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Report No: PAD1349

INTERNATIONAL DEVELOPMENT ASSOCIATION

PROJECT PAPER

ON A

PROPOSED ADDITIONAL GRANT

IN THE AMOUNT OF SDR 8.70 MILLION
(US$12 MILLION EQUIVALENT)

TO THE

CENTRAL AFRICAN REPUBLIC

FOR A

HEALTH SYSTEM SUPPORT PROJECT

May 4, 2015

Health, Nutrition and Population Global Practice (GHNDR)
Africa Region

CURRENCY EQUIVALENTS

(Exchange Rate Effective March 31, 2015)

Currency Unit	=	XAF
XAF 610	=	US$1
US$1	=	SDR 0.72490558

FISCAL YEAR
January 1 – December 31

ABBREVIATIONS AND ACRONYMS

AF	Additional Financing
AU	African Union
CAR	Central African Republic
CBO	Community Based Organizations
CFAF	*Communauté Financière Africaine Franc* (African Financial Community Franc)
CORDAID	Catholic Organization for Relief and Development Aid
EEA	External Evaluation Agency
FP	Family Planning
GRS	Grievance Redress Service
HIV/AIDS	Human Immunodeficiency Virus-Acquired Immunodeficiency Syndrome
HMIS	Health Management Information System
HR	Health Region
HRITF	Health Results Innovation Trust Fund
IDA	International Development Association
IDP	Internally Displaced Persons
IP	Indigenous Peoples
IPF	Investment Project Financing
IPPF	Indigenous Peoples Planning Framework
ISDS	Integrated Safeguards Data Sheet
M&E	Monitoring and Evaluation
MICS	Multi Indicator Cluster Survey
MCH	Maternal and Child Health
MDGs	Millennium Development Goals
MoHP	Ministry of Health and Population
MSF	*Médecins Sans Frontières* (Doctors Without Borders)
NGO	Non-Governmental Organization
NHDP	National Health Development Plan
NHP	National Health Policy
PBC	Performance-Based Contracting

PBF	Performance-Based Financing
PDO	Project Development Objective
PPA	Performance-based Partnership Agreements
PRSP	Poverty Reduction Strategy Paper
QBS	Quality Based Selection
QCBS	Quality and Cost Based Selection
RBF	Results Based Financing
SDR	Special Drawing Rights
TB	Tuberculosis
TF	Trust Fund
UN	United Nations
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children's Fund
WDI	World Development Indicators
WHO	World Health Organization

Regional Vice President:	Makhtar Diop
Country Director:	Gregor Binkert
Senior Global Practice Director:	Timothy G. Evans
Practice Manager / Manager:	Trina S. Haque
Task Team Leader(s):	Paul Jacob Robyn

CENTRAL AFRICAN REPUBLIC
ADDITIONAL FINANCING - HEALTH SYSTEM SUPPORT PROJECT (P153030)

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ADDITIONAL FINANCING DATA SHEET

Central African Republic

Health System Support Project Additional Financing (P153030)

AFRICA

GHNDR

Basic Information – Parent

Parent Project ID:	P119815	Original EA Category:	B - Partial Assessment
Current Closing Date:	31-Mar-2018	Current EA Category:	B - Partial Assessment

Basic Information – Additional Financing (AF)

Project ID:	P153030	Additional Financing Type (from AUS):	Scale Up
Regional Vice President:	Makhtar Diop	Proposed EA Category:	B - Partial Assessment
Country Director:	Gregor Binkert	Expected Effectiveness Date:	24-Aug-2015
Senior Global Practice Director:	Timothy Grant Evans	Expected Closing Date:	31-Mar-2019
Practice Manager/Manager:	Trina S. Haque	Report No:	PAD1349
Team Leader(s):	Paul Jacob Robyn		

Borrower

Organization Name	Contact	Title	Telephone	Email
Central African Republic	Dr Marguerite Maliavo Samba	Minister of Health and Population	23672300409	ma_samba@yahoo.fr

Project Financing Data–Parent (CF-Health System Support Project-P119815)

Key Dates

Project	Ln/Cr/TF	Status	Approval Date	Signing Date	Effectiveness Date	Original Closing Date	Revised Closing Date
P119815	IDA-51340	Effective	17-May-2012	31-Jul-2012	28-Oct-2012	31-Mar-2018	31-Mar-2018
P119815	IDA-H7840	Effective	17-May-2012	31-Jul-2012	28-Oct-2012	31-Mar-2018	31-Mar-2018
P119815	TF-13380	Effective	31-Jul-2012	31-Jul-2012	28-Oct-2012	31-Mar-2018	31-Mar-2018

Disbursements

Project	Ln/Cr/TF	Status	Currency	Original	Revised	Cancelled	Disbursed	Undisbursed	% Disbursed
P119815	IDA-51340	Effective	USD	9.35	9.35	0.00	8.06	1.08	86.20
P119815	IDA-H7840	Effective	USD	7.65	7.65	0.00	6.58	0.90	85.95
P119815	TF-13380	Effective	USD	11.20	11.20	0.00	2.11	9.09	18.80

Project Financing Data –Additional Financing Health System Support Project Additional Financing (P153030)

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

Total Project Cost:	12.00	Total Bank Financing:	12.00
Financing Gap:	0.00		

Financing Source – Additional Financing (AF)	Amount
BORROWER/RECIPIENT	0.00
International Development Association (IDA)	12.00
Total	12.00

Policy Waivers

Does the project depart from the CAS in content or in other significant respects?	No
Explanation	
Does the project require any policy waiver(s)?	No
Explanation	

Team Composition

Bank Staff

Name	Role	Title	Specialization	Unit
Paul Jacob Robyn	Team Leader (ADM Responsible)	Health Specialist	Public Health	GHNDR
Haoussia Tchaoussala	Procurement Specialist	Procurement Specialist	Procurement	GGODR

Enagnon Ernest Eric Adda	Financial Management Specialist	Senior Financial Management Specialist	Financial Management	GGODR
Aissatou Diallo	Team Member	Senior Finance Officer	Finance	WFALA
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Jean Claude Taptue Fotso	Team Member	Consultant	Public Health	GHNDR
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Siobhan McInerney-Lankford	Counsel	Senior Counsel	Counsel	LEGAM
Tazeem Mawji	Team Member	Consultant	Operations	GHNDR
Jean Owino	Team Member	Finance Officer	Finance	WFALA

Extended Team

Name	Title	Location

Locations

Country	First Administrative Division	Location	Planned	Actual	Comments
Central African Republic	Region 2	Baboua			
Central African Republic	Region 2	Berberati			
Central African Republic	Region 2	Bouar			
Central African Republic	Region 2	Sangha-Mbaere			

Central African Republic	Region 3	Bozoum			
Central African Republic	Region 3	Paoua			
Central African Republic	Region 4	Sibut/Kemo			
Central African Republic	Region 4	Bambari			
Central African Republic	Region 5	Ndélé			
Central African Republic	Region 6	Alindao			
Central African Republic	Region 6	Mobaye			
Central African Republic	Region 6	Kembe			

Institutional Data

Parent (CF-Health System Support Project-P119815)

Practice Area / Cross Cutting Solution Area

Health, Nutrition & Population

Cross Cutting Areas

[ ] Climate Change

[ ] Fragile, Conflict & Violence

[ ] Gender

[ ] Jobs

[ ] Public Private Partnership

Sectors / Climate Change

Sector (Maximum 5 and total % must equal 100)

Major Sector	Sector	%	Adaptation Co-benefits %	Mitigation Co-benefits %
Health and other social services	Health	91		
Public Administration, Law, and Justice	Public administration-Health	9		
Total		100		

Themes

Theme (Maximum 5 and total % must equal 100)

Major theme	Theme	%
Rural development	Rural services and infrastructure	25
Human development	Health system performance	25
Human development	Population and reproductive health	20
Human development	Child health	20
Human development	Other communicable diseases	10
Total		100

Additional Financing Health System Support Project Additional Financing (P153030)

Practice Area / Cross Cutting Solution Area

Health, Nutrition & Population

Cross Cutting Areas

[ ] Climate Change

[X] Fragile, Conflict & Violence

[ ] Gender

[ ] Jobs

[ ] Public Private Partnership

Sectors / Climate Change

Sector (Maximum 5 and total % must equal 100)

Major Sector	Sector	%	Adaptation Co-benefits %	Mitigation Co-benefits %
Health and other social services	Health	91		
Public Administration, Law, and Justice	Public administration-Health	9		

Total	100

☒ I certify that there are no Adaptation and Mitigation Climate Change Co-benefits information applicable to this project.

Themes

Theme (Maximum 5 and total % must equal 100)

Major theme	Theme	%
Rural development	Rural services and infrastructure	25
Human development	Health system performance	25
Human development	Population and reproductive health	20
Human development	Child health	20
Human development	Other communicable diseases	10
Total		100

I. Introduction

1. This Project Paper seeks the approval of the Executive Directors to provide an Additional Financing (AF) grant in the amount of SDR 8.70 million (US$12.0 million equivalent) to the Central African Republic Health System Support Project (HSSP; P119815), and a restructuring of the project. The HSSP is a SDR 6.05 million (US$9.35 million equivalent) IDA Credit (IDA-51340) and SDR 4.95 million (US$7.65 million equivalent) IDA Grant (IDA-H7840) co-financed by a US$11.2 million Grant from the Multi-Donor Trust Fund for Health Results Innovation (HRITF) (TF013380). The IDA Credit and IDA Grant were approved on May 17, 2012 and the HRITF Trust Fund was approved on July 31, 2012. The closing date of the original project is March 31, 2018. The HSSP was restructured on April 2, 2014 to support the government to address the emergency health situation in Central African Republic (CAR). As of March 2, 2015, eighty-six percent of the IDA credit, eighty-six percent of the IDA grant and nineteen percent of the Trust Fund proceeds have been disbursed.

2. The proposed AF would reorient interventions under the Health System Support Project towards rebuilding the health system and strengthening health service delivery in CAR. This will be achieved through Performance-Based Contracting (PBC) for implementation of a combination of Performance-Based Financing (PBF) and other interventions to rebuild the health system and reinforce the delivery of essential health services. The AF will:

(a) Support the scaling-up of results-based interventions for the strengthening of health service delivery in areas affected by the socio-political crisis through Performance-Based Contracting under Component 1 of the project;

(b) Strengthen the capacity of the Ministry of Health and Population (MoHP) in the delivery of maternal and child health services and monitoring and evaluation (M&E) systems under Component 2 of the project; and

(c) Support the provision of emergency health services to the population affected by the crisis, including internally displaced persons (IDPs) and vulnerable groups under Component 3 of the project.

