.

6. **Chad ranks 160 out of 162 on the Gender Inequality Index (UNDP 2018).** Gender Based Violence (GBV) is highly prevalent and it is estimated that 28.6 percent of women nationwide have experienced physical or sexual violence by an intimate partner at some point in their lives (DHS 2015). In addition, according to UNICEF, Chad has the third highest prevalence rate of child marriage in the world with 67 percent of girls married before the age of 18 and 29 percent under the age of 15 (UNICEF, 2018). This situation may be exacerbated in situations of high insecurity as families may see marrying their young daughters to older men as a way to protect them and to improve access to natural and financial resources. Furthermore, wife beating is seen as justified by 73.5 percent of women and 43.5 percent of women who have experienced IPV never sought help to stop the violence and never told anyone (DHS 2015). Compared to other countries in the region, Chad has a strong national legal framework that criminalizes domestic violence and sexual harassment, although these laws are not enforced or even known to citizens in most areas of the country. There are no laws against marital rape or prohibiting sexual harassment in education or public spaces.

7. **Chad is facing, like the rest of the World, the COVID-19 outbreak which is posing additional challenges to its economy and its health system which is already weak.** The first COVID-19 case in Chad was diagnosed on March 19, 2020. As of May 15, 2020, the outbreak has resulted in an estimated 399 cases, 83 recovered and 46 deaths in the country. While many efforts are concentrated on the response to COVID-19, there is a high risk of weakening the health system and undermining the response to the other health needs of the population. The proposed project will contribute to support the health system and make it more resilient to this pandemic.

Sectoral and Institutional Context

8. **Despite the positive trend on key health outcome indicators in recent years, improvements remain slow and insufficient in relation to development targets. Further, significant inequalities in health outcomes prevail.** The life expectancy at birth in Chad was reported at 54.07 years in 2017, and the UN projects that for 2020 to be 54.35, an increase of 0.51%. The maternal mortality ratio dropped from 1,450 per 100,000 live births in 1990 to 856 in 2015 (with an SDG target of 70 for 2030), while the under-five mortality rate fell from 213 per 1,000 live births in 1990 to 131 in 2015 (with an SDG target of 25 by 2030). Child mortality rate is higher among children whose mothers have no education (140 per 1,000 live births) and among children belonging to the poorest income quintile (161 per 1,000 live births).. Similarly, under-5 mortality rates are higher in the South, especially in those regions bordering Cameroon and Central African Republic. According to 2019 SMART (Standardized Monitoring and Assessment of Relief and Transition) survey carried out by UNICEF and the Government, the global acute malnutrition among children aged 6 – 59 months increased from 11.9 percent in 2016 to 12.9 percent in 2019 while chronic malnutrition increased from the 26% in 2016 to 32.0 percent in 2019. The prevalence of severe acute malnutrition exceeds the 2 per cent emergency threshold in 15 of the 23 regions of Chad.

9. **Chad's health system is highly centralized. Decision-making is heavily concentrated at the Ministry of Health and other** national health institutions based in N'Djamena. Each region has a Regional Health Delegation (RHD) responsible for the delivery of services within its region. Each region is then subdivided into Health Districts (HD) led by a District Health Authority. There are 138 HD of which 107 are fully functional. District Health Authorities supervise health facilities, oversee referrals and monitor the performance of the health system in their districts. Even though certain functions are devolved to the regional and district level, local level authorities are impeded to perform their functions given the lack of funding reaching their level.

10. **Health service delivery follows a pyramidal structure, with a tertiary level, a secondary level and a peripheral/primary level.** The tertiary level includes the national hospitals (all in N'Djamena). The secondary level consists of Regional Hospitals (RHs) in every region and District Hospitals (DHs) in each HD. With respect to RHs, only six (26 percent) are up to standard (Sarh, Moundou, Doba, Koumra, Abeche and Bongor). The peripheral/primary level is composed of health centers, mostly present in rural areas of the country. According to the 2019 Sara Survey there are 7 national hospitals, 22 RHs, 47 DHs and 1261 health centers. Pharmaceutical procurement and distribution are managed by the Central Supply Pharmacy in N'Djamena and Regional Supply Pharmacies in each region (only 13 are functional).

11. **Private provision of health services is weak and limited to urban areas, mostly N'Djamena**. There are 25 private-for-profit hospitals and clinics and 59 private-for-profit health centers in Chad. Faith-Based Organizations (FBOs) have a larger presence, including 252 health centers.

