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Report No: PAD2737

INTERNATIONAL DEVELOPMENT ASSOCIATION

PROJECT APPRAISAL DOCUMENT

ON A

PROPOSED IDA CREDIT

IN THE AMOUNT OF SDR 15.6 MILLION
(US$22.50 MILLION EQUIVALENT)

AND

A PROPOSED IDA GRANT
IN THE AMOUNT OF SDR 15.6 MILLION
(US$22.50 MILLION EQUIVALENT)

AND

A PROPOSED GRANT FROM THE MULTI DONOR TRUST FUND FOR THE GLOBAL FINANCING FACILITY
IN THE AMOUNT OF US$10.0 MILLION

TO THE

REPUBLIC OF GUINEA

FOR A

GUINEA HEALTH SERVICE AND CAPACITY STRENGTHENING PROJECT
April 4, 2018

Health, Nutrition & Population Global Practice
Africa Region

CURRENCY EQUIVALENTS

(Exchange Rate Effective February 28, 2018)
Currency Unit = GNF
GNF 9,0 = US$1.00
US$1.44 = SDR 1

FISCAL YEAR
January 1 - December 31

Regional Vice President:	Makhtar Diop
Country Director:	Soukeyna Kane
Senior Global Practice Director:	Timothy Grant Evans
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Task Team Leader(s):	Ibrahim Magazi, Christopher H. Herbst

ABBREVIATIONS AND ACRONYMS

Abbreviation	Definition
ATS	Technical Health Agent (*Agent Technique de Santé*)
BP	Bank procedure
BSD	*Bureau de Stratégie et Développement*
CHW	Community health worker
CMS	Central Medical Store
CRVS	Civil Registration and Vital Statistics
DHIS-2	District Health Information System
DPS	District health directorate (*Direction préfectorale de la santé*)
ESMF	Environmental and Social Management Framework
FY	Fiscal year
GDP	Gross domestic product
GFF	Global Financing Facility
GNF	Guinean franc
HIS	Health information system
HMIS	Health Management Information System
IBF	Input-based financing
IDA	International Development Association
IPF	Investment project financing
KIT	Royal Tropical Institute of Netherlands
M&E	Monitoring and Evaluation
MOH	Ministry of Health
NGO	Nongovernmental organization
OBF	Output-based financing
OP	Operational policy
PAD	Project Appraisal Document
PASSP	*Projet d'Amélioration des Services de Santé Primaire (Guinea Primary Health Services Improvement Project)*
PBF	Performance-based financing
PCU	Project coordination unit
PDO	Project development objective
PHD	Prefecture health directorate
PMT	Proxy means test

PNDS	National Health Plan 2015-2024 (*Plan National de Développement de la Santé*)
PPSD	Project Procurement Strategy for Development
RBF	Results-based financing
REDISSE	Regional Disease Surveillance Systems Enhancement
RMNCH	Reproductive, maternal, newborn, and child health
SARA	Service Availability and Readiness Assessment
SDI	Service Delivery Indicator
UN	United Nations
UNICEF	UN Children's Fund
USAID	U.S. Agency for International Development
WHO	World Health Organization

BASIC INFORMATION

Is this a regionally tagged project?	Country(ies)	Financing Instrument
No		Investment Project Financing

[✓] Situations of Urgent Need of Assistance or Capacity Constraints

[ ] Financial Intermediaries

[ ] Series of Projects

Approval Date	Closing Date	Environmental Assessment Category
25-Apr-2018	27-Jun-2023	B - Partial Assessment

Bank/IFC Collaboration
No

Proposed Development Objective(s)

Improve the utilization of reproductive, maternal, neonatal and child health services in target regions

Components

Component Name	Cost (US$, millions)
Strengthen supply of basic RMNCH services in target regions	17.00
Strengthen the demand for basic RMNCH services in target regions	13.00
Strengthen health financing capacity of the MOH to guide sector reform and long-term transformation	22.00
Strengthen project management, implementation, and donor coordination capacity	3.00

Organizations

Borrower : Ministry of Finance

Implementing Agency : Ministry of Public health and Hygiene

PROJECT FINANCING DATA (US$, Millions)

[ ] Counterpart Funding	[ ] IBRD	[✓] IDA Credit	[✓] IDA Grant	[✓] Trust Funds	[ ] Parallel Financing

Total Project Cost:	Total Financing:	Financing Gap:
55.00	55.00	0.00
	Of Which Bank Financing (IBRD/IDA): 45.00	

Financing (in US$, millions)

Financing Source	Amount
Global Financing Facility	10.00
IDA-62300	22.50
IDA-D3040	22.50
Total	**55.00**

Expected Disbursements (in US$, millions)

Fiscal Year	2018	2019	2020	2021	2022	2023	2024
Annual	0.62	5.19	8.76	10.90	8.95	7.40	3.19
Cumulative	0.62	5.81	14.57	25.46	34.41	41.81	45.00

INSTITUTIONAL DATA

Practice Area (Lead)

Health, Nutrition & Population

Contributing Practice Areas

Climate Change and Disaster Screening

This operation has been screened for short and long-term climate change and disaster risks

Gender Tag

Does the project plan to undertake any of the following?

a. Analysis to identify Project-relevant gaps between males and females, especially in light of country gaps identified through SCD and CPF

No

b. Specific action(s) to address the gender gaps identified in (a) and/or to improve women or men's empowerment

Yes

c. Include Indicators in results framework to monitor outcomes from actions identified in (b)

Yes

SYSTEMATIC OPERATIONS RISK-RATING TOOL (SORT)

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

9. Other	
10. Overall	Substantial

COMPLIANCE

Policy

Does the project depart from the CPF in content or in other significant respects?

[ ] Yes [✓] No

Does the project require any waivers of Bank policies?

[ ] Yes [✓] No

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

Legal Covenants

Sections and Description

As per the Financing Agreement, the Recipient shall take all action required on its behalf to ensure that, no later than three months after the Effective Date, the PCU is decentralized in the Target Regions with at least one manager specialized in public health, one accountant, and one monitoring and evaluation specialist in each office.

Sections and Description

As per the Financing Agreement, the Recipient shall, no later than twelve (12) months after the Effective Date, hire an agency satisfactory to the Association under terms of reference satisfactory to the Association, set out in the

Project Implementation Manual, for the independent verification of qualitative and quantitative results of the RMNCH service delivery under Part 3.1(a) of the Project and the carrying out of an independent verification.

Sections and Description

As per the Financing Agreement, the Recipient shall ensure that health workers hired under Part 1.2(a) of the Project for the public sector shall have job descriptions, employment conditions and salaries closely aligned to those of their civil service counterparts. Moreover, the Recipient will ensure a gradual shift of said health workers to the government budget upon Project closing in a manner satisfactory to the Association.

Conditions

Type	Description
Effectiveness	The Co-financing Agreement has been executed and delivered and all conditions precedent to its effectiveness or to the right of the Recipient to make withdrawals under it (other than the effectiveness of this Agreement) have been fulfilled.
Effectiveness	The PCU has hired adequate staff under terms of reference satisfactory to the Association to work on the day to day management of the Project, including the senior internal auditor.
Effectiveness	The PIM has been updated to reflect activities under the Project, including implementation details, including updated fiduciary procedures, in a manner satisfactory to the Association.
Disbursement	Notwithstanding the provisions of Part A of the FA, no withdrawal shall be made under Category 3 for Eligible Expenditures in respect of Part 3.1(a) of the Project, unless and until, prior to each withdrawal, the agency referred to in Section II.C.2(a) of Schedule 2 to this Agreement has been hired.

PROJECT TEAM

Bank Staff

Name	Role	Specialization	Unit
Ibrahim Magazi	Team Leader(ADM Responsible)		GHN13

Christopher H. Herbst	Team Leader		GHN05
Alpha Mamoudou Bah	Procurement Specialist(ADM Responsible)		GGOPF
Tahirou Kalam	Financial Management Specialist		GGOAW
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Toni Joe Lebbos	Team Member	economic analysis	GHN07

Extended Team

Name	Title	Organization	Location
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Philippe Compaore	RBF advisor		

GUINEA
GUINEA HEALTH SERVICE AND CAPACITY STRENGTHENING PROJECT

TABLE OF CONTENTS

I. STRATEGIC CONTEXT 1
A. Country Context 1
B. Sectoral and Institutional Context 2
C. Higher Level Objectives to which the Project Contributes 10
II. PROJECT DEVELOPMENT OBJECTIVES 11
A. PDO 11
B. Project Beneficiaries 11
C. PDO-Level Results Indicators 11
III. PROJECT DESCRIPTION 11
A. Project Components 12
B. Project Cost and Financing 16
C. Lessons Learned and Reflected in the Project Design 17
IV. IMPLEMENTATION 17
A. Institutional and Implementation Arrangements 17
B. Results Monitoring and Evaluation 18
C. Sustainability 18
V. KEY RISKS 19
A. Overall Risk Rating and Explanation of Key Risks 19
VI. APPRAISAL SUMMARY 20
A. Economic and Financial (if applicable) Analysis 20
B. Technical 20
C. Financial Management 21
D. Procurement 21
E. Social and Environmental (including Safeguards) 22
F. World Bank Grievance Redress 23
VII. RESULTS FRAMEWORK AND MONITORING 24
ANNEX 1: DETAILED PROJECT DESCRIPTION 33
ANNEX 2: IMPLEMENTATION ARRANGEMENTS 59
ANNEX 3: ECONOMIC AND FINANCIAL ANALYSIS 72

I. STRATEGIC CONTEXT

A. Country Context

1. Guinea is a resource-rich country with abundant natural resources, but it is also one of the poorest countries in the world. Guinea is home to a population of 12.6 million (2015) and is administratively divided into eight regions (Table 1). Its natural resources are vast, and the mining sector is an important driver of output growth and exports. However, the country's legacy of political instability, insecurity, and governance challenges has limited the potential for growth and shared prosperity with respect to its vast natural wealth. Poor governance, lack of private sector access to finance, and lagging infrastructure (especially roads and electricity) prevent rapid growth. Lack of job opportunities and access to rural infrastructure and services for poor households, low agricultural productivity, and low human capital (health and education) limit economic inclusion. Approximately 80 percent of the population is employed in the agriculture sector, with almost 90 percent of poor and extremely poor people living in rural areas (largely consisting of outside of Conakry and outside the district capitals in each region). With a 2015 per capita gross domestic product (GDP) of US$531, the country remains among the poorest in the world, with more than half of its population in poverty and ranked 182 of 188 countries on the Human Development Index in 2014.