3. The Project Development Objectives (PDO) remain unchanged and are to: (a) increase utilization and improve the quality of maternal and child health services in targeted rural areas of the Recipient's territory; and (b) provide emergency health services to the general population. An additional PDO indicator was added to capture results related to improvements in quality of care (Average score of the quality of care checklist). The one PDO outcome indicator that was added during the restructuring remains applicable for the AF (Number of women victims of violence supported by social and medical health providers). Due to the loss of over one year of project implementation time due to the crisis, the closing date of March 31, 2018 will be extended to March 31, 2019 to allow for more time for implementation of the project's activities. The targets for PDO and Intermediate Outcome Indicators have been updated to reflect changes in the closing date, the revised target population, and progress that has already been achieved under Component 3.

4. Along with other development partners, through the AF the HSSP aims to transition from emergency relief towards system strengthening interventions that will not only provide immediate support for the provision of maternal and child health services in areas affected by the crisis (provision of drugs, equipment, staffing and rehabilitation of health structures), but also provide investments in the health sector that would lead to long-term improvements in results (through PBC and PBF).

II. Background and Rationale for Additional Financing in the amount of US$12.0 million equivalent

A. Background

5. Originally intended to strengthen the health system through the introduction of PBF, the rollout of PBF was put on hold due to the socio-political crisis that began in December 2012. The project was restructured in April 2014 to respond to the socio-political crisis by providing support for the provision of emergency relief health services. The AF would introduce Performance-Based Contracting of NGOs to reorient interventions under the Health System Support Project towards rebuilding the health system and strengthening health service delivery. This will be done through a combination of Performance-Based Financing (PBF) and input-based interventions to rebuild the health system and reinforce the delivery of essential health services, as per the original project design approved in 2012.

6. The HSSP was restructured on April 2, 2014 to support the government to address the emergency situation in CAR. The changes included: (i) changing the PDO to expand the scope of the Project and of targeted beneficiaries in order to provide emergency health services in the Recipient's territory; (ii) adding a new component (Component 3) to support an emergency health response in the country, and a new sub-component to Component 2 (Component 2.3) to strengthen the capacity of the Ministry of Health and Population to support the delivery of maternal and child health services; (iii) creating two new categories of expenditures and reallocating some of the project's proceeds to allow for the financing of the new component and sub-component; (iv) revising the implementation arrangements by amending the procurement plan to include contracting of UN Agencies (WHO, UNICEF and UNFPA) to deliver emergency services to the population and by changing the disbursement arrangement to use the UN advance procedures for the new component; and (v) revising the Results Framework to reflect the changes in the scope and design of the Project.

7. The Bank received a request for Additional Financing for the HSSP from the government of the Central African Republic on February 26, 2015. The AF will support (i) scaling-up of Performance-Based Contracting for the strengthening of health system delivery in areas affected by the crisis; (ii) strengthening monitoring and evaluation capacity and support project implementation; and (iii) supporting the provision of emergency health services.

8. The request is consistent with the Bank's guidelines for Additional Financing, namely: (i) the Project is rated satisfactory on both the PDO and Implementation Progress; (ii) all legal covenants have been complied with and there are no outstanding audit reports; (iii) the Project will follow the World Bank's "Guidelines for the Procurement of Goods, Works and Non-Consulting Services under IBRD Loans and IDA Credits & Grants by World Bank Borrowers"

dated January 2011 (revised July 2014) and "Guidelines: Selection and Employment of Consultants under IBRD Loans and IDA Credits & Grants by World Bank Borrowers" dated January 2011 (revised July 2014); and (iv) the Project will follow the World Bank's "Guidelines on Preventing and Combating Fraud and Corruption in Projects Financed by IBRD Loans and IDA Credits and Grants", dated October 15, 2006 (revised January 2011).

Table 1: Allocation of financing by component, original project (2012) and restructuring (2014)

	Original PAD			**FY14 Restructuring**		
Components	**IDA**	**HRITF***	**Total**	**IDA**	**HRITF***	**Total**
1. Improvement of Health Facilities Performance Through Performance-Based Financing	15.064	10.636	**25.7**	1.9	9.6	**11.5**
2. Strengthening of the Capacity of the Recipient's Ministry of Health and Population	1.936	0.564	**2.5**	2.5	0.6	**3.1**
3. Emergency health services	0	0	**0**	12.6	1.0	**13.5**
Total	**17.0**	**11.2**	**28.2**	**17.0**	**11.2**	**28.2**

*Health Results Innovation Trust Fund

9. **The proposed Additional Financing meets the requirements of the Operational Policy (OP) 7.30, paragraph 5.** The following key developments were considered: (a) previous transition authorities were replaced in March 2014, and the new authorities have a more inclusive and technocratic profile; (b) there is stronger political backing from the international community to the new authorities, including at the African Union and United Nations (UN) level; in particular, the transition government is backed by the international community under the provision of the UN Security Resolution 2149 of April 2014 and has the legal authority to organize the August 2015 elections, in which transition leaders will not participate; (c) there is a significantly reinforced and diversified presence of stabilization forces under the UN Security Council umbrella; and (d) there is a strong mobilization by the donor community to help the transition move ahead.

10. This combination of circumstances enhances the potential of the new transition authorities to exercise effective control of the country, and to enjoy a degree of stability and public acceptance. Conversely, the lack of Bank support and other development partner support for the ongoing re-establishment of a visible functioning state could jeopardize the fragile gains recently achieved by the transition authorities in terms of stabilization and security. Based on the foregoing, the circumstances related to the five criteria that need to be weighed under OP 7.30 in respect of new operations are deemed to be met with respect to this Additional Financing.

B. Country and Sectoral Context

11. The Central African Republic is a land-locked country with an estimated population of 4.6 million (2013), and has an average per capita gross domestic product (GDP) of approximately US$333 (2013). Prior to the socio-political crisis that began in late 2012, sixty-

two percent of the population lived in poverty, and over three-fifths of the population subsisted on less than US$1.25 per day.[1] Prior to the ongoing crisis, CAR had suffered from more than a decade of conflict and political instability. Unsurprisingly, the country's history has had important adverse consequences for economic growth and welfare. CAR was ranked 185th out of 187 countries in the Human Development Index in 2014.

12. The country is currently in the initial stages of exiting the socio-political crisis that began in December 2012. The instability and violence in CAR over the last two years has resulted in the substantial deterioration of the health system. This has led to a situation where the needs for health care in the country far outweigh the available supply. Low immunization coverage, lack of functional structures and qualified staff, difficulties in accessing health services and lack of monitoring and epidemiological surveillance capabilities are major risk factors for the health of the population. As stability slowly returns to the country, the government and development partners have begun to reorient health sector interventions away from emergency relief and towards actions that will rebuild the collapsed health system.

13. **Effects of the crisis on the CAR health system:** The recent crisis has had a disastrous effect on the country's health system. According to a national health facility survey (*Enquête Rapide sur l'Estimation des Besoins de Santé des Populations Affectées par la crise en République Centrafricaine* - HeRAMS) that was conducted in October 2014 and covered 815 health structures in the 7 health regions of the country, 28 percent of health facilities were either partially or totally destroyed. There are variations across regions, with only 7 percent of facilities partially or totally destroyed in Health Region (HR) 1, while 46 percent fall into these categories in Health Region 3. At the national level, only 55 percent of health facilities are functional, varying from 24 percent in Health Region 3 to 75 percent in Health Region 2. Only 25 percent of health facilities have an energy source, while only 21 percent have a potable water source.

14. The level of service delivery, particularly for maternal and child health, varies substantially by region. At the national level, 51 percent of facilities currently offer family planning services, varying from 76 percent in HR4 to 21 percent in HR3. For prenatal care, coverage at the facility level ranges from 85 percent in HR6 to 24 percent in HR3. Trends are similar for other maternal and child health (MCH) services such as deliveries, post-natal care, and obstetric and neonatal care. The availability of vaccination services remains remarkably low, varying from less than 25 percent in Health Region 3, to over 75 percent in Region 1. According to the HeRAMS, the main causes for the unavailability of services are the lack of qualified personnel and the lack of training, followed by lack of inputs, equipment, and financing.

Table 2: Proportion of functional health facilities in CAR, by Health Region (HR)

	Functional	Non-functional	Partially functional
HR1	61.1%	22.1%	16.8%
HR2	74.7%	24.0%	1.4%
HR3	24.4%	51.7%	23.9%
HR4	57.0%	30.4%	12.7%

[1] World Bank, *World Development Indicators* (Washington, DC: 2010).

HR5	55.2%	17.9%	26.9%
HR6	59.3%	35.0%	5.7%
HR7	72.7%	21.2%	6.1%
National	55.2%	31.4%	13.5%

Source: HeRAMS, 2014

Table 3: Percentage of health facilities offering maternal and child health services in CAR, by Health Region (HR)

Services	HR1 (%)	HR2 (%)	HR3 (%)	HR4 (%)	HR5 (%)	HR6 (%)	HR7 (%)	National (%)
Family planning	**53.3**	**75.5**	**20.8**	**76.0**	**37.0**	**44.4**	**65.7**	**51.0**
Prenatal care	**77.8**	**80.9**	**24.4**	**83.5**	**51.2**	**84.8**	**75.2**	**69.1**
Normal delivery	**67.0**	**80.8**	**97.6**	**90.7**	**98**	**94.8**	**69.2**	**84.8**
Newborn essential care	**76.4**	**83.3**	**97.6**	**92.3**	**89.5**	**89.5**	**73.1**	**86.0**
Basic emergency obstetrical care	**56.9**	**86.7**	**97.6**	**80.9**	**35.7**	**68.4**	**76.2**	**73.6**
Complete emergency obstetrical care	**68.8**	**75.1**	**81.8**	**58.3**	**11.8**	**23.8**	**54.5**	**50.0**
Postnatal care	**69.5**	**75.9**	**18.7**	**86.8**	**88.6**	**89.7**	**86.1**	**70.9**
Assistance for abortion	**53.3**	**78**	**43.9**	**56.7**	**90**	**37.3**	**57.1**	**57.1**

Source: HeRAMS, 2014

C. Opportunities from Successful Implementation

15. The emergency response in the health sector has led to a multitude of humanitarian and aid organizations providing support to health facilities across the country. Currently, 44 percent of health facilities receive substantial support from these partners. Under Component 3 of the restructured Health System Support Project, US$14.5 million was transferred to UNICEF, WHO & UNFPA in mid-2014 for emergency needs in the health sector. Disbursement is currently at approximately 60 percent for UNFPA and WHO, and 85 percent for UNICEF. These contracts and emergency support financed by the project end on June 30, 2015.

16. Through Component 3 of the Health System Support Project, approximately 150 health facilities are currently receiving support from UNICEF, UNFPA and WHO. Specifically, UNICEF is distributing cold chain material for vaccinations, nutrition supplies, mosquito nets, obstetric and essential drug kits for maternal and child health and for HIV/AIDS treatment; teams are undergoing training to deliver services to rural and urban areas focusing on internally displaced populations. UNFPA is providing medical supplies and hygienic kits for reproductive health services, with particular attention to the provision of emergency services (psycho, medical and legal) to victims of sexual and other gender-based violence. WHO is focusing on maintaining the functionality of five priority hospitals and sixty health centers identified by the Government in both Bangui and rural areas, by restoring the infrastructure, providing equipment and providing subsidies to staff who work in these targeted facilities. An additional transfer of

US$2 million was made to UNICEF to address the shortage of anti-malarial drugs for the entire country.