12. **An important factor underpinning the underwhelming performance of Chad in terms of health outcomes is the poor performance of its health system.** The health systems in Chad is weak in all its six components. According to the WHO framework the health system is described in six core components or "building blocks": (i) service delivery, (ii) health workforce, (iii) health information systems, (iv) access to essential medicines, (v) financing, and (vi) leadership/governance. All this building blocks of Chad health system are weak.

(i) **In term of service delivery, health facilities have low readiness levels to deliver quality health services**. The number of health facilities in Chad is low and more than 3,000 facilities are needed to reach WHO target of two facilities per 10,000 inhabitants. Further, according to the most recent SARA survey, one in three health facilities had access to electricity and two in three had access to improved water sources. The availability of essential medical equipment (scales, thermometers, stethoscopes, etc.) and laboratory capacity were also substandard (WHO, 2019). Maintenance standards for healthcare equipment remains weak.

(ii) **In terms of health workforce, there is insufficient qualified health personnel**. in 2017 there were 9,146 health workers in Chad. The density of health personnel at the national level is estimated at 0.58 per 1000 inhabitants, far below the WHO standard of 2.3 per 1000 inhabitants. There are important disparities in the distribution of health professionals. Eighteen provinces out of 23 have a density of less than 0.6. N'Djamena has around 46 percent of the total number of health personnel while representing only 9 percent of the population of the country. There is limited evidence on the level of skills and competences from health workers. In-service training is rare and supportive supervision is not systematically used to upskill health workers.

(iii) **Access to essential medicines is challenging**. There are poor regulation of pharmaceutical sector and frequent stock outs of drugs and medical consumables due to an inefficient and ineffective supply chain which is mainly based on public monopoly and centralized planning.

(iv) **Health information systems is weak**. The routine health management information system has been highly dysfunctional. Little information was collected from the periphery level and is rarely used in planning of interventions. National Health Accounts data is not systematically produced. Efforts to modernize the Health Management Information System (HMIS) are being expanded. There are currently some initiatives by the Government and Development Partners (DPs) to reinforce the national health information system through the scale-up of DHIS2, which has started as a pilot in some regions with the support of the Swiss Cooperation. Operational data from the PBF program is published quarterly online (http://www.fbptchad.org/), and since the PBF program will be scaled-up, availability of high-quality verified data will also increase.

(v) **In term of financing, the availability, allocation and utilization of financial resources in the health sector appear to be an important factor underpinning the underwhelming performance of Chad health system.** Health financing is chronically insufficient, inefficient and highly inequitable. According to the WHO National Health Accounts database (2016), Chad's health expenditure stood at 4.5 percent of GDP while the average for SSA and Low-Income countries (LIC) stood at 5.1 percent and 5.7 percent respectively. In per capita terms, the country

only spent US$32 per capita, which is below the WHO target of USD 86 and below SSA ($82) and LIC ($35 dollars countries) targets respectively. Furthermore, health has not been sufficiently prioritized in Chad's public budget and the share of health to general government spending has declined over the last decade from over 12 percent in 2009 to less than 4 percent in 2018, well below the Abuja target of 15 percent. Only a small share of public resources reached the frontlines. Health expenditure is heavily skewed towards out-of-pocket health expenditure (OOPHE) with 61 percent of total health expenditure compared to the average of 36 percent for Sub-Saharan African. Moreover, the distribution of public health resources in Chad is not pro-poor. The poorest portion of the population receives only 6% of the total public subvention whereas the richest portion receives 46.5%. To improve equity in health access, the government extended free health care to pregnant women and children under five in 2013 (emergency care was already free since 2007), but heath facilities have not received adequate human and financial resources to implement this policy. Several allocative, technical and administrative inefficiencies are at the root of poor performance of the health system.

(vi) **In term of leadership and governance, there are limited institutional capacity, poor coordination and lack of transparency and accountability**. Several ministries (for example, Ministry of public security Army care services, Ministry of Justice with penitentiary medicine and Ministry of education with university medicine) act as health service providers and this bureaucracy affect effective government coordination and monitoring. Nevertheless, the stewardship, the technical supervision, the regulation and control of the sector are the responsibility of the Ministry of Public Health (MPH), which is also the largest service provider in the sector. There are also other departments involved in the financing and/or investments in the health field . In addition, the President also exercises leadership over the health sector, through Presidential investment programs and monthly coordination meetings with the government and stakeholders. Furthermore, there is poor coordination within the MPH. For example, it is the Finance Directorate that prepares the MPH budget. This work is not done in coordination with the Planning Directorate, who does the technical preparation of the National Health Development Plan. The lack of fiscal decentralization undermines the autonomy and accountability of the MPH. The Minister of Finance is the only authorizing officer in charge of the public expenditure circuit - from commitment to payment. Such monopoly does not allow the MPH structures to move towards relative autonomy that remains necessary for the accountability of decision-makers within the ministry. In other words, it is difficult to hold managers or decision-makers accountable for their performance/results when they have no control over a large part of their resources.