Table 1. Poverty Indicators According to Region

Region	Population (%)	Poverty incidence (%)	Contribution to poverty (%)	Per capita expenditure (GNF)
Boké	10.1	58.9	10.7	3,285,413
Conakry	17.4	27.4	8.7	5,183,357
Faranah	8.1	64.8	9.5	2,963,846
Kankan	13.6	48.7	12.0	3,725,699
Kindia	15.9	62.5	18.0	3,192,636
Labé	9.3	65.0	10.9	3,140,259
Mamou	8.0	60.8	8.8	3,221,060
Nzérékoré	17.7	66,9	21.4	3,052,875
Total	100	55.2	100	3,575,515

Source: Poverty Inequality in Guinea, 1994-2012 (2012)

2. Guinea is a fragile country vulnerable to internal and external shocks. According to the World Bank's definition, fragile countries are characterized by a combination of weak governance, policies, and institutions. Even though Guinea's Country Policy and Institutional Assessment (CPIA) score is less than 3.2 as a result of factors that engender fragility, Guinea is not on the World Bank's harmonized list of fragile situations because it does not host a peacekeeping or political peace-building mission. Nonetheless, the International Development Association (IDA 2018) has classified Guinea as an "exceptional FCV [fragility, conflict, and violence] risk mitigation regime," along with Niger, Nepal, and Tajikistan. A Risk and Resilience Assessment that was conducted in 2017 identified the several drivers of fragility, including conflict and violence, exposure to external shocks, youth exclusion and underemployment, as well as weaknesses in the delivery of services. A poverty rate of 55 percent in 2012 and probably higher after the devastating

Ebola epidemic (2013-16), and other external shocks are reasons for concern about Guinea's fragility.

3. Gender discrimination and violence against women remains a problem in all segments of the economy. For example, 70 percent of girls are enrolled in primary school compared to 81 percent of boys, and 24 percent of girls are enrolled in secondary school compared to 37 percent of boys. In 2013, 67 percent of the female working-age population was part of the labour force, while 80 percent of the male working-age population was part of the labour force**.** Despite a lack of data, sexual and gender-based violence against women and girls remains of grave concern. In 2013, the UN documented 72 cases of rape and sexual assault, 55 of which involved girls. Forced and child marriage is common, and according to government statistics, some 95 percent of girls and women undergo female genital mutilation (FGM), although the government is making efforts to address the problem.

B. Sectoral and Institutional Context

4. Guinea has an exceptionally low life expectancy, driven by high gross mortality. According to the latest World Health Organization (WHO) data published in 2015, life expectancy in Guinea is 58.2 years for men and 59.8 years for women; total life expectancy is 59.0 years, which gives Guinea a world life expectancy rank of 162 and is well below the overall world average of 68. Gross mortality in Guinea was 12 per 1,000 in 2015. The probability of dying between the ages of 15 and 60 in Guinea is 296 per 1,000 population for men and 273 per 1,000 for women (WHO 2015). Infectious disease dominates the mortality profile in Guinea, although noncommunicable diseases such as cancer and cardiovascular disease are on the rise.

5. Maternal mortality is among the highest in the region, in great part because of weak health service delivery which is disproportionately evident in remote areas. The 2016 maternal mortality ratio per 100,000 births for Guinea was 550, down from 743 in 2008 and 1,040 in 1990, although it is still higher than the regional average of 510 in sub-Saharan Africa (MICS 2016; WHO, UNICEF/WB, 2015). Mothers in rural areas are particularly disadvantaged when it comes to even basic service delivery (Table 2). Only around 40 percent of mothers in rural areas receive four (or more) prenatal health consultations (compared with 71 percent in urban areas), approximately 46 percent have skilled attendants deliver their babies (94 percent in urban areas), and approximately 43 percent deliver in health facilities (84 percent in urban areas). Nationally, almost half of women of reproductive age are anemic, which may be because of poor birth spacing, high prevalence of parasitic infections, and lack of access to or use of health supplies and services (Guinea Nutrition Assessment: Spring Project, 2015).

6. Children in Guinea are particularly disadvantaged, disproportionately so in remote areas. Although child mortality has decreased from 156 per 1,000 live births in 2002 to 94 per 1,000 live births in 2015, the rate remains higher than in the rest of the region (World Bank, 2016). At the same time, there are huge rural/urban variations (Table 2); under-5 mortality in rural Kankan is the highest (194 per 1,000), in line with children in rural areas being twice as likely to die as their urban counterparts. Only 43 percent of babies receive a postnatal examination in rural areas (as opposed to 84 percent in urban areas), and only 19 percent have complete vaccination coverage in the first year of life in rural areas (39 percent in urban areas). Malaria remains the leading cause of morbidity and mortality in health facilities. Although 73 percent of children sleep under insecticide-treated nets in rural areas (higher than the 58 percent in urban areas), the proportion of children who receive treatment for fever according to national guidelines is less than 15

percent in rural areas and 24 percent in urban areas. Lack of access to potable drinking water and adequate sanitation contributes to waterborne illnesses, causing diarrhea and subsequent dehydration. Thirty percent of children younger than 5 in rural areas are treated for diarrhea (45 percent in urban areas).

Table 2. Select Maternal and Child Health Indicators, 2016

Service Delivery Indicators	Total	Rural	Urban
Maternal health (%)			
Having four prenatal health consultations	51	40	71
Births attended by skilled birth attendants	63	46	94
Babies delivered in a health care facility	57	43	84
Child mortality indicators (per 1,000 live births)			
Infant mortality: Probability of dying between birth and first birthday	44	28	16
Juvenile mortality: Probability of dying between the first and fifth birthdays	46	57	23
Under-5 mortality: Probability of dying between birth and fifth birthday	88	104	52
Child health (%)			
Receiving at least one postnatal examination	57	43	84
Children aged 12-23 months receiving all recommended vaccinations according to the National Vaccination Program before their first birthday (measles before their second birthday)	26	19	39
Children younger than 5 sleeping under an insecticide-treated net the night before the latest survey	68	73	58
Children aged 6-59 months receiving vitamin A supplementation*	69	NA	NA
Children younger than 5 having high fever in the last 2 weeks who received treatment in accordance with national guidelines	17	14	24
Children younger than 5 treated for diarrhea using oral rehydration salts	34	30	45
Children younger than 5 treated for diarrhea using zinc	28	24	35
Children younger than 5 treated for diarrhea using oral rehydration salts and zinc	16	14	22

Source: MICS 2016; SMART Survey 2015

7. Child malnutrition is a serious health problem in Guinea. Table 3 shows that an estimated 8 percent of children suffer from moderate acute malnutrition (low weight for height) (MICS 2016). Nearly 32 percent of children in Guinea younger than 5 show signs of delayed growth and development. Nearly half of this group, approximately 15 percent, are severely stunted; the averages mask significant rural–urban differences. Stunting is a preventable condition directly linked to inadequate food intake (quantity and quality) and repeated episodes of infectious disease. Only 35 percent of children younger than 5 months are exclusively breastfed, and only 1.4 percent of breastfed children aged 6 to 23 months receive a minimum acceptable diet. Malnourished children are more likely to become sick. Vitamin A supplementation is a high-impact intervention; adequate vitamin A is essential for rapid growth and to fight infection in children. Although the overall percentage of children who receive vitamin A supplementation is reported at 69 percent, supplementation, as with many other nutrition interventions, depends highly on continuous financing and

functioning service delivery and outreach activities at both the community and health center level. As discussed further below, in remote areas in particular, financing and service delivery tends to be extremely weak.

8. Reproductive health indicators are equally problematic. Fertility rates declined slightly from 5.5 to 4.8 children per woman between 1999 and 2016, although there are large regional differences, ranging from 3.6 (Conakry) to nearly 7.0 (Kankan). Modern methods of contraception satisfy only 27 percent of demand in Guinea (MICS 2016). The current mix does not meet the need and is ineffective. Rates of early pregnancy in Guinea are high, with 37 percent of women aged 20 to 24 reporting having given birth at least once before the age of 18. The country also has one of the highest rates of adolescent fertility in the region—with a rate of approximately 26 percent. One problem is the lack of readily available condoms and other contraception methods, and the distribution of these to the community. Again, this is often worse in the remoter parts of the country.

Table 3. Select Child Nutrition and Reproductive Health Indicators, 2016

Indicators	Total (%)	Rural (%)	Urban (%)
Child nutrition			
Underweight children younger than 5 (weight for age)	18	21	13
Stunted children younger than 5 (height for age)	32	38	21
Wasted children younger than 5 (weight for height)	8	9	7
Reproductive health			
Fertility rate of women aged 15-49	4.8	3.7	5.5
Adolescent fertility rate of women aged 15-19	26.2	38	16
Early pregnancy: women aged 20-24 giving birth at least once before the age of 18	36.9	40	27
Prevalence of contraceptive methods: women aged 15-49 using contraception (traditional or modern)	8.7	7.8	10.2
Unmet contraceptive needs	27.6	26	19

Source: MICS 2016

9. Overall, the use of essential maternal and child health services has not returned to its pre-Ebola outbreak levels and is unlikely to do so without targeted interventions. Whereas hard empirical data on this are limited (the last Demographic and Health Survey was in 2012, 3 years before the Ebola outbreak), current service delivery related to reproductive, maternal, newborn, and child health (RMNCH) is generally worse than during the pre-Ebola period. Recent findings published in a Lancet article by Delamou et al. (2017) show that during the Ebola epidemic, for example, fewer women had institutional deliveries and received antenatal care coverage than before the epidemic, and in the post-Ebola period, overall trends in institutional deliveries and antenatal care generally stagnated. Similarly, significant immediate reductions in vaccination trends of most vaccine types during the epidemic followed an increasing trend in child vaccination completion during the pre-epidemic period. In the post-Ebola outbreak period, vaccination coverage for polio, measles, and yellow fever continued to decrease. The article stressed that targeted RMNCH interventions, particularly at the lowest level of the health system, those that focus on both demand and supply side interventions, in combination with broader systems strengthening, would be critical to reverse trends.

Health Systems and Service Delivery Challenges

10. Guinea's health sector is organized into three levels. The first level consists of health posts and health centers that are closest to communities and are predominantly found in rural areas (catering, in theory, to poor people). The second level consists of prefectural (district) and regional hospitals that are, respectively, first- and second-level referral hospitals for health centers. The third level has two specialized national teaching hospitals: Donka and Ignace Deen. In addition to the two national teaching hospitals, the government recently built the Sino-Guinéenne hospital. These hospitals cater largely to urban populations and more economically advantaged individuals. The majority of the population depends predominantly on health posts, health centers, and district hospitals for primary and slightly more advanced care, and it is often at this level that service provision capacity is the weakest.