17. Since beginning activities on the ground in July 2014, significant results have been achieved by the activities financed under Component 3. The availability of qualified staff, essential drugs, medical material and equipment has increased in the project zone. Statistics from quarterly reports provided by the UN Agencies (compiled by the Ministry of Health and Population during monthly coordination meetings) show a positive increase in the utilization of emergency and maternal and child health services. These results are reflected in the Results Framework of the project that show increasing trends in the delivery of outpatient, immunization, delivery, antenatal, nutritional and sexual and gender based violence services.

18. In addition to the contracts with UN agencies, the restructured HSSP is providing institutional support to the MoHP during the crisis phase under sub-component 2.3: Strengthening capacity of the Ministry of Health and Population to support the delivery of MCH services. This sub-component provides support to the MoHP in ensuring basic functions are available such as monitoring, surveillance of epidemic cases, training of staff, evaluation of the evolving needs of the population, organization of the supervision of health services, and in equipping key MoHP services with computers, printers, basic office supplies, cars, and motorbikes, as the Ministry was vandalized and robbed during the crisis.

19. **Rebuilding the health system in the post-crisis period:** As the country slowly emerges from the crisis, development partners have begun to implement initiatives that aim to rebuild the health system. All health sector actors are organized with a "Health Cluster" under WHO leadership. The Cluster meets regularly and has been effective in information sharing and coordination of relief efforts between actors. Several of these interventions will finance their support through Results-Based Financing. The Global Fund is using Results-Based Financing to expand support for HIV/AIDS across the country, alongside institutional support for the health management information system. The European Union is providing substantial support through the Bekou Fund (a special EU trust fund to support the rebuilding of national systems in the post-crisis phase), under which PBF will be expanded in Regions 3 and 6. In addition, the NGO Cordaid will continue to implement PBF in Region 2 through its own support, as they have done since 2009. Currently three Performance Purchasing Agencies for PBF are functioning across the country, one each in Regions 2, 3 and 6.

20. While efforts have been coordinated among partners to provide support to as much of the population as possible, there remain substantial geographic gaps in support. Along with other development partners, through the AF the HSSP aims to transition from emergency relief towards system strengthening interventions that will not only provide immediate support for the provision of maternal and child health services in areas affected by the crisis (provision of drugs, equipment, staffing and rehabilitation of health structures), but also provide investments in the sector that lead to long-term improvements in health sector results (through PBF).

21. As previously done in similar contexts such as Afghanistan in the early 2000s, PBC will be used to establish Performance-based Partnership Agreements (PPA) with NGOs to develop context-appropriate approaches for the implementation of PBF in specific geographic zones. Under this approach, the MoHP will specify a package of health services which the contracted

NGO will be responsible for delivering through a combination of PBF and other investments to strengthen health service delivery in a specific geographical location (by region). The performance of the NGO will be judged against progress on specific, measurable indicators that will be evaluated regularly. PBC will be used as a transitional strategy in the post-crisis phase to orient the health system towards a financing approach that is results-based, while taking into consideration that substantial investments will need to be combined with PBF to address the current challenges. In time and as needs change, the strategy may be revised so that financing will be purely based on performance.

22. While the original project budgeted support through PBF at approximately US$2-3 per capita per year, it is expected that due to the current needs of the health system, additional resources will be required to be effective in the post-crisis context. As such, the new intervention will provide support at US$5-6 per capita per year for 2.5 years of implementation. The scope of interventions applied to improve service delivery outcomes will be broadened to not only include PBF (as per the original project design) but also investments in equipment, materials, recruitment and training of human resources, and basic rehabilitation of health facilities. Due to the increased per capita investment and reduction in available resources for Component 1, the new target population will be approximately 1.6 million inhabitants, a reduction from the original target population of 2.5 million inhabitants.

23. While eighty-six percent of IDA financing has been disbursed to support the provision of emergency health services, eighty-two percent of the US$11.2 million from the HRITF remains for support to the scale-up of results-based interventions (PBC and PBF) in the Central African Republic. The Additional Financing of US$12 million will be used to replenish the IDA commitments that are to match the available HRITF funds for scaling-up PBF in targeted areas that are not currently being supported by other partners.

D. Higher Level Objectives to which the Project Contributes

24. The overall objective of the project is to improve the availability and quality of health services in regions of the country affected by the crisis that are receiving limited or no support in the health sector. The proposed changes will support the long term objectives of rebuilding the health system and of reducing maternal and child mortality and child malnutrition, thereby contribute to the attainment of the Millennium Development Goals (MDGs) 1c, 4 and 5. Thus, the AF will contribute to the Health, Nutrition and Population Global Practice goal of ending preventable deaths and disability through Universal Health Coverage. Better health and nutrition status improves human capital and produces more productive individuals who are better off economically. In addition, this project will be implemented in areas of the country that have been severely affected by the crisis and which need significant support in improving the availability of health services – improving health and development outcomes of at-risk and vulnerable populations, thereby, contributing to the Bank's twin goals of eliminating extreme poverty and boosting shared prosperity.

25. Prior to the current crisis, CAR was in dire need of more investment in health, especially in maternal, child and reproductive health, in order to make significant progress toward the MDGs. In the post-conflict period, the International Development Association's engagement in

the health sector is even more critical in responding to the needs of CAR's health system. The health situation in CAR remains grim.

26. The proposed AF is aligned well with CAR's Poverty Reduction Strategy Paper (PRSP) and with CAR's National Health Development Plan (NHDP/PNDS II) and the National Health Policy (NHP). The AF is in alignment with other partners' interventions in rebuilding the country's health system, and is expected to contribute to strengthening and extending the delivery of maternal and child health services, and thereby contributing to the achievement of MDGs 4 and 5 to reduce under-five mortality and improve maternal health. In so doing, the project will contribute to an increase in access to basic social services and will strengthen human capital, which is a specific long-term objective outlined in the PRSP. The proposed AF also directly focuses on promoting partnerships with the private non-profit sector and seeks to create a conducive environment to improve health by strengthening management capacity. Both of these are priorities outlined in the NHP and NHDP**.**

27. The activities financed by the Health System Support Project and its proposed Additional Financing are aligned with the ongoing Emergency Public Services Response Project (and its proposed Additional Financing). Since becoming effective in May 2014, the project finances the re-establishment of an operational government payroll and related financial management systems, including the payment of salaries of civil servants working in the health sector (public sector health care providers and administrative personnel). The two projects together support the functioning of the health system by ensuring that through the Public Services Response Project, base salaries are paid on time, and through PBF that essential resources are made available to providers based on results achieved.

28. Client interest in the proposed Additional Financing is high. Since 2011, the Ministry of Health and Population requested the World Bank to help sustain the development and expand the implementation of PBF in the health sector. While the scope of the proposed intervention has changed due to the crisis and a combination of PBF and input-financing will be implemented through performance contracts with NGOs, much of the technical groundwork for PBF has already been laid at the leadership level, with a draft national PBF manual in existence since 2012. During the original project's preparation phase, several workshops were jointly organized by the MOH in collaboration with key development partners, defining the road map for the rollout of PBF in CAR. This included the creation of a national technical unit that would oversee the coordination of various initiatives related to PBF as well as the preparation of the World Bank's PBF operation. In March 2015 government staff participated in a two-week regional course on PBF where they worked with international experts on the redesigning of PBF and introduction of PBC in the specific post-crisis context of CAR. The Bank's proposed interventions in PBF would complement the existing efforts of technical partners such as the Global Fund and Cordaid.

III. Proposed Changes

Summary of Proposed Changes

The proposed Additional Financing would help finance the costs associated with introducing results-based interventions that will contribute to the strengthening of Central African Republic's health system in the

post-crisis period. The AF will:

a. Through Performance-Based Contracting, introduce a combination of immediate support for the provision of maternal and child health services in areas affected by the crisis (provision of drugs, equipment, staffing and rehabilitation of health structures) and Performance-Based Financing for the strengthening of health system delivery under Component 1;

b. Strengthen monitoring and evaluation capacity through the creation of an independent External Evaluation Agency for verification of results achieved through the PBC approach and support the project implementation unit under Component 2; and

c. Support the provision of emergency health services under Component 3.

The PDO remains unchanged and is to: (a) increase utilization and improve the quality of maternal and child health services in targeted rural areas of the Recipient's territory; and (b) provide emergency health services to the general population. As the one PDO outcome indicator that was added during the restructuring remains applicable for the AF (Number of women victims of violence supported by social and medical health providers), the PDO-level indicators will remain the same.

The current project is providing emergency health services in regions affected by the socio-political crisis. Through PBC, the proposed AF would provide support to unassisted zones in the original four target regions through a package of interventions that combine PBF alongside the provision of key inputs, drugs, staffing and infrastructure investments. Due to the increased per capita investment and reduction in available resources for Component 1, the new target population will be approximately 1.6 million inhabitants, a reduction from the original target population of 2.5 million inhabitants.

Change in Implementing Agency	Yes [ ] No [X]
Change in Project's Development Objectives	Yes [ ] No [X]
Change in Results Framework	Yes [X] No [ ]
Change in Safeguard Policies Triggered	Yes [ ] No [X]
Change of EA category	Yes [ ] No [X]
Other Changes to Safeguards	Yes [ ] No [X]
Change in Legal Covenants	Yes [ ] No [X]
Change in Loan Closing Date(s)	Yes [ ] No [X]
Cancellations Proposed	Yes [ ] No [X]
Change in Disbursement Arrangements	Yes [ ] No [X]
Reallocation between Disbursement Categories	Yes [ ] No [X]
Change in Disbursement Estimates	Yes [X] No [ ]
Change to Components and Cost	Yes [X] No [ ]

Change in Institutional Arrangements	Yes [X] No [ ]
Change in Financial Management	Yes [ ] No [X]
Change in Procurement	Yes [ ] No [X]
Change in Implementation Schedule	Yes [ ] No [X]
Other Change(s)	Yes [ ] No [X]

Development Objective/Results

Project's Development Objectives

Original PDO

The development objective is to increase utilization and improve the quality of maternal and child health services in targeted rural areas of Central African Republic.

Current PDO

The revised project development objectives are to: (a) increase utilization and improve the quality of maternal and child health services in targeted rural areas of the Recipient's territory; and (b) provide emergency health services to the general population.

Change in Results Framework

Explanation:

The PDO was revised during the 2014 restructuring to include "and (b) provide emergency health services to the general population." For this Additional Financing, the PDO remains unchanged from the PDO approved during the 2014 restructuring. An additional PDO indicator was added to capture results related to improvements in quality of care (Average score of the quality of care checklist). The one PDO outcome indicator that was added during the restructuring remains applicable for the AF (Number of women victims of violence supported by social and medical health providers).