13. **The above-mentioned constraints of the health system, together with the significant geographic barriers enhanced by the poor transport infrastructure, lead to the poor quality, low utilization and low coverage of essential health services such as reproductive, maternal, neonatal and child health services and nutrition**. (i) In terms of utilization, according to the Health Statistics Yearbook, the total number of new cases (NC) reported in 2015 stand at 4,196,635, representing a rate of 0.27 NC per inhabitant with respect to curative consultation services. This is below the WHO standards of 1 NC per inhabitant in urban areas and 0.5 NC per inhabitant for rural areas. (ii) Coverage of essential health services is low, particularly among women in rural areas. Only a small fraction of women is covered by reproductive health services: 31 percent of pregnant women received at least 4 antenatal visits (ANC) from trained staff, 22 percent of women deliver in a health facility and 24 percent of deliveries are assisted by trained staff. Overall, 78 percent of women did not receive post-natal care or late care. Disparities are large between rural and urban

areas: for ANC, 57.9 percent of women in N'Djamena received at least 4 ANCs, compared to 26 percent in rural areas. Similar trends are observed for institutional deliveries and for access to postnatal care. Important drivers of these disparities relate to the lower availability of such services and the financial and geographic barriers to access in rural areas. (iii) Immunization coverage in Chad is extremely low and the coverage of essential child health services is weak. in 2017, only 22 percent of children were fully immunized before their first birthday. Counseling or treatment was sought from an institution or health provider for only 26 percent of children with symptoms of acute respiratory infection, 23 percent with fever and 25% with diarrhea. Exclusive breastfeeding for children aged 0-6 months was only performed for 7 percent of children. No significant differences in immunization coverages rates were observed between boys and girls.

14. **To respond to these challenges, the Government of Chad has developed the National Health Development Plan 2017 – 2021.** The Plan is being implemented with the support of DPs and its objectives include: (i) reducing maternal mortality; (ii) reducing morbidity and child mortality; (iii) reducing morbidity and mortality related to communicable diseases; (iv) reducing the morbidity and mortality associated with noncommunicable diseases; and (v) contributing to the achievement of Universal Health Coverage (UHC), that is, equitable access to curative, preventive, promotional and rehabilitation health services as well as protection against the financial risk related to the payment of care. There are several DPs that provide resources to the Chadian government for health to support some of these objectives. The main donors are the World Bank, AFD (France), the Swiss Cooperation, the African Development Bank, UNICEF, UNFPA, WHO, the European Commission, the Global fund, and GAVI. Activities supported are mainly input based activities related to service delivery which include: (i) Training and workshops; (ii) Supervision and evaluation; (iii) procurement of equipment and other inputs; (iv) coordination meetings; (v) and rehabilitation of infrastructures. Main area of intervention of Development partners are immunization (GAVI and UNICEF), Nutrition (European Commission and UNICEF), Mother and child health (almost all of them), Health information system (Swiss Cooperation), Development of norms and Capacity building (WHO, UNFPA), Analytical work on National health account, resources mapping and health financing strategy (AFD).

15. **To improve service delivery outcomes and to address the above-mentioned critical impediments confronting the delivery of services at frontline health facilities, the government piloted a performance-based financing (PBF) in 2011.** Instead of allocating physical and human resources (physical inputs) through central planning, a PBF approach addresses systemic challenges by allocating financial resources to frontline health facilities based on results achieved to enhance the availability, the accessibility and the quality of essential services. The PBF approach leverages existing sunken investments (building, equipment, and centrally planned human resources), vertical program investments and other resources. Moreover, it addressed health system bottlenecks in Chad by: (i) decentralizing health financing and decision making to front-line providers, thereby closing the gap between financial resources and effective service delivery; and (ii) empowering and encouraging health personnel to adopt an entrepreneurial approach aimed at increasing the use and quality of services provided. At the end of the pilot in June 2013, an evaluation showed that this approach had demonstrated its cost-effectiveness in increasing the use of services, doubling assisted delivery and immunization rates in targeted districts with less than US$1.55 spent per inhabitant.