11. The epidemiological profile of Guinea reflects a health system that has been historically underfunded and inefficient. Prior to the Ebola crisis, almost one third of total health expenditures came from external financing (PER, 2012), a proportion estimated to be much higher today (no current data exists). Government spending on health has been historically low and has only recently increased. Before the Ebola crisis, health expenditures funded through general tax revenues that the Guinean state collects accounted for only 2 percent to 3 percent of total public expenditures and only 0.5 percent of GDP. Per capita spending was US$23 in 2012 (PER 2014). Since the Ebola outbreak, the government has increased its share of spending, with the 2017 budget showing 8 percent of the government budget allocated to health (MOH 2017). This translates into approximately 1.33 percent of GDP and an estimated US$7.58 per capita spending. In addition, budget execution in Guinea has been historically poor, with only an estimated 44 percent of the planned Ministry of Health (MOH) investment budget spent in 2016 (MOH 2017).

12. The majority of public health spending is spent on a centralized bureaucracy and salaries and wages of the health workforce, with little left for priority health programs. The recent increase in public spending on health is almost entirely related to investments (particularly the hiring of an additional 2,764 staff on payroll in 2016).[1] For both operating expenditures and delivery of priority health programs, the percentage is roughly the same (approximately 6 percent). Since 2005, public expenditures for important health programs, including the Expanded Program on Immunization, the Comprehensive Care for Diseases of Newborn and Children (PECIMNE), and the Maternal Health Program, have constituted less than 7 percent of the MOH budget.

13. Households pay for most health resources, which is a burden, particularly for indigent households. The government pays for only one-third of health expenditures, compared with 45 percent across the region. Of private expenditures on health, which account for 4.3 percent of GDP (compared with the regional average of 3.5 percent), 92 percent are out-of-pocket expenditures (compared with 62 percent across sub-Saharan Africa). Poor households, most of which are outside of Conakry and in remoter parts of the country, spend significantly less than rich households on their health care (yet finance a greater share in total). Programs and insurance programs to support free delivery of certain health services and provide financial protection for poor households are largely nonfunctioning or nonexistent. People who are indigent are entitled (in theory) to an exemption from user fees (a budget line has been put in place

[1] Guinea has large numbers of health workers from public and private health training institutions. Aggregate health workforce supply exceeds labor market demand; the overall financing available to hire health workers is not sufficient to absorb all health workers into the public sector. As such, a large number of health workers are not on the government payroll but are unemployed or set up informal or formal private practices (usually in urban areas).

to compensate providers), but problems of underfunding and with identifying who is indigent limit the effectiveness of this policy.

14. Public health spending does not follow equity considerations and is heavily skewed toward Conakry in large part because this is where most of the health workforce is. Conakry houses only 15 percent of the population, yet it received more than one-third (and in 2012 more than half) of public spending. In 2012, for example, per capita public health expenditures in Conakry were approximately six times the levels that prevailed in the rest of Guinea. Adjusted for poverty, public health care expenditures in Conakry, with a poverty rate nearly half that of the rest of the country, received public health expenditures nearly 12 times the rest of the country. The region of Kindia, for example, which has the highest incidence of poverty, has the lowest per capita expenditure (Guinean francs (GNF) 3,200, compared with GNF 23,700 in Conakry). All these resource allocation numbers are largely based on administrative data, reflecting in part the official deployment pattern of health workers: resources are largely tied to health worker salaries and most health workers are in and around Conakry (Box 1).

Box 1. Health Labor Market Dynamics and the Skew of Resources to Urban Areas

In Guinea, most public health spending is allocated and directly linked to health worker salaries. It is not decentralized and allocated, for example, to fund health posts at the facility level. Most doctors, nurses, and midwives work in urban areas, despite often being officially deployed elsewhere, shifting the distribution of public resources accordingly. There are no functioning accountability systems to ensure that health workers stay where they have been officially deployed. The predominantly urban job preference of health workers is not surprising. Per capita salaries are extremely low by regional standards (a doctor earns less than US$2,200 a year, a nurse or midwife earns less than US$1,700 a year, and a technical health agent earns US$1,400), and urban areas hold greater potential for health workers to augment their incomes to make ends meet. Most facilities and health workers function as de facto private providers, depending on income from formal and informal user fees while using public sector facilities. The recent increase in public health expenditures, most of which reflects the recruitment of more extremely low-paid health workers, is unlikely to meet health worker needs or shift health spending to the periphery. The fact that recruitment continues to be done largely at the central level and of health workers who were largely trained in Conakry does not help. Global evidence shows that, to increase the likelihood of rural job uptake and retention, health workers *from* remote areas should be trained *in* and *for* remote areas and then deployed (through funded rural positions) in remote areas.

15. A key limitation to addressing the skewed distribution of public resources (financial and otherwise) is ultimately linked to weak decision-making authority and capacity at the decentralized level. District health directorates (*Directions préfectorales de la santé,* DPS) and/or health facilities have financial autonomy and decision-making and monitoring authority in theory only, with their capacity to locally recruit, deploy, supervise and continuously train health workers extremely limited. Subsidies, capacity-building support, recruitment/deployment and financial transfers usually disproportionately benefits urban centers and their hospitals (in particularly Conakry and regional and national hospitals), neglecting the lower levels in the remoter parts of the country. A weak health information system at district level contributes to the capacity limitations at decentralized level. Only recently has the District Health Information System (DHIS-2) received some financial support from partners, but it has yet to be made fully operational and expanded to the community level to serve its desired objectives. Similarly, a civil registration and vital statistics (CRVS) system, one that registers births and deaths and issues birth and death certificates, largely does not exist. Readily available data from such systems are critical for planning and monitoring purposes.

16. When not supported by donors, the utilization of health services, especially in remoter parts of the country and lower level health facilities, is constrained by supply- and demand-side challenges. Anecdotal evidence suggests that without donor support, up to two thirds of health posts and health centers in some remote districts are not operational (i.e. they don't function). In those that are operational moreover, the quality of services is usually substandard.

- *Availability and quality of health workers are a key impediment on the supply side*: One of the biggest challenges is the insufficient numbers of health workers particularly at lower level health facilities in remoter parts of the country. Health workers tend to work where there are opportunities for additional income generation, and where there is a market for their services. Lower level cadres are thus generally found at the health post and health center levels, and in remoter areas. Higher level cadres, such as doctors, nurses and midwives are largely found at the hospital level (in particular the regional and national hospitals).[2] Without external support, few health workers particularly those at the periphery of the health system receive the necessary financing, supervision, mentoring, and continuous training and skills upgrading from the government that is needed for the delivery of a basic package of RMNCH services of appropriate quality.

-*Availability and quality of pharmaceuticals are another key impediment on the supply side:* The lack of a regular provision of inputs such as pharmaceuticals, micronutrient supplements (vitamin A, iron, folate, zinc) adds to supply side constraints. In addition, many health facilities have insufficient access to water and electricity preventing them to meet storage quality and sanitation requirements. The Central Medical Store (CMS) has had difficulty obtaining foreign bids for the procurement of supplies- often explained by the overall instability and uncertainty of the business environment. Instead, pharmaceuticals are often obtained on the black market, with obvious safety concerns. United Nations (UN) organizations (e.g., UN Children's Fund, UNICEF) are well placed to procure inputs and supplies, while the CMS, when sufficiently funded, is generally considered well equipped to distribute supplies across the country (following concerted technical assistance from the EU). The absence of public financing for supplies is notable, particularly in remote parts of the country - this also means that drug revolving funds, originally designed to sustain facilities financially, are largely non-functional.

- *Demand side constraints are linked to issues of affordability and outreach:* Even when inputs and services are available, they are often only available to those who can afford them, with the indigent poor often unable to afford service fees. In theory, the government provides free antenatal care and delivery services in all public health facilities, providing delivery kits, including supplies for cesarean section. In reality, the lack of financing (and the dependency of workers to augment their incomes and charge fees), transparency, accountability, and support of these programs renders them nonfunctional. Other demand-side constraints include long distances, cultural taboos, and perceptions

[2] When health facilities such as health posts and health centers in remote areas are operational, they are usually staffed by technical health agents (ATS) who receive 2 years of basic training (in decentralized locations across the country – similar to health extension workers) and often function as de facto doctors or nurses (taking on all their functions). Other auxiliary providers and volunteer community health workers (VCHWs) are sometimes provided with training to extend services into the community, but this is largely dependent on donor funding. Doctors, nurses and midwives, when not absent, are found mostly at the hospital level, in particular the bigger regional national hospitals close to, or in, Conakry.

of poor service delivery (which grew with Ebola). Without the use of community level actors (and relevant funding by partners), outreach activity is limited.

17. Strengthening RMNCH service delivery and utilization in remoter parts of the country requires donor support and improved coordination. Post-Ebola, the government and partners today are committed to strengthening delivery of RMNCH services, particularly at the primary level of the health system. The National Health Plan 2015-2024 (*Plan National de Développement de la Santé,* PNDS) outlines the government's goal of reaching a set of conservative RMNCH indicator targets in each of the eight administrative regions by 2024. Partners, including the European Union, the U.S. Agency for International Development (USAID), and the Global Fund, are providing support to implement elements of this plan in one or more of the eight administrative regions. International funding and technical assistance accounts for approximately one-third of all health expenditures in Guinea. At the same time, less than 5 percent of donor funding is channeled directly through the MOH and most partners finance their own coordination units, contractors, and nongovernmental organizations (NGOs) to implement their support programs. With the aim of strengthening donor coordination and increasing MOH ownership in the planning and implementation of partner resources, the government is starting to explore placing all donor coordination units under one MOH umbrella and authority.