The indicator related to intermittent preventive treatment for malaria during last pregnancy (Proportion of mothers in the project areas who received two doses of intermittent preventive treatment for malaria during last pregnancy) was changed from proportion to number, as the high mobility of the population and difficulties in estimating target populations make it challenging to estimate proportions.

In addition, two new intermediate outcome indicators have been added to monitor results related to monitoring and evaluation and reinforcement of the health management information system (HMIS):
(i) Number of health personnel trained in HMIS (number); and
(ii) Number of health facilities submitting complete monthly HMIS reports (number);

Targets of the original indicators have also been adjusted to reflect the change in activities financed by the project. The amended Results Framework is shown in Annex 1.

Compliance

Covenants - Additional Financing (Health System Support Project Additional Financing - P153030)

Source of Funds	Finance Agreement Reference	Description of Covenants	Date Due	Recurrent	Frequency	Action

IDA	Schedule 2, Section I.G	Under Part B.2 of the Project, the Recipient shall, no later than nine (9) months after the Effective Date, engage in accordance with the provisions of Section III of Schedule 2 and thereafter maintain, an EEA whose terms of reference, qualifications and experience shall be satisfactory to the Association, to monitor, evaluate and report on Part A(1) of the Project, and to conduct independent verifications of the delivery of Technical Support Packages and MCH Packages by each Health Service Provider under its respective MCH Sub-project, including through interviews with consumers of Technical Support Packages and MCH Packages and inspections of the Health Service Provider's documentation and facilities.	Nine months after effectiveness	☐	Once	New

Conditions

Source Of Fund	Name	Type
IDA	Amendment of HRITF Grant Agreement	Effectiveness

Description of Condition

ARTICLE IV. 4.01: The amendment of the Co-financing Agreement to be consistent with the terms of this Financing has been executed by the parties thereto.

Risk

Risk Category	Rating (H, S, M, L)

1. Political and Governance	High
2. Macroeconomic	Substantial
3. Sector Strategies and Policies	High
4. Technical Design of Project or Program	Moderate
5. Institutional Capacity for Implementation and Sustainability	High
6. Fiduciary	Substantial
7. Environment and Social	Low
8. Stakeholders	Moderate
9. Other	
OVERALL	Substantial

Finance

Loan Closing Date - Additional Financing (Health System Support Project Additional Financing - P153030)

Source of Funds	Proposed Additional Financing Loan Closing Date
IDA Grant from CRW	31-Mar-2019

Change in Disbursement Estimates (including all sources of Financing)

Explanation:

Under the Additional Financing, although Component 3 will remain under the AF, the expected disbursements for emergency support provided by UN Agencies will be substantially reduced, and the focus will be reoriented under Component 1 to provide support through Performance-Based Contracting to unassisted zones in five regions of the country (Region 2, 3, 4, 5 and 6) through a package of interventions that combine PBF alongside the provision of key inputs, drugs, staffing and infrastructure investments.

Expected Disbursements (in USD Million)(including all Sources of Financing)[2]

Fiscal Year	2016	2017	2018	2019
Annual	5.00	6.00	7.00	5.07
Cumulative	5.00	11.00	18.00	23.07

Allocations - Additional Financing (Health System Support Project Additional Financing - P153030)

Source of Fund	Currency	Category of Expenditure	Allocation	Disbursement %(Type Total)
			Proposed	Proposed
IDA	XDR	(1) Goods, non-consulting services, consultants' services, Training and Operating Costs in Packages required for each MCH	4,300,000	100% of amounts paid by the Recipient under the MCH Sub-grant

[2] Including undisbursed balance of HRITF Original Financing

		Subproject provided under each Technical Support Package and MCH Package and to be financed out of a MCH Sub-grant under Part A(1) of the Project and paid at the Unit Price for said MCH Package		
IDA	XDR	(2) Goods, non-consulting services, consultants' services, Training and Operating Costs for Part A(2) of the Project	2,200,000	100%
IDA	XDR	(3) Goods, non-consulting services, consultants' services, minor works, Training and Operating Costs for Parts B and C B of the Project	2,200,000	100%
		Total:	8,700,000	

Components

Change to Components and Cost

Explanation:

The Additional Financing will support (i) scaling-up of results-based interventions such as PBC and PBF for the strengthening of health system delivery in areas affected by the crisis; (ii) strengthening monitoring and evaluation capacity and support project implementation unit; and (iii) the provision of emergency health services.

Component 1: Improvement of Health Facilities Performance Through Performance-Based Financing
- Provision of Performance-Based Financing
- Support to the implementation and supervision of Performance-Based Financing

Component 2: Strengthening of the Capacity of the Recipient's Ministry of Health and Population
- Strengthening Project monitoring and evaluation
- Support for Project implementation and coordination
- Strengthening the capacity of the MOHP in monitoring and evaluation and in the delivery of MCH services

Component 3: Emergency Health Services
- Provision of emergency health services

COMPONENT 1: Improvement of Health Facilities Performance Through Performance-Based Financing

(US$9.0 million equivalent IDA Additional Financing): Under the original project design, the HSSP was supposed to introduce PBF across nine prefectures in Regions 2, 3, 4 and 6 to cover a total population of 2.3 million. Several of these prefectures are either now supported by other partners or are currently inaccessible due to the security situation, while other zones in these regions remain without assistance. At the time of preparing the original project, the country's health system did not face the same needs in pharmaceuticals, equipment, and personnel, as it does in the post-crisis period.

As such, the Additional Financing would provide support to unassisted zones in the original four target regions plus targeted zones in Region 5 through a package of interventions that combine PBF alongside the provision of key inputs, drugs, staffing and infrastructure investments.

COMPONENT 2: Strengthening of the Capacity of the Recipient's Ministry of Health and Population (US$2.5 million equivalent IDA Additional Financing): Prior to the crisis, the health sector's health management information system was very fragmented, and the data generated remained unreliable. The crisis has crippled the routine monitoring system even further. The main causes of the current weaknesses are a lack of health personnel trained in routine reporting, and a lack of equipment to make the national system work. Component 2 will therefore support the overall health information system in the country, as well as supporting external verification of PBF-financed services and results of contracted NGOs through health facility and community-based surveys. These verification activities will be conducted by an independent third party. The independent External Evaluation Agency (EEA) will be contracted by the Ministry of Health and Population. The EEA's roles will include ex-post fact verification of service volumes and quality delivered by health facilities contracted with the PPA and for which PBF payments have been made. The EEA will also be tasked with building in-country monitoring and evaluation capacity. Component 2 will also cover the operating costs of the PIU and National PBF Technical Unit, including financing goods, consultant services, some training, and other operating costs, as well as strengthening capacity of the Ministry of Health and Population to support the delivery of MCH services (sub-Component 2.3).

COMPONENT 3: Emergency Health Services (US$0.5 million equivalent IDA Additional Financing): Component 3 will be used to continue to support the provision of emergency health services to the population affected by the crisis, including IDPs and vulnerable groups (mother and children), through contracting with UN Agencies and NGOs.

Below is the proposed cost allocation of the Additional Financing per component:

Current Component Name	**Proposed Component Name**	**Current Cost (US$M)**	**Proposed Cost (US$M)**	**Action**
Component 1: Improvement of health facilities performance through Performance-Based Financing	Component 1: Improvement of Health Facilities Performance Through Performance-Based Financing	11.60	20.60	Revised
Component 2. : Strengthen monitoring and evaluation capacity and support project implementation unit	Component 2. : Strengthening of the Capacity of the Recipient's Ministry of Health and Population	3.10	5.60	Revised
Component 3:	Component 3:	13.50	14.00	Revised

Emergency health services	Emergency health services			
	Total:	28.20	40.20	

Other Change(s)

Implementing Agency Name	Type	Action

Change in Institutional Arrangements

Explanation:

The implementation arrangements for the AF will undergo changes from the restructured project and will now reflect more the institutional arrangements under the original project design. At the Central level, the Ministry of Health and Population will continue to implement the project through the project implementation unit and National RBF Technical Unit.

Under the institutional arrangements of the original project, a private Performance Purchasing Agency (PPA) was to implement the PBF approach through contracting with individual health facilities to provide Maternal Child Health (MCH) services to the population in four of the seven regions. Such arrangements could no longer be applied during the emergency period because: (i) health workers were not available in the health facilities; (ii) the private sector PPA would not be able to carry out its activities given the crisis situation in the country; and (iii) the World Bank team was not able to provide implementation support to the project on the ground. As such, under the restructured project, UN agencies (WHO, UNICEF, UNFPA) were contracted on a sole source basis to provide the emergency services to the population. UN agencies were responsible for implementing component 3 and sub-component 2.3 and might rely on international organizations as they have rapidly expanded emergency relief activities to respond to the scale and severity of the crisis in CAR. The UN agencies have strengthened their presence with additional human resources contracted on a short-term basis to provide emergency services in the health sector. WHO for instance is the agency coordinating the emergency response.

The scale-up of the PBC and PBF interventions will be done through Performance-Based Contracting (PBC) to establish Performance-based Partnership Agreements (PPA) with NGOs to develop context-appropriate approaches for the implementation of PBF in specific geographic zones. Under this approach, the MoHP will specify a package of health services which the contracted NGO will be responsible for delivering through a combination of PBF and other investments to strengthen health service delivery in a specific geographical location (by region). The performance of the NGO will be judged against progress on specific, measurable indicators that will be evaluated regularly.

In addition, as per the original project design, the MoHP will recruit an independent External Evaluation Agency. The EEA's roles will include ex-post fact verification of service volumes and quality delivered by health facilities contracted with the PPA and for which PBF payments have been made. The EEA will also be tasked with building in-country monitoring and evaluation capacity.

The changes in implementation arrangements emanating from the proposed changes in activities are detailed in Annex 3.

IV. Appraisal Summary

Economic and Financial Analysis

Explanation:

The AF is expected to (i) scale-up results-based interventions for the strengthening of health service delivery in areas affected by the socio-political crisis; (ii) strengthen the capacity of the Ministry of Health and Population in the delivery of maternal and child health services; and (iii) support the provision of emergency health services to the population affected by the crisis, including IDPs and vulnerable groups. The investments have potential high development impact and are operationally efficient.

1. DEVELOPMENT IMPACT

A comprehensive economic assessment for the proposed project could not be done due to the limited up-to-date data and information available to develop a formal cost-benefit analysis. However, the operation is expected to improve the living conditions of the population through improved access to quality health care in areas affected by the socio-political crisis. Components 1 and 3 will support health service supply through the Performance-Based Contracting and Performance-Based Financing. Components 1 and 2 will strengthen the HMIS for more effectiveness in the M&E and outcomes of the health system as a whole. Project activities will likely yield other direct and indirect benefits in the short- and long-term.