16. **The Government of Chad further pursued the PBF model and introduced a budget line to continue PBF operations**. In 2015, the Government developed the current Mother and Child Health Services Strengthening Project (P148052) financed by the World Bank. Results of this Project have confirmed the potential of PBF to address important systemic challenges of the health system and to improve the quality and the utilization of health services in Chad.
    (i) In term service delivery, as of December 2019, the number of pregnant women who received antenatal care during a visit by a health professional increased from 48,300 to 171,046, the number of deliveries attended by qualified health personnel increased from 20,836 to 70,827, the number of children fully vaccinated increased from 15,389 to 92,604 while the facility quality score increased from 25% to 65%.
    (ii) Concerning the human resources, 65% of health facilities with PBF contract were able to recruit at least one qualified staff and pay their salary regularly in addition to performance bonus payed to all their staff. According to the government evaluation report, the civil servant in area covered by the project was stabilized, motivated to stay and no one asked to be transferred elsewhere. They came regularly to work on time, since working time was one of criteria used to share performance bonuses.
    (iii) Concerning availability of drugs, part of resources generated from PBF was used to purchase drugs. According to the Government report stock out of drugs was limited in PBF Health facilities and appeared only when district or regional wholesalers didn`t have the drugs and there was no private wholesaler to supply the concerned drugs.
    (iv) In term of financing, PBF subside provided additional resources of US$2.5 dollar per capita per year to frontline health facilities and created more transparency in financial management.
    (v) In term of Governance and leadership, the number of health facilities with bank account to receive and keep their resources moved form 30 before PBF to 184 during PBF and 100% of health facilities under PBF contract used PBF management tools called index tool to manage their health facilities in participatory and transparent manner. Each Health facility was regularly (at least once a quarter) supervised and coached by health district, or provincial delegation and verification agency on the utilization of Index tool for financial management. Coordinating meetings were held each quarter with regular monitoring of results.
    (vi) In term of Health information system, the quality of health information in project area improved in all health facilities thanks to the verification system of PBF. A dedicated PBF portal was developed to managed PBF health information.

17. **In addition to PBF, the Mother and Child Health Services Strengthening Project (P148052) has also supported the implementing of other institutional capacity building activities.** These include: (i) Training of 26 general practitioners from 15 hospitals in surgery and emergency obstetric and neonatal care, 100 maternity staff in the review of maternal deaths and emergency obstetric and neonatal care, 256 health workers in preventive maintenance of the cold chain equipment, 485 staffs in drugs management, 492 community health workers in communication skills; (ii) Development of Guideline and management tools of drugs; (iii) procurement of 155 solar refrigerators, 195 motorcycles and obstetrical equipment for health facilities, 29 vehicles for supervision. 98% and 95% of health facilities were equipped with Motorcycle and Fridge respectively.

18. **In light of this success, the Government of Chad has adopted PBF as one of the financing mechanisms for UHC and it is committed to institutionalize this approach.** During the period 2017 – 2019, a strategic plan for UHC was developed. On June 3, 2019, the National Assembly unanimously adopted the Universal Health Coverage Act, and PBF appears as one of the financing mechanisms to be scaled up to improve coverage of essential health services while protecting the population from financial hardship due to accessing needed health care.

Relationship to CPF

19. **The proposed Project is well aligned with the Chad Country Partnership Framework (CPF).** The Chad CPF for the period FY16-20 focuses on three themes of engagement: (i) strengthening management of public resources; (ii) improving returns to agriculture and building value chains; and, (iii) building human capital and reducing vulnerability. The propose project will contribute to the first and third theme and especially to its first and third objectives which are: 1.1 more effective and transparent public financial management; 3.1 to improve rural access to reproductive health services. A Systematic Country Diagnosis is currently being developed and a new CPF is expected in FY 2021.

20. **This proposed Health System Performance Strengthening Project is relevant to the Chadian development objectives for the health sector.** It will contribute to the promotion of UHC by addressing weaknesses of its health system which prevent adequate health care delivery to the population and especially to the most vulnerable in rural areas**.** The proposal responds to the request submitted by the Government of Chad, which especially identified PBF as project component for which the verification mechanism should be built in the national system, more precisely within the Inter-ministerial Unit in charge of Universal Health Coverage. The Commitment of the Government to move towards UHC, together with the GFF process, will facilitate coordination and dialogue with development partners working on these issues.