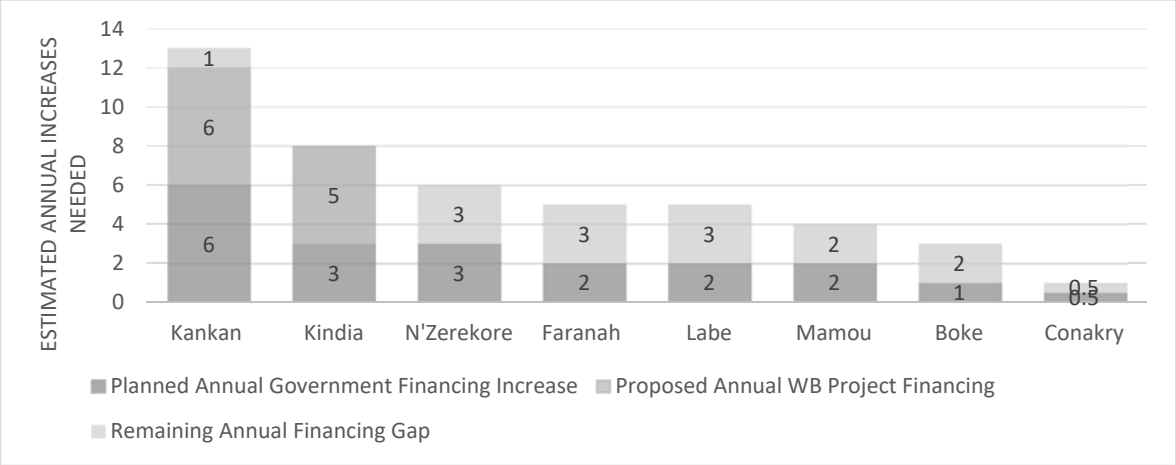
18. Through a number of projects, the Bank is currently supporting systems strengthening and service delivery in three of Guinea's eight regions. Two regional operations are active which benefit Guinea—one focuses on strengthening disease surveillance capacity (Regional Disease Surveillance Systems Enhancement, REDISSE Project – P154807), the other finances health facility infrastructure (a remnant of the successful Ebola Recovery Project-P152359). In Faranah and Labe, two of Guineas poorest regions, the Bank is providing direct service delivery support through the US$15 million Primary Health Services Improvement Project (P147758), and in the Mamou Region, through the US$5 million Mamou Project (P158579). Both projects are strengthening the financial and technical capacity of the government to address critical supply- and demand-side barriers to the provision of RMNCH services at primary and community levels of care. Both projects support interventions that move away from business as usual, including an institutionalized and continuous training and mentoring program for auxiliary health workers and CHWs (frontline health workers), building capacity for supportive supervision, funding a small-scale results-based financing (RBF) experiment, and launching a system to identify and finance access to basic services for the indigent poor. The interventions have started to show some early results: Today an increasing number of better trained, equipped, supervised and motivated health and community workers in the target regions are serving an increasing fee exempted population and resulting in better health outcomes.

19. Much more support however is needed to achieve the targets set in the PNDS, with a financing gap for RMNCH particularly large in the regions of Kankan and Kindia. The recently developed investment case for RMNCH, produced with technical assistance from the Global Financing Facility (GFF),[3] calculated the additional annual financing that would be needed to achieve the RMNCH targets outlined in the PNDS. *Figure 1* shows that despite the needs in many regions (including Boke), the additional financing needs are greatest in Kankan and Kindia, where an additional US$13 million and US$7 million, respectively, are needed annually (on top of already existing government and donor

[3] Guinea was selected for support from the GFF in 2016. An investment case was developed that outlines the key priorities and funding gaps for reaching the PNDS targets and a plan for strengthening capacity in health care financing and evidence-based policy-making.

financing) to meet the PNDS targets. Both regions have large populations, particularly high incidence of poverty, poor health outcomes, and insufficient financing from other sources.[4] As a result, the government has committed itself to increasing its annual allocation in all regions but particularly so in Kankan and Kindia. This alone, however, will not be sufficient. The proposed annual investments by the Bank through this project, of US$6 million in Kankan and US$5 million in Kindia over the next 5 years, would help reduce this gap significantly, although not fully eliminate it in Kankan. While the remaining financing gap in Kankan is not expected to impact the expected achievements under the proposed Project (the PNDS targets are broader), the Bank will continue to engage the government and other partners in order to raise the funds to fully bridge this gap.

Figure 1. Annual Additional Budget Needed, According to Region, to Reach Reproductive, Maternal, Newborn, and Child Health (RMNCH) Targets by 2020, As Specified in the National Health Plan (PNDS) (USD Million) *



Source: Donor mapping cost analysis – Global Financing Facility Investment Case, 2017.
**The amount indicates the additional financing needed (e.g., USD13 million annually in Kankan and USD7 million in Kindia) for these regions to meet the 2020 RMNCH targets set in the PNDS).*

20. Although strengthening service delivery in Kindia and Kankan is critical, simultaneous capacity building is needed for systemic reform in the longer term. At lower levels of the health system, despite a move toward decentralization in theory, subnational authorities, including the district-level health authorities (prefectures), lack the funding, information systems, incentives, and staff motivation to effectively plan for, implement and monitor service delivery. At the central level, the current lack of a functioning health financing unit and related planning capacity at the MoH is a critical bottleneck for long-term health financing reform. There are long delays in producing national health accounts, and the MOH is unable to track health expenditures accurately and effectively. There is a need for a gradual shift toward greater and more effective planning capacity at the central level, more pooled and efficient use of government funding, and more autonomy and decision-making authority at the district level and below. This should result in a shift

[4] Partners providing some financing to Kindia and Kankan include the Global Fund and the President's Malaria Initiative for malaria services, supply chain, and HMIS strengthening and USAID for some inputs and improving MNCH service delivery (no longer focusing on reproductive health aspects).

from the disproportionate financing of health worker salaries toward the financing of other operational costs and inputs. And to support all this, data and information systems will require strengthening, and capacity on health financing needs to be built at all levels including at the central level.

21. Accordingly, the proposed project will address the financing needs in Kindia and Kankan while simultaneously strengthen capacity for systemic reform in the long term. Proposed interventions will expand overall Bank support on maternal and child health from three to five of the eight regions in Guinea which together will cover more than half of the country's population. Support will be provided for the implementation of innovative supply- and demand-side interventions, to improve service delivery and utilization of basic RMNCH services at the health post, health center and district hospital level in both regions. Interventions will build on the innovative reforms commenced under the existing projects in Faranah, Labe and Mamou and will involve significant capacity building at the district level in addition to strengthening the financing and planning capacity at the central level. In addition to improving health outcomes, the interventions will simultaneously serve as a demonstration effect to inform systemic and longer-term reform efforts across the country. The project will demonstrate the powerful benefits of greater decision-making authority and capacity at the decentralized level, including subnational recruitment, training, supervision and monitoring capacity, accountability for results, and innovatively covering the indigent population. All of these elements, and an understanding of their benefits at the central level, are critical elements of longer-term, nationwide reform efforts.

22. All proposed interventions will be closely aligned with national and Bank planning documentation, and the objectives of the GFF to support system-wide reform, namely, the PNDS 2015–24; the health system recovery plan 2015–17 (based on the PNDS); narrower subsector strategies, including a new community health plan (a strategy is currently under development); recommendations of recent analytical work by Ramesh et al. (2016) that assessed post-Ebola response plans and provides guidance to the Ebola-affected countries (Guinea, Sierra Leone, Liberia);[5] the new Bank development policy operation, which aims to track the health indicator *public health workers working outside Conakry as verified by the monitoring system*; and the objective of the GFF to bring about more systemic change by helping the government improve donor coordination, the allocative and technical efficiency of health sector spending, and overall coordination and prioritization of investments in RMNCH.

C. Higher Level Objectives to which the Project Contributes

23. Interventions under the project remain consistent with, and aligned with, the strategic area of the World Bank Group's Country Partnership Strategy (FY14-17) and the newly drafted Country Partnership Strategy (FY18-21), which emphasizes the need to improve human development indicators in Guinea and covers basic education, social protection, and health. The proposed project mitigates some important drivers of fragility, conflict, and violence that have emerged from a Risk and Resilience Assessment that was conducted in 2017 (and outlined in the IDA 18 Risk Mitigation Regime Implementation Note), including exposure to external shocks, youth exclusion and underemployment, and weaknesses in the delivery of services. The proposed interventions are also in line with the new Systematic Country Diagnostic (WB, 2018), which emphasizes the need to strengthen human capital through

[5] Recent analytical work by the Bank (Ramesh et al. 2016), which assessed post-Ebola response plans and provides guidance to the Ebola-affected countries (Guinea, Sierra Leone, Liberia), emphasizes the need to support interventions that maximize allocative and technical efficiency gains (including a focus on community-level services and lower-level health workers) and strategies that increase accountability, decentralization, and resource allocations toward results.

education and health and address high levels of poverty, particularly in Kankan and Kindia, where many of the poor people live. In addition, the project remains fully aligned with the government's PNDS, community health strategy, health workforce strategy, and GFF country investment case and will ultimately contribute to the twin goals of the World Bank Group of ending extreme poverty and promoting shared prosperity with the bottom 40 percent.

II. PROJECT DEVELOPMENT OBJECTIVES

A. PDO

Improve the utilization of reproductive, maternal, neonatal and child health services in target regions.

The project target regions are Kankan and Kindia. Achieving the PDO will require strengthening of decision-making authority, and technical and financial capacity at the health facility, district, and central levels. The interventions supported by the project are intended to simultaneously result in a demonstration effect to inform continuous policy dialogue for long-term systemic and transformational change of the entire health system.

B. Project Beneficiaries

24. The immediate project beneficiaries are women and children who depend on primary health services (community level, health posts, district hospitals) for their needs, in particular pregnant women and children under 5. Kankan and Kindia have a population of just over 3.5 million (1,986,329 and 1,561,374, respectively), accounting for approximately one-fourth of the total population of Guinea (12.4 million). Of those, 1,844,805 are female, 922,402 (26 percent) are of child-bearing age, 177,385 (5 percent) are pregnant women, and 709,540 (20 percent) are children under five.

C. PDO-Level Results Indicators

25. The following outcome indicators will be used to measure the achievement of the PDOs in the targeted regions (covering district hospitals and below).