1.1. Delivery of quality health care services and health system strengthening

Addressing basic maternal, child and reproductive health brings dividends in both the short- and long-term. The package of services included in the project is technically sound and consistent with the country's health strategy and Lancet's recommendation on priority, high-impact interventions to reduce child and maternal mortality rates. Life expectancy at birth in CAR has decreased between 1990 and 2013 from 51 years to 49.5 years. According to the most recent Multiple Indicators Cluster Survey made available in 2010, infant mortality remained almost unchanged at 116 deaths per 1,000 live births in 2010 from 115 per 1,000 in 2008, and under-five mortality has worsened (179 in 2010 and 173 per 1000 in 2008). These rates are substantially higher in rural areas. The maternal mortality ratio estimated at 880 deaths per 100,000 live births in 2013 remains very high[3]. Prior to the conflict, one driving factor of these poor maternal and child health outcomes was low service coverage. Less than 57 percent of health facilities offer any immunization services. It is assumed that health service coverage has decreased even further since the onset of the crisis.

Investing in reproductive health is a high-impact intervention. Evidence show that in sub-Saharan Africa, two-thirds of the disease burden for women of reproductive age is attributable to sexual and reproductive health problems. One of the most cost-effective reproductive health interventions is family planning (US$1.55 per new user per year) which can prevent up to one-third of all maternal deaths by delaying childbearing, spacing births, and avoiding unintended pregnancies. Family planning can also reduce infant mortality and morbidity through birth spacing and improved adolescent health by reducing high risks of

[3] World Development Indicators, 2014, Model estimates

pregnancy-related deaths. For every US$1 invested in family planning, the future savings are as high as US$4 in Zambia, US$7 in Bangladesh and US$8 in Indonesia[4]. The bulk of the project resources will go to maternal, reproductive and child health services supported via PBC and PBF. Hence, the returns on investment are potentially high especially when integrated with maternal and child health services in a fragile context as in this project.

1.2. Child nutrition

The AF will also target child nutrition. Evidence indicates that children under the age of 24 months who are stunted earn significantly lower incomes throughout their productive lives[5][6][7]. Thus, the benefits of reducing stunting in the project areas may contribute to increase income-earning capacity of the beneficiaries for whom stunting is prevented. The most recent empirical estimates of the negative effects of stunting on worker productivity and adult earnings range from 10 to 20 percent. In the meantime, a significant proportion of child mortality in CAR can be attributed to the poor nutritional status of children. About 23.5 percent of children under the age of five are underweight and 40.7 percent are severely stunted (MICS, 2010). Prevalence of malnutrition has been on the rise in 2013, again driven by the conflict and collapsing health system particularly among children. Child nutrition services will be targeted and supported by the PBF intervention. Economic benefits linked to child nutrition have been documented in the economic and scientific studies in many developing countries. Estimates from a number of studies in the last 20 years indicate that the economic returns of nutrition interventions rank among the highest in comparison with other developmental interventions[8]. These results are achieved by the high productivity-enhancing effects of nutrition programs. The 2008 and 2012 Copenhagen Consensus concluded that nutrition investments, notably micronutrients and community nutrition, generate returns among the highest of 30 potential development investments[9]. Investments in micronutrients were rated above those in trade liberalization, malaria and water and sanitation. Overall the benefit-cost ratios for nutrition interventions range from 5 to 200[10]. It is therefore expected that in CAR, economic return of child nutrition aspects of the program is high.

2. JUSTIFICATION FOR PUBLIC INVESTMENT

Due to the nature and the scope of the ongoing crisis in CAR, this emergency operation is an appropriate instrument to provide assistance to the most vulnerable and affected people. On account of the ongoing insecurity crisis in CAR, economic activities have significantly declined with a drop of GDP growth estimated at -36 percent. The political crisis also contributed to the price surge due to road blocks and shortages in essential supplies. Domestic resource mobilization is low, making the government highly dependent on external assistance and vulnerable to liquidity crunches. The Central African Republic currently has one of the lowest domestic revenue-to-GDP ratios in sub-Saharan Africa. At less than 12 percent of GDP, it barely covers current expenditures, limiting investment in and rehabilitation of basic infrastructures, including in the health sector. As a result, CAR is dependent on donor assistance, which

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4 D. Hughes and A. McGuire, The cost-effectiveness of family planning service provision, Journal of Public Health Medicine, Vol. 18. No. 2, pp. 189-196, 1996; (2) Gaverick Matheny, Family Planning Programs: Getting the Most for the Money, International Family Planning Perspectives, Volume 30, Number 3, September 2004

5 John Hoddinott and Agnes Quisumbing, *Methods for Microeconometric Risk and Vulnerability Assessments*, The World Bank, Social Protection Discussion Paper Series No. 0324 2003;

6 S. Gillespie and L. Haddad. *The Double Burden of Malnutrition in Asia and the Pacific*, Sage Publications, New Delhi and London

7 Sally Grantham-McGregor, Yin Bun Cheung, Santiago Cueto, Paul Glewwe, Linda Richter, Barbara Strupp, Developmental potential in the first 5 years for children in developing countries, The Lancet child development in developing countries series, 2007

8 H Alderman, J Hoddinott, B Kinsey, Long term consequences of early childhood malnutrition, Oxford economic papers, 2006; (2) Sue Horton, The case for investment in nutrition as part of global and national development agendas, University of Waterloo, World Health Forum, April 2013; (3)

9 The Copenhagen Consensus 2012 Expert Panel: www.copenhagenconsensus.com

10 Repositioning Nutrition as Central to Development: A Strategy for Large-Scale Action. World Bank, Washington, 2006

has been quite volatile. The most recent household survey was conducted in 2008; the results became available in 2009 and revealed that two-thirds of the population in CAR was living in extreme poverty. The current political and security crisis has undoubtedly worsened the situation. Moreover, prior to the crisis, the government had made a determined effort to increase public expenditures on health. In 2012, the level of per capita expenditure estimated at US$17.7 is below the African average and the lowest in the sub-region (WDI, 2014). In addition, the state contribution to the total funding for health is very low; general government expenditures on health as a percentage of total expenditures on health was 49.6 percent in 2012, while general government expenditures on health as a percentage of total government expenditures was modest at 11.1 percent, a decline from an average of 13.1 percent in 2007-2009 (WDI, 2014). The share of private expenditures, mainly out-of-pocket expenses, in total health spending continues to increase, ranging from 39.8 percent in 2008 to 45.6 percent in 2012. Donors finance the bulk of the public investment program in health with a contribution of nearly 30 percent of expenses every year. The GDP drop and poverty headcounts worsening have dramatically reduced total health expenditures that are being compensated by emergency foreign donations only to a limited extent.

The cost effectiveness and return on investment for the delivery of primary health care services and overall health system strengthening were analyzed based on core interventions that will be introduced under the AF. The bulk of these resources will go to health facilities under performance-based contracts for the delivery of packages of health services, the management and technical assistance necessary to enable them to deliver high quality health services. As such there is strong justification for financing the PBF and PBC interventions supported by the AF.

Finally, the health management and information system is critical in assuring the effectiveness of the health system through timely data and information availability. Albeit extremely weak prior to the crisis, the information is now severely weakened. Prior to the conflict, less than half of health facilities submitted monthly activity reports and the percentage of facilities doing so now has decreased even further. Vertical programs also face substantial challenges in keeping information systems running. Humanitarian organizations and UN agencies provide punctual data on the health situation of the population affected by the humanitarian crisis.

3. VALUE ADDED OF BANK'S SUPPORT

The World Bank has extensive experience with health system strengthening in conflict countries, as well as technical expertise in designing PBF programs. This experience and technical knowledge will contribute to the results achieved through the project. The health, nutritional, social and economic impact of the project should be very high since it is targeting populations living in a fragile context as well as vulnerable populations emanating from a political crisis. The restoration and strengthening of health facilities will have a positive impact on the populations of the targeted areas. The project and Bank's technical assistance will also contribute to strengthening the health system as a whole for better results delivery in areas not directly covered by the project.

4. EFFICIENCY ON IMPLEMENTATION

The AF will reorient the Health System Support Project towards its original objective, transcribed this time in Component 1, which is to improve utilization and quality of maternal and child services through PBF. Before the original project was restructured to provide emergency assistance during the crisis, the preparation phases for implementation of PBF were already well on progress: the RBF Technical Unit was created within the Ministry of Health and Population, the project implementation unit was operational, and both units were well-trained in PBF. Therefore, the incremental cost of adding activities linked to the AF is marginal. Moreover, PBF monitoring and verification tools have already been developed, benefitting from the extensive experience of the approach both within CAR and the region. A M&E system using the cloud system technology is being finalized and will be operational at the launch of PBF activities under the

Additional Financing.

Technical Analysis

Explanation:

As the country slowly emerges from the crisis, development partners have begun to implement initiatives that aim to rebuild the health system. Several of these interventions will finance their support through Results-Based Financing. The Global Fund is using Results-Based Financing to expand support for HIV/AIDS across the country, alongside institutional support for the health management information system. The European Union is providing substantial support through the Bekou Fund (a special EU trust fund to support the rebuilding of national systems in the post-crisis phase), under which PBF will be expanded in Regions 3 and 6. In addition, Cordaid will continue to implement PBF in Region 2 through its own support, as they have done since 2009. Currently three Performance Purchasing Agencies for PBF are functioning across the country, one each in Regions 2, 3 and 6.

While efforts have been coordinated among partners to provide support to as much of the population as possible, there remain substantial geographic gaps in support. Along with other development partners, through the Additional Financing the HSSP aims to transition from emergency relief towards system strengthening interventions. These interventions will not only provide immediate support for the provision of maternal and child health services in areas affected by the crisis (provision of drugs, equipment, staffing and rehabilitation of health structures), but also reinforce the health system through Performance-Based Financing, leading to improvements in quality of care through proper use of health protocols, improved supervision, provision of autonomy for health service provides, and performance management and tracking.

The project supports a package of maternal and child health interventions aimed principally at reducing child and maternal mortality in the four selected regions. The approach of investing in maternal and child health interventions is supported by both a recent World Bank study in CAR and a body of evidence, notably in a series of Lancet articles published in 2003, 2006, and 2008 as well as Cochrane collaboration reviews on interventions to reduce maternal mortality . The 2011 World Bank study identified how MCH service availability and quality have changed between 2006 and 2011 with data collected from public and nonprofit health facilities in five rural regions of CAR. Findings from the analysis suggest that even prior to the conflict, the availability of health services is quite limited and has worsened over the preceding five years. In 2011, there were only 1.5 health facilities and 0.18 doctors for every 10,000 people. Furthermore, a very small proportion of health facilities offer critical MCH and family planning (FP) services, (only 57 percent offer immunizations, 44 percent offer FP, and 26 percent offer Tuberculosis (TB) treatment), and the proportion of health facilities offering non-HIV-related services has declined between 2006 and 2011. On average, health facilities had less than 44 percent of basic delivery equipment and less than half of the cold chain equipment they are required to have as per national protocols. Clinical health workers' knowledge on MCH is very low and is a serious constraint to delivering quality services. About 40 percent of staff engaged in maternity wards in nonurban areas could not correctly list the components of prenatal care. The same proportion could not list the elements for monitoring the delivery. Worse, less than one agent in two (40 percent) know the signs to look for/monitor in pregnancy-related abnormal bleeding and less than one agent in three (30 percent) knows the signs to look for in a woman who, immediately after delivery, is bleeding profusely. These results have deteriorated even further over the past two years during the crisis period.