C. Proposed Development Objective(s)

The Project Development Objective is to improve the service delivery of essential health services in project-supported areas

Key Results (From PCN)

21. **Progress in the area of service delivery under the project will be measured by the following indicators:**

1) Proportion of health centers and district hospitals with a quality evaluation score of at list 75%;
2) Proportion of health centers and district hospital which offer at least 75% of basic services defined in their activity packages defined by the regulations in force;
3) Number of deliveries attended by skilled health personnel in health facilities;
4) Number of children fully immunized before their first birthday.

D. Concept Description

22. **The proposed project will focus mainly on improving the health service delivery of essential health care,** through institutional capacity building and the institutionalization of PBF, building on lessons learned from the Mother and Child Health Services Strengthening project (P148052) and from other world bank operations in Chad. The GFF Process in Chad, together with PBF and institutional capacity building will contribute to address above-mentioned challenges of the Chad`s Health system.

23. **The proposed project will scale-up the PBF model to address critical challenges faced by the health system including:** (i) the low readiness of health facilities to deliver quality health services to the population, especially at the operational level; (ii) the poor distribution of financial resources as well as allocative, technical and administrative inefficiency which result into low availability and poor utilization of resources at the frontline health facilities; (iii) the lack of decentralization of decision making, which undermines the autonomy, empowerment and accountability of health facilities, especially at the operational level; (iv) the shortage of qualified health personnel especially in rural areas; (v) the weakness of the health information system and; (vi) the low institutional regulation, poor coordination and lack of transparency and accountability at different level of the health system.

24. **The scale-up of the PBF model will be supported by the contributions from the Global Financing Facility (GFF).** Chad recently (2018) became a GFF country. The Government has put in place a Country Platform, which has participation across stakeholders and includes civil society, UN agencies, the private sector, and non-Governmental organizations (NGOs). It is in the initial stages of developing an Investment Case (IC). In light of increased fragmentation of donor support to Chad's health sector, there is substantial momentum among partners to capitalize on the opportunity presented by WB and GFF to re-establish an effective health sector coordination mechanism. Through strengthened partner coordination utilizing the GFF process, the proposed project will complement service delivery efforts currently supported by other DPs including, among others, Gavi, the Global Fund, UNICEF, UNFPA, WHO, the European Union, the French Development Agency, the Swiss Cooperation and local and international NGOs. In doing so, the task team will coordinate with DPs to reduce fragmentation and enhance development effectiveness by aligning resources around the Government's priorities. In addition, recognizing existing WB projects and other partner`s engagement in the country, the team will also seek areas of collaboration with them to avoid duplication and confusion on the ground**.**

25. **The project will also strengthen institutional capacity Building of the health systems aspects that will improve services delivery.** This include (i) the low capacity of health personnel especially in rural areas, lack of up-to-date standards and procedures standards, lack of good functional equipment which all result into poor quality of health care delivered to the population and low impact on health outcome; (ii) The weak leadership/stewardship and governance which result into poor coordination, too much centralization, confusion of roles and all kind of technical, allocative and administrative inefficiencies in the health system. This leads to the loss of resources and

misalignment of the activities of directorates at the central level to the needs of frontline providers, and finally to the poor service delivery at the operational level. (iii) The lack of good health information system which results into poor decision making without evidence. of functioning equipment; (vi) The poor regulation of the Health system, especially the drugs sector, which result into fake drugs and other input in the country with negative impact on the quality of health care and health outcomes. Performance Contracting of directorates of the ministry of health with specific deliverables for each quarter will be introduced to boost the implementation of institutional capacity building activities. This performance contracting will also facilitate, separation of roles, alignment with operational level, regular coordination and improvement of leadership and Stewardship.

26. **The proposed project will contribute to the following corporate priorities, gender-based violence, climate co-benefit and citizen engagement.** GBV and citizen engagement activities will be integrated in the project. The project will be evaluated for climate co-benefit.