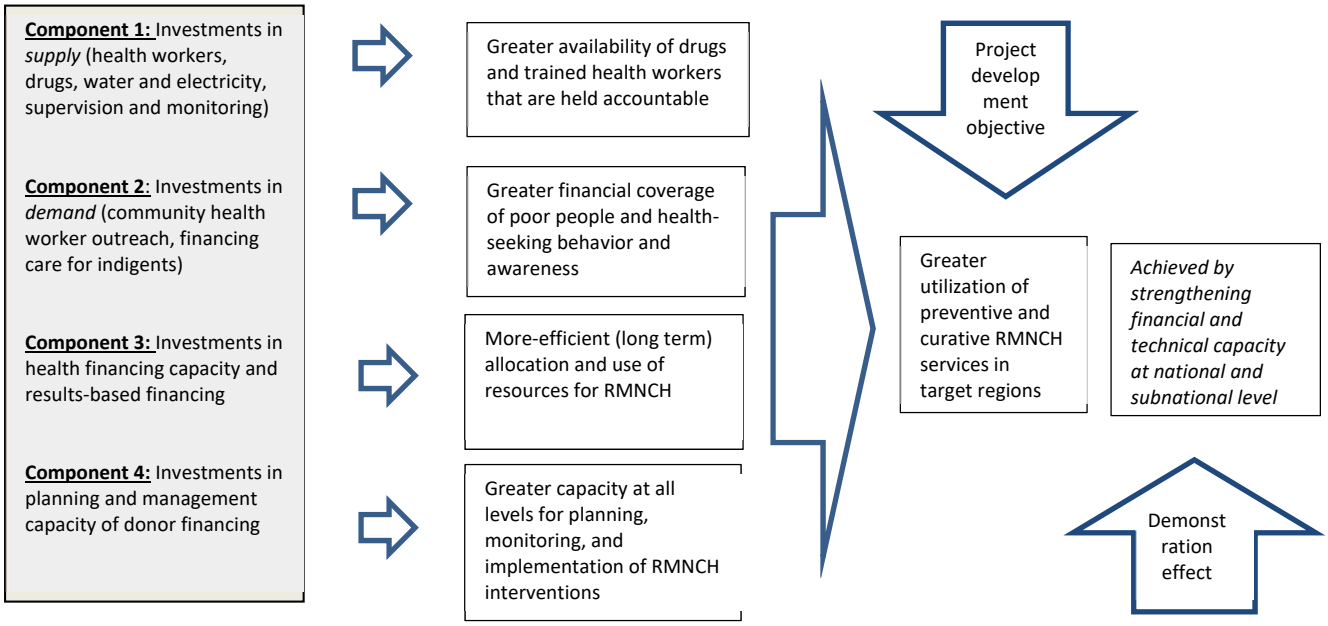
- Number of deliveries assisted by trained health personnel
- Number of pregnant women who received 4 antenatal care visits
- Number of children (0-11 months) fully vaccinated
- Number of children (0-1) receiving vitamin A supplementation every 6 months
- Number of women who have received modern contraception

III. PROJECT DESCRIPTION

26. The project intends to achieve the PDO by strengthening RMNCH service delivery and uptake at the district level and below in both target regions. This will require and involve substantial systems strengthening at both district and central level. In line with this, the project is organized around four complementary components which aim to: 1) strengthen the supply of basic Reproductive, Maternal, Neonatal and Child Health (RMNCH) services in target regions; 2) strengthen the demand for basic RMNCH services in target regions 3) strengthen the MOH's health financing capacity

to guide sector reform and long-term transformation; and 4) strengthen project management, implementation and donor coordination capacity. **The interventions supported under each component will serve as a demonstration effect to inform policy dialogue for long-term transformation.** Figure 2 provides an overview of the theory of change between intervention and project development outcome.

Figure 2. Theory of Change Between Intervention and Project Development Outcome



A. Project Components

Component 1: Strengthen supply of basic RMNCH services in target regions (US$12 million IDA, US$5 million GFF)

27. This component will finance the inputs needed to deliver the basic package of RMNCH services at the district level and below in Kankan and Kindia. The interventions expand those currently developed and implemented in Labé, Faranah, and Mamou and significantly empower decentralized (district) authorities to implement services and strengthen their financing, supervision, and monitoring capacity and authority. Specifically, this component will support the three subcomponents summarized below and detailed in Annex 1.

28. Subcomponent 1.1: *Increasing availability of drugs, commodities, and access to water and electricity at the district level in the target regions* (US$4 million IDA, US$2 million GFF) to enable delivery of a basic package of RMNCH services. The project aims to invest in equipment, supplies (including insecticide-treated nets and contraception), micronutrient supplements (particularly vitamin A), and drugs to revitalize and replenish drug revolving funds at the health center and district hospital level and operationalize the targeted health posts, centers, and district hospitals (i.e. ensure the delivery of services). The project will provide financing for the procurement of supplies and commodities (likely through UNICEF) and to the national CMS to deliver these inputs through the national supply chain structure. The subcomponent will also address the lack of running water and electricity at the level of health centers and district

hospitals. Drawing on the experience of the Mamou region project, this subcomponent will finance the construction of water wells and towers in primary health facilities and district hospitals, as well as the installation of solar panels (covering close to half of all health centers in the two regions). This will increase access to running water at service delivery points and electricity in the target regions.

29. Subcomponent 1.2: *Strengthen district-level capacity to recruit, and improve the competencies of health workers* (US$4 million IDA). The goal is to increase the availability and competency of health workers (e.g., technical health agents (ATS), health assistants, nurses, midwives) at the health post, health center, and district hospital levels to deliver the basic package of RMNCH services. The project will strengthen the financial and technical capacity of DPSs to fill critical health workforce gaps, supporting district authorities with local recruitment efforts (currently always done centrally) and financing the contracting of health workers to fill staffing needs (ATSs, nurses, midwives, doctors). Financing will be provided for the recruitment of workers already living in the targeted districts but not on government payroll (the majority of health workers in Guinea are not on payroll; Guinea overproduces vis-a-vis labor market demand). Their recruitment will be as contractors for the public sector with job descriptions, employment conditions and salaries closely aligned to those of their civil service counterparts. Moreover, the project will work closely with the government to ensure a gradual shift in the financing of these contractors to the government budget upon project end. In addition to financing their recruitment, the goal of the project is to strengthen the RMNCH competencies of health workers. This will involve expanding the innovative district-level training and mentoring scheme that has been developed in Faranah and Labé under the existing health project and providing continuous, team-based, horizontal RMNCH skills upgrading and mentoring to all district-level health workers. An expanded, trained district health team (rather than NGOs, as is often done) will organize and provide the training.

30. Subcomponent 1.3: *Strengthen the District Health Directorate's capacity to supervise and monitor RMNCH service delivery* (US$4 million IDA, US$3 million GFF). This subcomponent will ensure that the above inputs translate into delivery of quality services, largely by strengthening the capacity of DPSs to regularly and effectively supervise their health posts, health centers and district hospitals. The DPSs will receive financial and technical support in planning and implementing supervision visits to improve the performance of personnel and the quality of services in their health facilities. The districts will rely on supportive supervision methods, including the use of quality checklists for supervision. The component will finance implementation of existing supervision strategies that the government has developed, including training of district health teams, and key costs linked to providing supportive supervision. In addition, investments will be made to reinforce the Health Management Information System (HMIS) (community level, health post, health center, district hospital) by expanding DHIS-2, strengthening and linking to it the CRVS system to report cause of death, and providing support mechanisms to strengthen data quality at all levels.

Component 2: Strengthen the demand for basic RMNCH services in target regions (US$11 million IDA, US$2 million GFF)

31. This component will address some of the demand-side barriers limiting the use of RMNCH services (even when health workers and relevant inputs exist) that occur because of financial, geographical and sociocultural inaccessibility of services. Whereas it is expected that the supply-side improvements under component 1 will increase utilization of

RMNCH services, this component will further increase use by reducing the financial burden on poor people to access services and engaging CHWs in outreach and demand-generation activities. The component is organized into two subcomponents, as summarized below and detailed in Annex 1.

32. Subcomponent 2.1: *Implementing an innovative district level fee financing scheme to mitigate out of pocket expenses for the indigent poor* (US$8 million IDA). This will address a critical barrier to accessing health services—the fact that the poorest people often cannot afford even the smallest user fees charged at health facilities. To cover the poorest people, the project will support implementation of an indigent safety net program that has been developed and piloted under the existing health project. The program which builds on the lessons from the Bank's *Productive Social Safety Net Project*, focuses on a local, community-driven process to identify indigents, verify such indigents through independent local NGOs, develop an electronic database on these people administered by the district health authorities, and provide all selected indigents with a corresponding indigent health card, which will allow the poorest people to access RMNCH services free of charge at primary level facilities. The facilities providing services to the indigent population will bill the central government (the project) for services rendered (after NGO verification). The activities to be financed under this component will focus on financing the community selection of indigents and the NGO verification process, administrative expenses related to management of the database, issuing cards, training and communication activities, and reimbursement to health facilities for services rendered to indigents.

33. Subcomponent 2.2: *Supporting the District Health Directorates recruitment, training, supervision, and mentoring of Community Health Workers for outreach and basic RMNCH service delivery* (US$3 million IDA, US$2 million GFF). This subcomponent will support the government in implementing a new community health plan that is being developed with the goal of recruiting and better and more strategically using CHWs for demand generation and basic service delivery functions at the community level. In line with the CHW plan, such support will strengthen the financial and logistical capacity of district health authorities to recruit and provide continuous training to CHWs and strengthen local capacity to supervise and mentor CHWs. The support provided under this subcomponent would expand current efforts in Guinea to move away from the sporadic, non-standardized, vertical training programs that different NGOs currently provide and institutionalize into the public sector horizontal training of community lay workers in RMNCH promotion (which may include behavior against gender based violence and female genital mutilation) and basic service delivery at the community level. The program will draw on recently developed training modules developed with support from the Royal Tropical institute (KIT) and the Johns Hopkins Program for International Education in Gynecology and Obstetrics (JHPIEGO). Support under this component will be relatively flexible and aim to support the implementation of the governments CHW strategy as this takes on more detail. Support will draw closely on the global lessons learned with scaling up CHWs, and will be aligned to the fiscal realities of the country (a full costing and fiscal space analysis of a CHW scale up plan has not yet been carried out). Investments will be ultimately linked to financing basic salaries of CHWs, district-level training of CHWs (including training of trainers), and continuous mentoring and supervision.

Component 3: Strengthen the MOH's health financing capacity to guide sector reform and long-term transformation (US$20 million IDA, US$2 million GFF)

34. This component will support the government in developing and implementing comprehensive medium- and long-term strategies for health financing and broader service delivery reform. This will be done by supporting the introduction of RBF mechanisms at the health center and community levels in four districts in the target regions, as well as capacity building and evidence generation for health financing and service delivery at the central level to support the policy dialogue and the vision for more comprehensive health financing reform in the health sector. Accordingly, this component is organized into two subcomponents, as summarized below and detailed in Annex 1.