The design of PBF and PBC arrangements in CAR is based on the best practices observed in other successful PBF projects. For instance, external entities (such as the independent External Evaluation Agency) will be strongly involved in monitoring the performance of NGOs under PBC contracts, as well

as PBF results at the health facility level (Component 2). Similarly, as with other successful PBF programs in the region, the mechanism to determine PBF credits will be a "fee-for-service conditional on quality" system (Component 1). Such a system ensures that (i) the PBF mechanism is clear and can easily be understood by health workers and communities; and (ii) the increase in the quantity of care is not detrimental to quality.

Social Analysis

Explanation:

The instability and violence in CAR during the last two years has resulted in the collapse of the health system. This has led to a situation where the needs for health care in the country far outweigh the available supply. Low immunization coverage, lack of functional structures and qualified staff, access difficulties and lack of monitoring and epidemiological surveillance are major risk factors for the health of the CAR population.

Health needs remain acute for much of the population and the availability of quality health services has deteriorated substantially. As stability returns to the country and the number of internally displaced populations reduces, the health system needs to be strengthened at the primary and secondary care levels to ensure the availability of essential health services and basic functionality of health centers in areas affected by the crisis.

At the same time, displaced populations remain and continue to experience significant demand for drinking water (currently they tend to consume surface water unfit to drink) and sanitation (lack of latrines). In addition, women and children are particularly vulnerable to violence. As a result of the crisis, surgical emergencies related to injuries, infectious diseases (including malaria, the leading cause of consultation, as well as lower tract respiratory and waterborne diseases - diarrhea and cholera), maternal and reproductive health, as well as malnutrition are the priority issues in the health sector. In addition, destruction of property and loss of livelihoods have exacerbated vulnerabilities of an already fragile population, and the population movements have resulted in increased incidence of disease.

In order to reorient the project to a systems strengthening approach, the basic health services packages initially planned under the project, which were reoriented under the project restructuring towards priority activities that respond to the emergency context, will be reintroduced through PBC and PBF. As IDPs still exist, the project will continue to support the provision of emergency health services, albeit with a substantially reduced scope.

The ISDS has been updated to reflect the Additional Financing. The project expects to increase the production of Medical Wastes. The existing Medical Waste Management Plan prepared under the initial project will continue to be implemented but will be updated during the implementation of the Additional Financing. In addition, the AF will not be implemented in the areas where Indigenous People are located. Even though the project is not expected to have an adverse impact on indigenous peoples (IP), it was important to ensure that IPs will share project benefits. An Indigenous People Planning Framework (IPPF) was therefore prepared for the initial project. Under the Additional Financing, this IPPF will be translated in an Action Plan to be implemented.

The project is expected to have a positive social impact by improving access to health care services for vulnerable households. Component 1 (through the payment for performance) will provide incentives for health facilities to reduce staff absenteeism and to improve staff responsiveness with patients. As a result, health facilities with PBF contracts will in turn provide more and better care for marginalized populations.

The project will have a positive impact on gender in CAR. Given that the project's objectives are to improve maternal and child health in target areas, improving women's health is an essential component of the intervention. Particular attention will also be given to ensuring active participation of women in project areas through the use of community CBOs (local NGOs, women's groups, agricultural groups, etc.). The project is expected to have a positive impact not only on pregnant women but on all women, as PBF credits will improve the quality of care for the identified package of health services essential for the general population.

Environmental Analysis

Explanation:

New activities implemented would not modify the safeguard arrangements of the original project, which had triggered the Environmental Assessment policy OP4.01 due to the potential for increased medical waste and is being mitigated by a new nationally validated Health Care Waste Management Plan. The new activities to be financed under Component 1 reflect the original project design of PBF activities and thus do not trigger additional safeguards. Therefore, the proposed changes are not expected to have any significant or irreversible environmental or social impacts. The ISDS was updated to reflect the Additional Financing.

Risk

Explanation:

The overall risk continues to be rated as Substantial as indicated in the SORT. The unstable security environment provides additional risks that did not exist during the preparation phase of the original project. The original main risk related to the introduction of a new Performance-Based Financing (PBF) instrument in a relatively low capacity setting, remains relevant, however, the project's design addresses these issues by involving experienced NGOs and emphasizing training efforts at the central, regional, and local levels. In the post-crisis context, there is a risk of inefficiency and waste of resources if the actions of the development partners and humanitarian organizations engaged in CAR are not carefully coordinated between contracted NGOs and other development partners. The current shortage of skilled human resources in rural areas could inhibit smooth implementation of project activities. Furthermore, the risk of having health workers manipulating results indicators is significantly reduced through ex-ante verification by the Performance Purchasing Agencies, and ex-post verification by the independent External Evaluation Agency. In addition, given the limited number of actors with appropriate experience for PBC, PBF and external evaluation in contexts similar to CAR, there may be potential risks related to conflicts of interest between the NGOs implementing PBF and the independent External Evaluation Agency. To ensure a clear separation of functions and that appropriate regulatory frameworks are in place, the MoHP and in particular the RBF Technical Unit will play a key role in the validation of results declared by NGOs (for both PBF and non-PBF activities) and payments to providers, as well as the validity of the counter-verification of these results and estimation of performance indicators of NGOs by the PPA. Finally, weak governance including contract negotiations and management (contract award, monitoring & evaluation, fraud and corruption prevention, etc.) could result in NGO contracts that do not deliver value-for-money. The implementing agency, design, and delivery quality risks are rated as High.

The risks of delay in producing acceptable Interim Financial Reporting and non-compliance of transactions with fiduciary procedures will be mitigated by the recruitment of one qualified Financial Management Specialist and the provision of training on fiduciary procedures to the project's team. Emphasis will be maintained during implementation on the compliance with the World Bank fiduciary procedures, including transparency and accountability mechanisms.

Applying the climate and disaster risks screening tool indicates that the primary climate and geophysical hazards that may impact the project are shorter with more erratic rainy seasons in the future leading to increased opportunity for drought and instability in the target populations' livelihood stability. In the case of any potential effects of increased drought, the project will contribute to the improvement in the availability and quality of health services for the targeted population, including nutritional services.

V. World Bank Grievance Redress

29. Communities and individuals who believe that they are adversely affected by a World Bank (WB) supported project may submit complaints to existing project-level grievance redress mechanisms or the WB's Grievance Redress Service (GRS). The GRS ensures that complaints received are promptly reviewed in order to address project-related concerns. Project affected communities and individuals may submit their complaint to the WB's independent Inspection Panel which determines whether harm occurred, or could occur, as a result of WB non-compliance with its policies and procedures. Complaints may be submitted at any time after concerns have been brought directly to the World Bank's attention, and Bank Management has been given an opportunity to respond. For information on how to submit complaints to the World Bank's corporate Grievance Redress Service (GRS), please visit http://www.worldbank.org/GRS. For information on how to submit complaints to the World Bank Inspection Panel, please visit www.inspectionpanel.org.

Annex 1: Revised Results Framework and Monitoring Indicators

Central African Republic: Health System Support Project Additional Financing (P153030)

Revisions to the Results Framework		**Comments/ Rationale for Change**
PDO		
Current (PAD)	*Proposed*	
To (a) increase utilization and improve the quality of maternal and child health services in targeted rural areas the Recipient's territory; and (b) provide emergency health services to the general population.	No change	
PDO indicators		
Current (PAD and Restructuring Paper)	*Proposed change**	
PDO#1: People with access to a basic package of health, nutrition, or reproductive health services (number)	Target revised	Original project indicator: Target increased from 600,000 to 1,000,000[1]
PDO#2: Children immunized (number)	Target revised	Original project indicator: Target reduced from 41,000 to 40,000[1]
PDO#3: Number of births attended by trained personnel in health facility in targeted areas	Target revised	Original project indicator: Target reduced from 33,819 to 30,000[1]
PDO#4: Number of women victims of violence supported by social and medical health providers	Target revised	New indicator introduced at 2014 restructuring: Target increased from 300 to 2,500[1]
PDO#5: Direct project beneficiaries (number)	Target revised	Original project indicator: Target increased from 674,819 to 1,072,500[1]
PDO#5a: Female beneficiaries (percent)	Target revised	Original project indicator: Target increased 400,429 to 536,250[1]
PDO#6: Average score of the quality of care checklist	New	New indicator for Additional Financing: Target set at an increase in 35% from baseline value (baseline to be determined upon first facility quality assessment)
Intermediate Results indicators		
Current (PAD and Restructuring Paper)	*Proposed change**	
IOI#1: Number of HIV+ pregnant women receiving PMTCT care	Target revised	New indicator introduced at 2014 restructuring: Target reduced from 4,669 to 3,500[1]
IOI#2: Number of mothers in the project areas who received two doses of intermittent preventive treatment for malaria during last pregnancy	Type of indicator and target revised	Original project indicator: Indicator changes from proportion to number due to the mobility of the population. Target set at 40,000 women[1]
IOI#3 Number of health facilities operating on a daily basis[2]	Target revised	New indicator introduced at 2014 Restructuring: Target increased from 155 to 200 based on number of facilities covered by AF
IOI#4: Number of health professionals available in health facilities on a monthly basis[3]	Target revised	New indicator introduced at 2014 Restructuring: Reduced from 1,200 to 500 based on results of March 2015 health facility baseline survey
IOI#5: Number of children under age of five treated for Severe Acute malnutrition	No change	New indicator introduced at 2014 Restructuring: No change
IOI#6: Number of health facilities submitting complete monthly HMIS reports	New	New indicator for Additional Financing: Target set at 175 health facilities
IOI#7: Number of health personnel trained in HMIS	New	New indicator for Additional Financing:

Revisions to the Results Framework		Comments/ Rationale for Change
		Target set at 460 health personnel

[1] Based on results already achieved through the support to emergency services under Component 3

[2] Defined as a health facility open seven days a week with emergency staff on call during hours the facility is closed

[3] Defined as qualified health personnel (doctor, nurse, midwife, lab technician, health aide, midwife aide, health technician)

Project Name:	Health System Support Project Additional Financing (P153030)			Project Stage:	Additional Financing	Status:	DRAFT
Team Leader(s):	Paul Jacob Robyn	Requesting Unit:	AFCC1	Created by:	Tazeem Mawji on 03-Feb-2015		
Product Line:	IBRD/IDA	Responsible Unit:	GHNDR	Modified by:	Paul Jacob Robyn on 30-Apr-2015		
Country:	Central African	Approval FY:	2015				
Region:	AFRICA	Lending Instrument:	Investment Project Financing				
Parent Project ID:	P119815	Parent Project Name:	CF-Health System Support Project (P119815)				

Project Development Objectives

Original Project Development Objective - Parent:

The development objective of this proposed operation is to increase utilization and improve the quality of maternal and child health services in targeted rural areas of Central African Republic.