27. **The proposed project will complement other World bank projects in Chad to promote synergies and to maximize impact. For example, the Sahel Women's Empowerment and Demographics Dividend (SWEDD) Project (P150080)** will complement the effort of the health project to improve the uptake of family planning and to support the reduction of high fertility rates and high child and maternal mortality rates. The scaling up of activities supported by the new health project to new regions will prioritize regions covered by SWEDD to increase synergies between the two projects where it will be possible while avoiding duplication of activities. The **Chad Refugees and Host Communities Support Project (P164748)** will collaborate with the new project to align the efforts to reach refugees and host communities with basic health services. This project has funding to support PBF activities and is ready to work with the proposed project to have a single PBF model that will be applied in the areas covered by the two projects. The identification method of poor people used by this project will be used by the proposed project to identify the poorest people who will benefit from free care in health facilities under PBF. The **REDISSE IV Project (P167817)** will co-finance the operational cost of the project implementation unit (PIU), which will manage the two projects, and the activities which will contribute to strengthen the disease surveillance and the health information system including the DHIS2. The PIU will make sure to avoid duplication and to harmonize the activities of the two projects.

28. **The proposed project will integrate important lessons learned from the implementation of Mother and Child Health Services Strengthening Project**. These include: (i) PBF has shown its potential to improve some pillars of the health system which resulted in improvement of the quality and utilization of health services in Chad. (ii) Given the extent of the needs and the limited resources, strengthening partnerships was necessary. The project has worked successfully with UN Agencies (WHO, UNICEF, UNFPA) to deliver training sessions and procure equipment for health facilities. Their performance was satisfactory for training. However, there were long delay in procurement of some equipment. Going forward, the technical assistance of UN Agency will focus on development of norms, procedure, policy document and training in RMNCAH-N. (iii) PBF contributed to improve the quality of health information thanks to its verification mechanism, which is critical for program implementation. (iv) The short period of implementation of PBF and some issues in PBF Design and verification (lack of dedicated PBF Unit in the Ministry of health, high cost of verification by an international NGO, long delay in the procurement process of the Verification Agency, no renewal of

contract of verification Agency, Absence of counter verification Agency) are some weakness to be taken care of in the new project. The Government has requested to build PBF verification mechanism of the proposed project in their own system to support their Universal health Coverage process.

29. The project will have two components:

a) **Component 1: Scaled-Up Performance-Based Financing (US$ 45 million: US$ 35 million IDA, US$ 10 million GFF TF).** The number of provinces and health districts to be covered will depend on the costing of PBF which will be done during preparation. The project will cover the 37 districts of the five (5) Provinces previously covered by Mother and Child Health Services Strengthening project. New provinces and districts to be covered under the project based on criteria to be defined with the government during the preparation. Based on lessons learned from the Mother and Child Health Services Strengthening Project, the following new features will be added to the PBF design: (i) Building of verification system in the national institution; (ii) Establishment of PBF national Unit at the Ministry of health; (iii) Adding a quality/ investment bonus and community activities to the scheme; (iv) Improving the targeting of the poorest for free health care in PBF health facilities;

b) **Component 2: Capacity building of RMNCH-N Services Delivery (US$ 20 million: US$ 15 million IDA, US$ 5 million GFF TF).** The capacity building program will include: (i) Reinforcement of Humane Resource through training in technical and managerial skills, regular supervision and coaching of health personnel and community health workers, ; (ii) Improvement of leadership and governance through Development of norms, policy documents and guideline, training in management skills, separation of functions, regular coordination meetings between different levels of the health system, evaluation of different level of the health system including financial management evaluation, Performance contracting of directorates of the ministry of health ; (iii) Improvement of health information system by supporting implementation and effective utilization of DHIS2 and IT for management of health information system, regular production of annual health statistic report and national health Account, contribution to national surveys like DHS; (iv) Support to health Care delivery by Procuring equipment and others input that cannot be procured directly by health facilities in the country and financing any other activity of the GFF investment case not yet cover in above-interventions, including immunization, nutrition and Civil Registration and Vital Statistics systems (CRVS). The Team is working closely with the Government and other partners, to make sure immunization, nutrition and CVRS activities to be supported by this project are well covered in the GFF investment Case; (v) This component will also support activities related to Gender-Based Violence and citizen engagement. The capacity building activities will be implemented with the technical support of development partners, especially the UN Agencies (WHO, UNICEF, UNFPA). The partnership with UN Agencies to provide Technical Assistance (TA) to conduct some training and capacity building of health personnel and community workers in Emergency Obstetric Care (EmoC) and Immunization during the implementation of Mother and Child Health Services Strengthening Project was satisfactory. Their performance in procurement of equipment for health facilities was moderately satisfactory due to the long delivery period.

Legal Operational Policies	Triggered?
Projects on International Waterways OP 7.50	No
Projects in Disputed Areas OP 7.60	No

Summary of Screening of Environmental and Social Risks and Impacts

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