35. Subcomponent 3.1: *Enhancing the quality of RMNCH services and the quantity of RMNCH services for recipients in selected districts (US$17 million IDA).* Building on the experience of a small pre-pilot RBF experiment supported under the existing World Bank project in the Mamou region, this subcomponent will support implementation of an expanded RBF model at health centers and the community level in four districts in the target regions, where health facilities and CHWs will be financed based on achievement of a number of quantity- and quality-related performance indicators on RMNCH. The existing pre-pilot, which is still ongoing, has garnered interest in a larger expansion of RBF using government facilities to administer the scheme. Whereas an outside technical agency (Health Focus inc.) is implementing the small pre-pilot, which covers just a few health centers, this project will cover all health centers and their catchment areas in four entire districts, drawing on district and public sector capacity for implementation and monitoring. The four districts cover approximately one-third of the population in these regions, corresponding to approximately 1.3 million inhabitants. For such an output-based financing model to realize its potential as a driver of long-term systematic change, the *Bureau de Stratégie et Développement* (BSD), which oversees health financing at the central level, will be heavily involved in the design, monitoring, and evaluation of the schemes. An evaluation will also be funded to generate lessons to steer the policy dialogue toward more systemic change. Indeed, the interventions in this sub-component will inform the discussions around longer term, nationwide health financing and service delivery reform (focusing on the principles of decentralization, autonomy, accountability and incentives), and the eventual reorientation from financing inputs towards financing results.

36. Subcomponent 3.2: *Strengthening the capacity of the MOH in health financing and development of long-term reform strategies* (US$3 million IDA, US$2 million GFF). This subcomponent will strengthen institutional capacity to shift the health financing paradigm progressively from monitoring inputs to managing results by endowing MOH staff with the skills and knowledge needed to use new health financing and related budgeting, planning, and monitoring tools. Part of the support under this component (US$3 million in IDA funds) will be spent for the BSD to recruit full-time, engaged health financing staff and cover costs related to the planning, design, implementation, and dissemination of various studies and evidence-generation activities related to health financing and service delivery strategies and quality of care (e.g., medium-term expenditure framework, national health accounts, service delivery indicator surveys, fiscal space analysis for CHW scale up etc). The other part (approximately US$2 million) will finance capacity building, technical support, and training for the BSD and Division of Administration and Finance in the MOH on new tools needed to strengthen health financing planning, management, and monitoring capacity (including for RBF) and help the BSD lay the ground for systematic, long-term reform (focused on decentralized financing, decision-

making authority, and accountability systems). This activity will be conducted with the support of an international technical assistance agency with a well-defined terms of reference to ensure that there is transfer of knowledge and skills to MOH staff after the contract is completed.

Component 4: Strengthening project management, implementation, and donor coordination capacity (US$2 million IDA, US$1 million GFF)

37. This component will provide support for managing the project and related monitoring and evaluation (M&E) activities through the existing Project Coordination Unit (PCU), and support the possible eventual integration of the PCU into a broader donor coordination unit headed by the Ministry (which is being planned). Specifically, with USD2 million from the IDA, the component will finance the recurrent costs of the PCU team, the same team currently managing the existing World Bank projects. The current PCU will be expanded to include extra staff at the regional level for ease of implementation. In addition, with a contribution of USD1 million in GFF grant funding, the component will support the ministry in better coordinating overall donor support (including with this project). There are ministry plans to bring all the project PCUs of different partners under one roof in Guinea and to have a MOH official head and coordinate them. The GFF grant will support these efforts, including financing the initial salary of one person to head the donor coordination unit and any start-up costs of this unit. Additional details on this component can be found in Annex 1.

B. Project Cost and Financing

38. The lending instrument for the proposed project is the investment project financing (IPF), which can directly support implementation of the key objectives and reforms of the Guinean government. The total cost of the proposed project is estimated at US$55 million, to be implemented over 5 years. IDA will finance US$45 million of total project costs, and the GFF will finance the balance of US$10 million. Table 4 provides an overview of the cost per component.

Table 4. Overview of Components and Financing According to Component (US$ million)

Project Component	Project cost	International Development Association financing	Global Financing Facility financing	% financing
1. strengthen supply of basic RMNCH services in target regions	**17.0**	**12.0**	**5.0**	100
1.1 *Increasing availability of drugs, commodities, and access to water and electricity*	6.0	4.0	2.0	100
1.2 *Strengthen district-level capacity to recruit and improve the competencies of health workers*	4.0	4.0	0.0	100
1.3 *Strengthen the District Health Directorates capacity to supervise and monitor RMNCH service delivery (includes support on District Health Information System and civil registration and vital statistics)*	7.0	4.0	3.00	100
2. Strengthen the demand for basic RMNCH services in target regions	**13.0**	**11.0**	**2.0**	**100**

2.1 *Implementing an innovative district-level fee-financing scheme to mitigate out-of-pocket expenses for the indigent poor*	8.0	8.0	0.0	100
2.2 *Supporting the District Health Directorates recruitment, training, supervision, and mentoring of Community health workers for outreach and basic RMNCH service delivery*	5.0	3.0	2.0	100
3. Strengthen the MOH's health financing capacity to guide sector reform and long-term transformation	**22.0**	**20.0**	**2.0**	**100**
3.1 *Enhancing the quality of RMNCH services and the quantity of RMNCH services for recipients in selected districts (through RBF)*	17.0	17.0	0.0	100
3.2 *Strengthening the capacity of MOH in health financing and development of long term reform strategies*	5.0	3.0	2.0	100
4. Strengthen project management, implementation and donor coordination capacity	**3.0**	**2.0**	**1.0**	**100**
Total project costs	**55.0**	**45.0**	**10.00**	**100**

Notes: RMNCH, reproductive, maternal, newborn, and child health; MOH, Ministry of Health.

C. Lessons Learned and Reflected in the Project Design

39. Lessons incorporated into the proposed project design were derived from current and previous IDA health operations in Guinea and from regional experience in strengthening health services. The key lessons emphasized in the project design include ***ensuring country ownership*** by aligning interventions with national planning documentation including the GFF investment case, the National Health Policy, the Community Health Plan, and other documentation; ***coordinating investments closely with partners*** including the European Union, USAID, GIZ, WHO, UNICEF, GAVI, Global Fund. The support provided by the GFF funded technical assistance was central to ensuring complementarity of investments with partners; ***building on existing experience and capacity***, including on the innovative demand and supply side service delivery strategies and implementation arrangements that were already developed and used in the existing Bank projects; ***the importance of raising awareness on gender based violence across the service delivery spectrum*** including the need to raise awareness during health worker training on gender based violence; and ***addressing broader sector financing challenges*** for long-term solutions and sustainability by strengthening the health financing and planning capacity of the MOH (as supported in particular by the GFF financed components of the project).

IV. IMPLEMENTATION

A. Institutional and Implementation Arrangements

40. As with the *Guinea Primary Health Services Improvement Project* (P147758) and Mamou region project (P158579), the MOH will be the implementation agency for the new operation at all levels, in addition to providing technical stewardship at the central level. A steering committee, the same currently engaged in the existing projects, will provide strategic direction and monitor the overall progress of the project.

41. Day-to-day management of the project will be the responsibility of the PCU (in close collaboration with the BSD and other directorates at the Ministry) that existing Bank projects use. The PCU will be expanded to ensure regional

reach in the two target regions. The PCU may eventually become integrated into a new, broader Donor Coordination Unit (which will comprise all donor PCUs and will be headed by a government official) should such plans materialize. More information on the institutional implementation arrangements, including staffing and reporting arrangements, are discussed in Annex 2(A).

B. Results Monitoring and Evaluation

42. DHIS-2 will be primarily used to collect monitoring data, with the project's M&E team providing additional support to ensure the quality of data collected. Indigents will be verified as part of the quality checklist supervision visits, combined with independent spot checks, of the District Health Team. For the PBF specifically, monitoring data will be aggregated for the project's quarterly and annual indicators linked to the national HMIS system (currently reinforced through the strengthened DHIS-2). A comprehensive description of the project's results framework is described in Section IIV of this PAD, and the arrangements for M&E in Annex 2(E).

C. Sustainability

43. Sustainability of any project intervention in Guinea is a significant risk, and it is likely that external financing will have to remain a key source of financing in the short to midterm. As the country is increasing its share of the public budget on health, this is a crucial time to invest in capacity and learning to improve the efficiency of the system. The goal of this project is to support service delivery in the short term where needs are greatest and simultaneously use this support to strengthen capacity and learning for more-systemic change and reduce inefficiencies associated with external financing by aligning donors on common approaches.

44. The support that the GFF provides is an invaluable contribution to project sustainability. The GFF-financed investment case complements Bank-executed and GFF-financed technical assistance to strengthen health financing capacity in Guinea, further refining community and primary-level service delivery strategy in Guinea and identifying optimal yet realistic service delivery models to enable long-term reform in the sector.

45. All of the service delivery models supported under the project are closely linked to the activities outlined in the new national health strategies and policy documentation, address the weaknesses identified in the national investment case for RMNCH, and reflect global discussions on interventions to be prioritized in a post-Ebola setting. All were prepared in close consultation with the government and all development partners and related stakeholders, which maximizes potential for complementary and subsequent government and partner funding to become available to sustain the interventions. Moreover, all are deeply embedded in provision of existing public sector services (e.g., recruitment and training).

46. Sustainability arguments also largely determined the goal of strengthening and focusing on interventions at the primary level (community, health post, health center and district hospital levels), for example focusing on frontline health workers and delivering key maternal and child health services by supporting their local recruitment, training, and supervision. Frontline health workers, including CHWs, are specifically trained for service delivery at the

community and primary level. They are less expensive and more likely to be retained and absorbed at that level than higher-level health workers, who are currently trained in urban settings, more expensive to employ, and unlikely to remain in rural areas.

47. The RBF pilot and fee exemption scheme are unlikely to be fully funded through domestic resources in the short term. The goal is rather to demonstrate how resources can be effectively and efficiently shifted to the frontlines and technical capacity built around such learning to bring about more-sustainable reform.

48. Achieving financial sustainability for many of the other interventions after the close of the project will be an ongoing process, but the government has demonstrated its commitment to increasing the budget for maternal and child health, hiring health workers (including through the development policy operation), and implementing cost-effective interventions at the primary level (as detailed in the PNDS, GFF investment case, and related sectoral strategies). This signals government recognition of the importance of continuing to deliver results once Bank support ends.

49. These efforts will also require continued capacity building at all levels of the system (from civil society upward) and close collaboration with other development partners. Collaboration with all development partners has already improved significantly with the support of the GFF's highly consultative and participatory process, culminating in the launch of the investment case for RMNCH and the joint commitment to strengthen health financing capacity in Guinea.