Current Project Development Objective - Parent:

The revised project development objectives are to: (a) increase utilization and improve the quality of maternal and child health services in targeted rural areas of the Recipient's territory; and (b) provide emergency health services to the general population.

Proposed Project Development Objective - Additional Financing (AF):

Results

Core sector indicators are considered: Yes

Results reporting level: Project Level

Project Development Objective Indicators

Status	Indicator Name	Core	Unit of Measure		Baseline	Actual(Current)	End Target

Revised	People with access to a basic package of health, nutrition, or reproductive health services (number)	☒	Number	Value	400000.00	593287.00	1000000.00
				Date	28-Sep-2012	01-Feb-2015	31-Mar-2019
				Comment		The February 1 2015 estimates (covering July-December 2014) include only facilities covered by the Bank operation. Source of 'Actual' data: health facility HMIS reports	
Revised	Children immunized (number)	☒	Number	Value	31360.00	32625.00	40000.00
				Date	28-Sep-2012	01-Feb-2015	31-Mar-2019
				Comment		The February 1 2015 estimates (covering July-December 2014) include only facilities covered by the Bank operation. Source of 'Actual' data: health facility HMIS reports	
Revised	Number of births attended by trained personnel in health facility in targeted areas	☐	Number	Value	26500.00	15675.00	30000.00
				Date	28-Sep-2012	01-Feb-2015	31-Mar-2019
				Comment		The February 1 2015 estimates (covering July-December 2014)	

						include only facilities covered by the Bank operation. Source of 'Actual' data: health facility HMIS reports	
Revised	Number of women victims of violence supported by social and medical health providers	☐	Number	Value	0.00	2062.00	2500.00
				Date	04-Mar-2014	01-Feb-2015	31-Mar-2019
				Comment		The February 1 2015 estimates (covering July-December 2014) include only facilities covered by the Bank operation. Source of 'Actual' data: health facility HMIS reports	
Revised	Direct Project beneficiaries,	☐	Number	Value	0.00	622822.00	1072500.00
				Date	28-Sep-2012	01-Feb-2015	31-Mar-2019
				Comment		The February 1 2015 estimates (covering July-December 2014) include only facilities covered by the Bank operation. Source of 'Actual' data: health facility HMIS reports	

No Change	Of which female (beneficiaries)	☐	Number Sub Type Supplemental	Value	0.00	301805.00	536250.00
New	Average score of the quality of care checklist	☐	Percentage	Value	0.00		35.00
				Date	01-Feb-2015		31-Mar-2019
				Comment	Data will become available after PBF baseline quality assessment		

Intermediate Results Indicators

Status	Indicator Name	Core	Unit of Measure		Baseline	Actual(Current)	End Target
Revised	Number of HIV+ pregnant women receiving PMTCT care	☐	Number	Value	1049.00	1826.00	3500.00
				Date	14-Feb-2014	01-Feb-2015	31-Mar-2019
				Comment		The February 1 2015 estimates (covering July-December 2014) include only facilities covered by the Bank operation. Source of 'Actual' data: health facility HMIS reports	
Revised	Number of mothers in the project areas who received two doses of intermittent preventive treatment for malaria during last pregnancy	☐	Percentage	Value	1312.00	13588.00	40000.00
				Date	28-Sep-2012	16-May-2014	31-Mar-2019
				Comment		The February 1 2015 estimates	

						(covering July-December 2014) include only facilities covered by the Bank operation. Source of 'Actual' data: health facility HMIS reports	
Revised	Number of health facilities operating on a daily basis	☐	Number	Value	0.00	124.00	200.00
				Date	03-Feb-2014	01-Feb-2015	31-Mar-2019
				Comment		Source: World Bank/MOH rapid health facility survey (February 2015)	
Revised	Number of health professionals available in health facilities on a monthly basis	☐	Number	Value	0.00	124.00	500.00
				Date	03-Feb-2014	01-Feb-2015	31-Mar-2019
				Comment		Source: World Bank/MOH rapid health facility survey (February 2015)	
Revised	Number of children under age of five treated for Severe Acute Malnutrition	☐	Number	Value	14077.00	12823.00	16800.00
				Date	30-Dec-2013	01-Feb-2015	31-Mar-2019
				Comment		The February 1 2015 estimates (covering July-December 2014) include only facilities covered by the Bank	

						operation. Source of 'Actual' data: health facility HMIS reports	
New	Number of health facilities submitting complete monthly HMIS reports	☐	Number	Value			175.00
				Date			31-Mar-2019
				Comment			
New	Number of health personnel trained in HMIS	☐	Number	Value			460.00
				Date			31-Mar-2019
				Comment			

Annex 2: Detailed Description of Modified or New Project Activities

Central African Republic: Health System Support Project Additional Financing (P153030)

1. The Additional Financing of the Central African Republic Health System Support Project will support (i) scaling-up of Performance-Based Contracting and Performance-Based Financing for the strengthening of health system delivery in areas affected by the crisis; (ii) strengthening monitoring and evaluation capacity and support project implementation unit; and (iii) support the provision of emergency health services.

2. **Component 1: Improvement of Health Facilities Performance Through Performance-Based Financing** (US$9.0 million equivalent IDA Additional Financing): Under the original project design, the HSSP was supposed to introduce PBF across nine prefectures in Regions 2, 3, 4 and 6 to cover a total population of 2.3 million. Several of these prefectures are either now supported by other partners or are currently inaccessible due to the security situation, while other zones in these regions remain without assistance. At the time of preparing the original project, the country's health system did not face the same needs in pharmaceuticals, equipment, and personnel, as it does in the post-crisis period.

3. As such, the AF would provide support to unassisted zones in the original four target regions through a package of interventions that combine PBF alongside the provision of key inputs, drugs, staffing and infrastructure investments. As previously done in similar contexts such as Afghanistan in the early 2000s, Performance-Based Contracting (PBC) will be used to establish Performance-based Partnership Agreements (PPA) with NGOs to develop context-appropriate approaches for the implementation of PBF in specific geographic zones. Under this approach, the MoHP will specify a package of health services which the contracted NGO will be responsible for delivering through a combination of PBF and other investments to strengthen health service delivery in a specific geographical location (by region). The performance of the NGO will be judged against progress on specific, measurable indicators that will be evaluated regularly. PBC will be used as a transitional strategy in the post-crisis phase to orient the health system towards a financing approach that is results-based, while taking into consideration that substantial investments will need to be combined with PBF to address the current challenges. In time and as needs change, the strategy may be revised so that financing will be purely based on performance.

4. While the original project budgeted support through PBF at approximately US$2-3 per capita per year, it is expected that due to the current needs of the health system, additional resources will be needed to be effective in the post-crisis context. As such, the new intervention will provide support at US$5-6 per capita per year for 2.5 years of implementation. The scope of interventions applied to improve service delivery outcomes will be broadened to not only include PBF (as per the original project design) but also investments in equipment, materials, recruitment and training of human resources, and rehabilitation of health facilities through PBC. Due to the increased per capita investment and reduction in available resources for Component 1, the new target population will be approximately 1.6 million inhabitants, a reduction from the original target population of 2.5 million inhabitants.

Table 4: Targeted districts and population, 2014

Contract zone	Health Region	Health District	Sub--Prefecture	Number of health facilities	Population 2014
Zone 1	Region 2	BABOUA	Abba	7	95,223
			Baboua	15	
		BERBERATI	Berbérati	22	171,868
		BOUAR	Bouar	22	198,537
			Baoro	6	
		NOLA	Nola	25	127,069
			Bambio	5	
			Bayanga	7	
	Sub-total			***109***	***592,697***
Zone 2	Region 3	BOZOUM	Bossemptele	5	90,663
			Bozoum	20	
		PAOUA	Paoua	28	200,470
	Sub-total			***53***	***291,113***
Zone 3	Region 4	SIBUT/KEMO	Sibut	4	148,875
			Dékoa	5	
			Mala	1	
			Ndjoukou	5	
		BAMBARI	Bambari	20	199,125
	Region 5	NDELE	Ndélé	10	53,000
	Sub-total			***45***	***401,000***
Zone 4	Region 6	ALINDAO	Alindao	16	115,549
			Mingala	9	
		MOBAYE	Mobaye	6	121,728
			Zangba	5	
		KEMBE	Kembé	6	78,439
			Satéma	2	
	Sub-total			***44***	***315,716***
	TOTAL			**251**	**1,600,526**

5. **Component 2: Strengthening of the Capacity of the Recipient's Ministry of Health and Population** (US$2.5 million equivalent IDA Additional Financing): Prior to the crisis, the health sector's health management information system was very fragmented, and the data generated remained unreliable. The crisis has crippled the routine monitoring system even further. The main causes of the current weaknesses are a lack of health personnel trained in routine reporting, and a lack of equipment to make the national system work. Component 2 will therefore support the overall health information system in the country, as well as supporting external verification of PBF-financed services and results of contracted NGOs through health facility and community-based surveys. These verification activities will be conducted by an independent third party. The independent External Evaluation Agency will be contracted by the

Ministry of Health and Population. The EEA's roles will include ex-post fact verification of service volumes and quality delivered by health facilities contracted with the PPA and for which PBF payments have been made. The EEA will also be tasked with building in-country monitoring and evaluation capacity. Component 2 will also cover the operating costs of the PIU, including financing goods, consultant services, some training, and other operating costs, as well as strengthening the capacity of the Ministry of Health and Population to support the delivery of MCH services.

6. **Component 3: Emergency Health Services** (US$0.5 million equivalent IDA Additional Financing): Component 3 will be used to continue to support the provision of emergency health services to the population affected by the crisis, including IDPs and vulnerable groups (mother and children) through contracting of UN Agencies and NGOs.

7. **Financing:** The total cost of the Additional Financing is US$12.0 million equivalent. It will be provided through 100 percent IDA financing. The costs and financing plan for the original operation, restructured operation, and for the AF are presented below. Prior to effectiveness of the Additional Financing, the undisbursed balance of the HRITF portion of the original financing will be restructured and the financing will be fully allocated to Component 1.