V. KEY RISKS

A. Overall Risk Rating and Explanation of Key Risks

50. The overall risk in achieving the development objective of the project is *substantial:* (i) with regards to political and governance risks, Guinea still suffers from limited transparency and accountability; weak health budget, procurement, and financial management processes; (ii) macro-economic risks are high, with the risk of emerging or continuing external and/or domestic imbalances a real possibility; (iii) although solid health sector strategies now exist, and technical design of the project has been kept moderately complex given existing capacity constraints, the bottlenecks inherent in the health system could constrain the effective delivery of services, at least until broader reform is enacted; (v) there is a substantial likelihood that weak institutional capacity for implementing and sustaining the operation or operational engagement may adversely impact the PDO; (iv) procurement and financial management risks of the project are also rated substantial and high, respectively, reflecting the continued challenges with World Bank fiduciary procedures. Table 5 provides an overview of the most relevant risk ratings, and Annex 2(F) provides corresponding details and mitigation measures. In summary, strong political will to achieve better economic management and efforts to address the fiscal deficit (and wider WB support provided to the government in this regard) can be a mitigating force to the political and macro risks; continued emphasis through the project on the need for broader more systemic reform efforts can help mitigate sector strategy and technical design risks; and the strong emphasis on capacity building at all levels and continuous support on procurement and financial management can help mitigate institutional capacity and fiduciary risks.

In addition to these risks, the International Development Association (IDA 2018), has classified Guinea as an "exceptional FCV [fragility, conflict, and violence] risk mitigation regime," along with Niger, Nepal, and Tajikistan. A Risk and Resilience Assessment that was conducted in 2017 identified several drivers of fragility, including conflict and violence in Guinea to exposure to external shocks, youth exclusion and underemployment, as well as weaknesses in the delivery of services. The project's aim to improve the quantity and quality of health service delivery, including by recruiting additional health workers is expected to help mitigate these risks.

Table 5: Overview of Key Risk Rating

Type of risk	Rating
Political and governance	Substantial
Macroeconomic	High
Sector strategies and policies	Substantial
Technical design of project	Substantial
Institutional capacity for implementation and sustainability	Substantial
Fiduciary risk	Substantial

VI. APPRAISAL SUMMARY

A. Economic and Financial (if applicable) Analysis

51. As detailed in Annex 3, investment in the health sector in Guinea will provide major benefits that fit well with the country's priorities. By focusing interventions at the community and primary care levels, the project is expected to have a large effect at relatively low costs. The project will also contribute to greater technical and allocative efficiency in the health service delivery system.

52. Taking into account the present value of project costs (estimated at US$50,376,779) and the present value of expected benefits (estimated at US$101,477,596), the net present value of the proposed project is expected to be US$51,100,817. The positive net present value indicates that project benefits outweigh project costs, making this a sound investment. The benefit-cost ratio resulting from the analysis is estimated at 2.01, meaning that for each US dollar of investment through the proposed project, a return of US$2.01 is expected. These results are based on extremely conservative assumptions, and it is likely that they underestimate total project benefits.

B. Technical

53. The project is comprehensive and technically sound. It focuses on strengthening the utilization of services at the primary level of care by increasing supply and demand, in addition to overall health financing and management capacity at the central level. A sound implementation plan and monitoring framework accompany the proposed interventions. The design of this project builds on several years of World Bank investment in Guinea's health sector, including the experience with the currently Primary Health Services Improvement Project, as well as international experience with some of the interventions proposed.

C. Financial Management

54. The financial management arrangements for this project will be based on existing arrangements under the PASSP (P147758), REDISSE (P154807), and the Post-Ebola Support Project—Mamou (P158579), which are managed by the same PCU.

55. The overall performance of the PCU was rated satisfactory after the last financial management assessment of PASSP, conducted in May 2017. At the time of that assessment, the supervision mission of the Post-Ebola Support Project—Mamou, was ongoing. The primary finding of the mission did not reveal any critical problems; the first disbursement to UNICEF, one of the two implementing entities, was made on August 14, 2017. Staffing has remained adequate, and proper books of accounts and supporting documents have been kept for all expenditures. The PCU is familiar with Bank financial management requirements.

56. At the same time, the overall fiduciary risk for the Health Service and Capacity Strengthening Project remains substantial as the continuous and timely production of information produced by the PCU requires substantial capacity. The hiring of qualified FM such staff will be supported under the project as a key risk mitigation measure, alongside the updating of the Implementation manual and fiduciary procedures, the term of reference of the external auditor, and the configuration of accounting software. Further details regarding financial management and disbursement arrangements, including key risk mitigation strategies to be followed, are detailed in Annex 2(B) of this PAD.

D. Procurement

57. Works, goods, and non-consulting and consulting services for the project will be procured in accordance with procedures specified in the World Bank Procurement Regulations for IPF Borrowers, dated July 2016 (Procurement Regulations), and the World Bank Anti-Corruption Guidelines: Guidelines on Preventing and Combating Fraud and Corruption in Projects Financed by IBRD Loans and IDA Credits and Grants, dated October 15, 2006, and revised in January 2011 and on July 1, 2016, as well as the provisions stipulated in the Project's Financing Agreement.

58. All goods, works, and non-consulting services will be procured in accordance with the requirements set forth or referred to in Section VI of the Procurement Regulations—Approved Methods: Goods, Works and Non-Consulting Services; the consulting services will be procured in accordance with the requirements set forth or referred to in Section VII—Approved Selection Methods: Consulting Services of the Procurement Regulations, the Project Procurement Strategy for Development (PPSD), and Procurement Plan, which the World Bank has approved.

59. The borrower prepared and submitted the PPSD to the Bank on October 9, 2017. The project will finance procurement of medications, medical equipment, information technology equipment, vehicles, sanitation works, and consultant services. The Bank has reviewed the PPSD (including procurement plan), which describes how fit-for-purpose procurement activities will support project operations for achievement of PDOs and deliver value for money. The strategy includes a summary of procurement risk, a mitigation action plan, a market analysis, and procurement approaches. A procurement assessment conducted in September 2017 rated the overall procurement risk as substantial,

which was mainly related to weak procurement capacity in the MOH and limited experience with Bank procedures and delays in the procurement process. A number of procurement mitigation measures were proposed, based on the PPSD and procurement risk assessment, which include recruitment of a procurement assistant, training of a procurement specialist, develop a strong procurement section in the project implementation manual (PIM) and set up an acceptable filing system in the PCU. In addition, procurement risk mitigation includes regular Bank pre- and post-reviews, independent procurement reviews and regular support missions.
Further details related to procurement, including details on the procurement plan, requirements and actions for national open competitive procurement, and the procurement risk assessment and mitigating measures, are detailed in the Annex 2 (C) of this document.

E. Social and Environmental (including Safeguards)

60. The project will mostly fund activities focused on availability of medicines, essential supplies, and equipment to support maternal and child health at the health post and health center level; training and deployment of CHWs to generate demand and deliver basic services in maternal and child health; and availability of health centers with access to water. Activities related to the proposed operation may increase health care waste, and there are potential adverse effects associated with water well construction, although it is anticipated that these potential adverse effects will be limited, site specific, small scale, and manageable to an acceptable level, so the project is rated as environmental assessment category "B."

61. The project triggers two environmental safeguard policies: *Operational Policy* (*OP)/Bank Procedure (BP) 4.01—Environmental Assessment:* Potential negative environmental and social risks and effects related to handling and disposal of medical and health waste (e.g., placentas, syringes, material used for delivery of babies) in health facilities and water well construction are anticipated. *OP/PB 4.11—Physical Cultural Resources:* Well construction will require land excavations that could result in chance finds. The ESMF describes procedures to be followed in this case.

62. Safeguard instruments: Two main safeguard instruments were prepared for the purpose of the project: an ESMF and two regional (Kankan and Kindia) medical waste management plans. The ESMF that will be used was updated, discussed, and disclosed to serve as guidance to the project. The updated ESMF has been reviewed, consulted upon and disclosed at the Infoshop on September 20, 2016, and published in a newspaper in Guinea on September 21, 2016. The two regional Medical Waste Management actions plans (NSWP) focused on the two regions targeted by the project. The regional waste management action plans were aligned with the national medical waste management plan that was prepared under Ebola. The actions have identified the main weaknesses in the medical waste management in each targeted region and mitigation measures were proposed. Both waste management plans were published in a newspaper in Guinea on January 15, 2018, and disclosed at the Bank on January 16, 2018.

63. *Institutional arrangement to manage environmental and social safeguard*s: The project will be implemented by an existent PCU. The PCU will hire at least one full time environmental and social specialist with relevant skills on Environmental and Social medical waste management and nosocomial diseases. The environmental and social specialist will support the PCU during the whole life cycle of the project, and will ensure that the project is implemented

in a satisfactory manner in terms of the environmental and social commitments of the project. In addition, the PCU will ensure that Guinean Environmental Office (BGEEE) is fully involved in the project environmental and social monitoring. Periodic reports will be prepared to provide relevant information on the safeguards implementation status.

64. Consultation: The Government consulted stakeholders during the update exercise of the safeguards instruments in the targets areas including Conakry. To ensure that the stakeholders voices will continue to be considered, the project will prepare each year a stakeholder's consultation action plan which will describe the consultation approach, targets, locations and report the disclosure strategy. Additional details related to the social and environmental aspects of this project are described in Annex 2(D) of this PAD.

65. ***Climate Change****:* The Project design takes into account that extreme heat, rising sea-levels, changes in precipitation and other environmental changes can cause floods and droughts, intense storms, shifting disease vectors and degraded air quality, all or any of which affect human health and vulnerability to infectious disease. The project components and sub-components addressing surveillance and information systems, as well as, and human resource capacity, will factor in the impact of climate change, influencing the location and degree of country's intervention, while ensuring other climate change planning, programming and funding can complement and be coordinated with the health project, including that provided through external partner support (e.g. new climate-specific finance mechanisms, such as the Green Climate Fund, Global Environment Facility, and NDC Partner Support Facility). The World Bank Climate Change Action Plan has established a target of 20 percent of new Health, Nutrition, and Population (HNP) projects to include climate change in their design. Further, the World Bank has recently developed health-sector specific operational guidance, and forged critical partnerships with collaborating partners and technical agencies, including additional resources, directed at improving HNP investments while launching a new era of "climate smart healthcare" (World Bank 2017). Guinea will be encouraged to actively pursue these opportunities to enhance climate change adaptation strategies for improved health outcomes.

F. World Bank Grievance Redress

66. 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/en/projects-operations/products-and-services/grievance-redress-service*. For information on how to submit complaints to the World Bank Inspection Panel, please visit www.inspectionpanel.org.