Table 5: Financing by project component for original project, restructured project and Additional Financing

	Original PAD			**FY'14 Restructuring**			**FY'15 Additional Financing IDA**			**Total Project Financing**		
Components	**IDA**	**TF**	**Total**	**IDA**	**TF**	**Total**	**IDA**	**TF**	**Total**	**IDA**	**TF**	**Total**
1. Improvement of Health Facilities Performance Through Performance-Based Financing	15.064	10.636	**25.7**	1.9	9.6	**11.5**	9.0	No additional funds	**9.0**	**10.9**	**9.6**	**20.5**
2. Strengthening of the Capacity of the Recipient's Ministry of Health and Population	1.936	0.564	**2.5**	2.5	0.6	**3.1**	2.5		**2.5**	**5.0**	**0.6**	**5.6**
3. Emergency health services	0	0	**0**	12.6	1.0	**13.5**	0.5		**0.5**	**13.1**	**1.0**	**14.1**
Total	**17.0**	**11.2**	**28.2**	**17.0**	**11.2**	**28.2**	**12.0**		**12.0**	**29.0**	**11.2**	**40.2**

Table 6: Allocation of IDA Additional Financing and Undisbursed balance of HRITF Original Financing for the scaling up of PBF in Central African Republic

Components	Additional Financing IDA
Component 1: Improvement of Health Facilities Performance Through Performance-Based Financing	**9.0**
Sub-Component 1.1: Provision of Performance-Based Financing	*6.0*
Sub-Component 1.2: Support to the implementation and supervision of Performance-Based Financing	*3.0*
Component 2: Strengthening of the Capacity of the Recipient's Ministry of Health and Population	**2.5**
Sub-Component 2.1: Strengthening Project monitoring and evaluation	*1.0*
Sub-Component 2.2: Support for Project implementation and coordination	*1.0*
Sub-Component 2.3: Strengthening the capacity of the MOHP in monitoring and evaluation and in the delivery of MCH services	*0.5*
Component 3: Emergency health services	0.5
Total	**12.0**

Annex 3: Revised Implementation Arrangements and Support
Central African Republic: Health System Support Project Additional Financing (P153030)

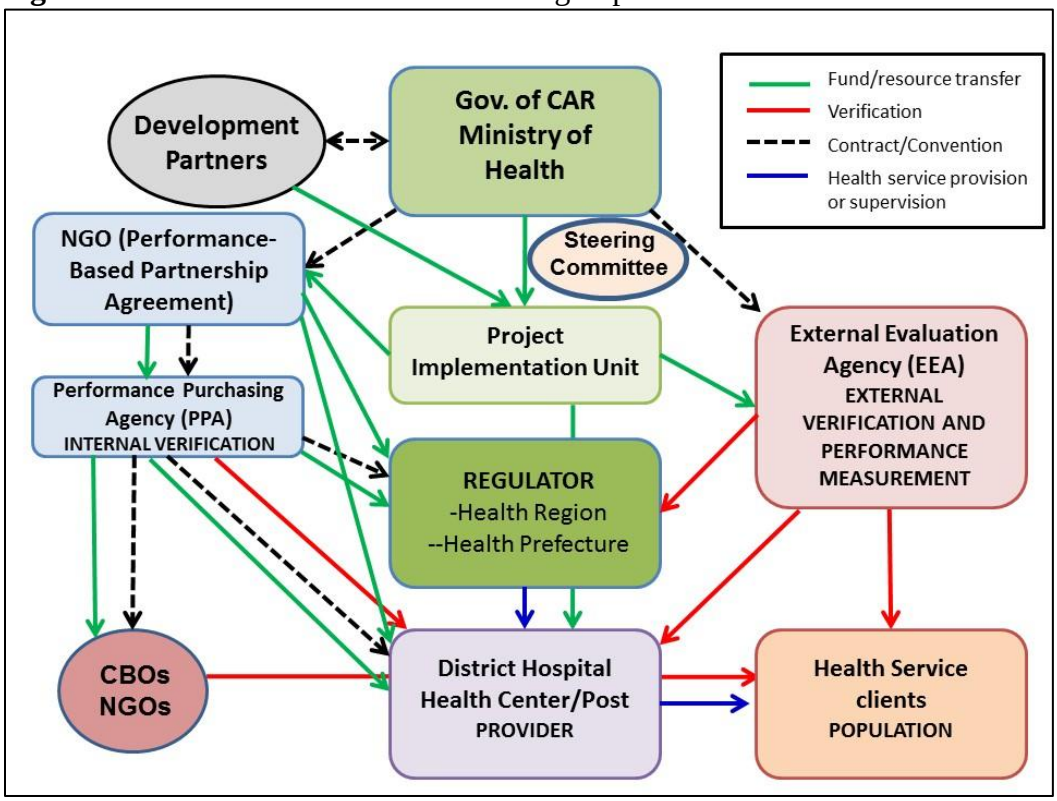
1. The implementation arrangements for the Additional Financing will remain the same as for the original project design. The MoHP will continue to implement the project through the HSSP Project Implementation Unit (PIU). The PIU is placed under the Director of the Cabinet (DC), with technical support from the relevant MOH directorates. The PIU is staffed by a multidisciplinary team including: a project manager, an accountant, and a procurement specialist. Nevertheless, one qualified financial and administrative management specialist will be recruited to strengthen PIU's capacity. Prior to the HSSP, members of the PIU had developed the skills and experience needed for project implementation through the implementation of the Bank-financed Multisectoral HIV/AIDS Project (P073525). Their experience in project implementation has continued to be strengthened throughout the duration of the ongoing HSSP. The PIU is responsible for the development of annual work plans and budgets, coordination and review of project implementation progress, regular monitoring and supervision, monitoring and scoring of performance contracts, implementation support, and preparation of quarterly and annual reports. At the central level, implementation is coordinated by the National Results-Based Financing Technical Unit, who has remained active in project coordination throughout the project duration. The technical unit has been the main coordinating body within the MoHP throughout implementation of the restructured project, leading monthly meetings between the MoHP, contracted UN Agencies and the PIU. The technical unit also coordinates all aspects related to RBF in the country, including with other partners using RBF, such as the EU, Global Fund and Cordaid.

2. Under Component 1, NGOs will be contracted through Performance-Based Partnership Agreements (PBPA) to rapidly expand the availability of basic health services through PBF, improve the quality of care, build the capacity of Central African health workers and managers to deliver essential health services, and ensure smooth coordination between the government and NGOs as well as among NGOs working in the same areas. Through the PBC contracts, NGOs will be tasked to set-up and make operational PBF in their respective zones, including contract management, verification and fund transfer activities. Specifically, NGOs will be tasked with creating Performance Purchasing Agencies (PPA) for PBF contract management, verification, coaching, and in the majority of cases, fund transfers to providers. PBF payment requests will be submitted by the purchasing agencies to the RBF Technical Unit at the central level. Upon validation, funds for PBF payments will transferred by the PIU to a designated account at the PPA, who will then assure funds are transferred to contracted health facilities and regulatory bodies. This is due to the fact that the banking system outside of Bangui is largely non-existent and direct payments to health center bank accounts will not be an option in the majority of cases. In addition, at the onset of PBF contracts, PPAs will assist health facilities in the development of investment plans to allow facility staff to identify appropriate solutions to challenges they face in providing health services in their catchment areas. The investment plans will be financed through PBF grants.

3. In addition to establishing the PBF setup, and particularly at the initial stages of the intervention, they will provide additional activities to support service delivery, which may be more input-based. Alongside setting-up the PBF-related structures, NGOs will provide a

combination of inputs (drugs, supplies, recruitment of staff and rehabilitation of health centers) to further reinforce service delivery. The MoHP will encourage successful innovation in the creation of packages of performance-based interventions that improve the availability, quality and utilization of health services. Exactly how these objectives are achieved will mostly be up to the NGO so long as it complies with the technical guidelines, standards, and laws of the government.

Figure 3.1: Performance-Based Contracting implementation structure



4. Under Component 2, the National Results-Based Financing Technical Unit will lead coordination and dialogue related to implementation of the national PBF strategy, Performance-based Partnership Agreements with contracted NGOs, activities related to strengthening the health management information system and the provision of emergency services to IDPs and vulnerable populations. The PIU will provide operational support for execution of related activities. The independent External Evaluation Agency will be contracted by the Ministry of Health and Population. The EEA's roles will include ex-post fact verification of service volumes and quality delivered by health facilities contracted with the PPA and for which PBF payments have been made. The EEA will also be tasked with building in-country monitoring and evaluation capacity. The component will also support the financing of goods, consultant services, training, and other operating costs related to strengthening the capacity of the Ministry of Health and Population to support the delivery of MCH services.

5. Under Component 3, the provision of emergency health services will continue to be supported through direct contracting with UN Agencies and NGOs as per the implementation arrangements applied since the 2014 project restructuring.

6. Project implementation is progressing well with milestones being met in a timely manner. No outstanding financial audit reports are noted and the previous year's financial audit report did not reveal any pending significant issues. For procurement-related activities, additional measures will be put in place to ensure transparency and appropriate checks and balances in the project's fiduciary activities. These measures will be closely coordinated with World Bank's Procurement and Financial Management Specialists and would include, tentatively: (i) use of the Regulatory Body (Public Procurement Regulatory Authority) for conducting the post-reviews for all contracts awarded; (ii) clearance of all contracts by the Procurement Division in the Ministry of Health; (iii) including an independent observer in procurement-related activities; and (iv) ensuring the local press and civil society are informed about the project's interventions and fiduciary activities through organization of a large-scale public launching ceremony.

7. The proceeds of the AF will be disbursed following similar arrangements as under the original financing. A new segregated designated account will be opened in a commercial bank acceptable to the Association. The ceiling of the designated account has been set to 1 billion CFAF (Communauté Financière Africaine Franc). Withdrawal Applications for advances to the Designated Account will be supported with statements of expenditures or certified statements of expenditures for the PBF component. The HRITF Grant under the Original Financing will be restructured prior to effectiveness of the AF and its undisbursed balance at the time will be reallocated to Component 1 (PBF subsidies and operational costs for implementation of the PBF scheme). The financing percentages for Category (1) and Category (2) (financing the PBF intervention under Component 1) will be set to 100% (inclusive of taxes) under both the HRITF and the IDA Additional Financing. However in order to minimize the risk of financing the same expenditures, the HRITF funds will be fully exhausted before the proceeds of the IDA AF allocated to Component 1 (Category (1) and (2) are disbursed. The proposed table for the IDA Additional Financing is set out below.

Table 7: Table of eligible expenditures

Category	IDA Amount of the Grant Allocated (expressed in USD)	Percentage of Expenditures to be Financed (inclusive of Taxes)
(1) Goods, non-consulting services, consultants' services, Training and Operating Costs in Packages required for each MCH Subproject provided under each Technical Support Package and MCH Package and to be financed out of a MCH Sub-grant under Part A(1) of the Project and paid at the Unit Price for said MCH Package	6,000,000	100% of amounts paid by the Recipient under the MCH Sub-grant
(2) Goods, non-consulting services, consultants' services, Training and Operating Costs for Part A(2) of the Project	3,000,000	100%
(3) Goods, non-consulting services, consultants' services, minor works Training and Operating Costs for Part B and C of the Project	3,000,000	100%
TOTAL AMOUNT	12,000,000	

Annex 4: Map of the CENTRAL AFRICAN REPUBLIC