VII. RESULTS FRAMEWORK AND MONITORING

Results Framework

COUNTRY : Guinea

Guinea Health Service and Capacity Strengthening Project

Project Development Objectives

Improve the utilization of reproductive, maternal, neonatal and child health services in target regions

Project Development Objective Indicators

Indicator Name	Core	Unit of Measure	Baseline	End Target	Frequency	Data Source/Methodology	Responsibility for Data Collection
Name: Number of deliveries assisted by trained health personnel		Number	66544.00	94320.00	Bi-Annual	HMIS	MOH/PCU
Description: The number of women 15-49 years who had births attended by skilled health personnel in a health center or district hospital (doctors, nurses, midwives or trained ATS)							
Name: Number of pregnant women who received 4		Number	77951.00	141479.00	Bi-Annual	HMIS	MOH/PCU

Indicator Name	Core	Unit of Measure	Baseline	End Target	Frequency	Data Source/Methodology	Responsibility for Data Collection
antenetal care visits							
Description: The number of pregnant women who have received 4 antenatal care visit from a health provider during their pregnancy							
Name: Number of children (0-11 months) fully vaccinated		Number	94640.00	136239.00	Bi-Annual	HMIS	MOH/PCU
Description: The number of children under 1 year who have received full immunization according to national immunization policies for their age group							
Name: Number of children (0-1 years) receiving vitamin A supplementation every 6 months		Number	11407.00	70740.00	Bi-Annual	HMIS	MOH/PCU
Description: The number of children (0-1year) who received an age-appropriate dose of vitamin A in the 6 month reporting period.							
Name: Number of women who have received modern contraception		Number	52812.00	1117899.00	Bi-Annual	HMIS	MOH/PCU
Description: The number of women who have received at least one form of contraception							

Intermediate Results Indicators

Indicator Name	Core	Unit of Measure	Baseline	End Target	Frequency	Data Source/Methodology	Responsibility for Data Collection
Name: Number of women and children who utilized health centers for RMNCH services		Number	458412.00	733596.00	Bi-Annual	HMIS	MOH
Description: The number of women and children who have come to a health post, health center or district hospital for RMNCH services							
Name: Proportion of health centers with more than 30 percent of stock-outs of tracer drugs		Percentage	100.00	25.00	Bi-Annual	Quality of care assessment	MOH
Description: Numerator: Health facilities reporting more than 30 percent stock outs of tracer medicines and medical supplies. Denominator: The total number of health facilities of the same type and reporting in the same time period. X100							
Name: Proportion of health centers with access to water		Percentage	71.00	90.00	Bi-Annual	UNICEF survey/MOH	MOH
Description: Nominator: The number of health centers with access to water (according to UNICEF survey). Denominator: The total number of health centers of the same type reporting in the same period.X100							
Name: Proportion of health centers offering integrated management of childhood		Percentage	0.00	90.00	Bi-Annual	Supervision Checklist	MOH

Indicator Name	Core	Unit of Measure	Baseline	End Target	Frequency	Data Source/Methodology	Responsibility for Data Collection
illnesses							
Description: Numerator: The number of health centers offering integrated management of childhood diseases in project areas. Denominator: Total number of health centers in project areas in the same time period x100							
Name: Number of community health workers recruited and trained in RMNCH competencies		Number	0.00	585.00	Bio-Annual	HMIS	MOH
Description: The number of community health workers who have completed their training modules and are confirmed to be working at the community level on RMNCH services							
Name: Number of health facility health workers trained in RMNCH competencies		Number	0.00	400.00	Bi-Annual	Supervision Checklist	MOH
Description: The number of health workers who have completed their district training modules and are confirmed to be working at the community, health center and/or district hospital level							
Name: Number of new indigents covered under exemption mechanisms (identified and provided with card)		Number	0.00	150000.00	Bi-Annual	District/NGO report	MOH

Indicator Name	Core	Unit of Measure	Baseline	End Target	Frequency	Data Source/Methodology	Responsibility for Data Collection
Description: The number of indigents provided with an indigent card							
Name: Number of health centers under results-based financing mechanisms receiving due payments for their results on time		Number	0.00	46.00	Bi-Annual	Facility reports/survey	MOH
Number of RBF Contracts Signed between the purchasing Agency and identified RBF facilities		Number	0.00	46.00			
Description: Number of health centers under RBF who report to have received their payments on time							
Name: Proportion of health centers who benefited from at least one supportive supervision per timester		Percentage	0.00	80.00	Bi-Annual	survey	MOH
Description: The numerator is the number of health facilitates in a district who have received at least one supportive supervision per trimester. The denominator is the total number of operational facilities in the district in the same time period. X100							
Name: Proportion of health centers transmitting health data on time		Percentage	0.00	90.00	Quaterly	HMIS	MOH
Description: Numerator: Number of health facilities that send a complete quarterly report to the districts on time.							

Indicator Name	Core	Unit of Measure	Baseline	End Target	Frequency	Data Source/Methodology	Responsibility for Data Collection
Denominator: Total number of health facilities expected to report in the time period. x100							
Name: Health Financing Strategy Produced (incorporating evidence from PER and NHA)		Yes/No	N	Y	Once	Actual Document Received and Disseminated	MOH
NHA and PER produced		Yes/No	N	Y			
Description: Production of a new health financing strategy that is evidence based (incorporating evidence from PER and NHA) and has been widely consulted on.							
Name: Satisfaction of users with basic RMNCH services provided		Percentage	0.00	60.00	Bi-Annual	NGO survey	MOH/PCU
Description: Numerator: The Number of individuals over 18 years of age who report to be sufficiently satisfied or highly satisfied with the services provided by the respective heath facility in their catchment area. Denominator: The total Number of Individuals over 18 years of age who have been surveyed.							

Target Values

Project Development Objective Indicators

Indicator Name	Baseline	YR1	YR2	YR3	YR4	YR5	End Target
Number of deliveries assisted by trained health personnel	66544.00	66544.00	76673.00	82210.00	90344.00	94320.00	94320.00
Number of pregnant women who received 4 antenetal care visits	77951.00	77951.00	93251.00	108171.00	124224.00	141479.00	141479.00
Number of children (0-11 months) fully vaccinated	94640.00	94640.00	106836.00	115832.00	124474.00	136239.00	136239.00
Number of children (0-1 years) receiving vitamin A supplementation every 6 months	11407.00	11407.00	41445.00	50480.00	60230.00	70740.00	70740.00
Number of women who have received modern contraception	52812.00	52812.00	69075.00	84133.00	100383.00	117899.00	1117899.00

Intermediate Results Indicators

Indicator Name	Baseline	YR1	YR2	YR3	YR4	YR5	End Target
Number of women and children who utilized health centers for RMNCH services	458412.00	458412.00	557202.00	612969.00	672564.00	733596.00	733596.00
Proportion of health centers with more	100.00	100.00	70.00	60.00	50.00	25.00	25.00

Indicator Name	Baseline	YR1	YR2	YR3	YR4	YR5	End Target
than 30 percent of stock-outs of tracer drugs							
Proportion of health centers with access to water	71.00	71.00	75.00	80.00	85.00	90.00	90.00
Proportion of health centers offering integrated management of childhood illnesses	0.00	0.00	20.00	40.00	60.00	90.00	90.00
Number of community health workers recruited and trained in RMNCH competencies	0.00	0.00	100.00	300.00	400.00	585.00	585.00
Number of health facility health workers trained in RMNCH competencies	0.00	0.00	100.00	200.00	300.00	400.00	400.00
Number of new indigents covered under exemption mechanisms (identified and provided with card)	0.00	0.00	30000.00	80000.00	110000.00	150000.00	150000.00
Number of health centers under results-based financing mechanisms receiving due payments for their results on time	0.00	0.00	21.00	46.00	46.00	46.00	46.00
Number of RBF Contracts Signed between the purchasing Agency and identified RBF facilities	0.00	0.00	30.00	46.00	46.00	46.00	46.00
Proportion of health centers who benefited from at least one supportive	0.00	0.00	40.00	50.00	60.00	80.00	80.00

Indicator Name	Baseline	YR1	YR2	YR3	YR4	YR5	End Target
supervision per timester							
Proportion of health centers transmitting health data on time	0.00	0.00	50.00	60.00	80.00	90.00	90.00
Health Financing Strategy Produced (incorporating evidence from PER and NHA)	N	N	N	N	Y	Y	Y
NHA and PER produced	N	N	N	Y	Y	Y	Y
Satisfaction of users with basic RMNCH services provided	0.00	0.00	30.00	40.00	50.00	60.00	60.00

ANNEX 1: DETAILED PROJECT DESCRIPTION

COUNTRY : Guinea
Guinea Health Service and Capacity Strengthening Project

1. This section provides additional detail on each of the project components, all of which take into account complementary partner activities in both Kankan and Kindia (see end of Annex 1 for an overview). The proposed interventions were developed in close consultation with all stakeholders and partners in Guinea, and benefited from the discussions on the joint national investment case on RMNCH which was supported by the GFF.

Component 1: Strengthen the supply of basic reproductive, maternal, newborn, and child health (RMNCH) services in target regions **(US$12 million IDA, US$5 million GFF).**

2. This component will finance the inputs needed for delivery of a package of basic services at the district level and below in Kankan and Kindia. The interventions expand those currently developed and implemented in Labé, Faranah, and Mamou and significantly empower district authorities to implement services and strengthen their financing, supervision, and monitoring capacity and authority. Specifically, this component will support the following three subcomponents.

Subcomponent 1.1: Increasing availability of drugs, commodities, and access to water and electricity at the district level in the target regions (USD4 million IDA, USD2 million GFF)

3. Overview: The project will invest in equipment, supplies (including insecticide-treated nets and contraception), micronutrient supplements (particularly vitamin A), and drugs to revitalize and replenish drug revolving funds at the health center and district hospital level and operationalize targeted health posts, health centers, and district hospitals. The project will aim to procure these supplies and commodities, possibly through the UN Children's Fund (UNICEF), and provide financing to the national Central Medical Store to deliver these inputs through the national supply chain structure. The subcomponent will also address the lack of running water and insufficient electricity access points at the health center and district hospital level. Drawing on the experience of the Ebola response support and the Mamou region project, this subcomponent will finance the construction of around 90 water wells and towers in primary health facilities and installation of solar panels in 66 health centers (close to half of all health centers in the two regions), improving access to running water at service delivery points and electricity in the target regions. Specifically, the component will finance the following.

***4. Drugs and commodities (USD2.1 million IDA)*:** Delivered by contract with UNICEF, the supplies financed under this component (see table 6 for examples) will serve to equip the 117 health centers and 13 district hospitals in Kindia and Kankan with drugs and commodities necessary to deliver the basic package of needed RMNCH services. The drugs and commodities will be most likely procured through UNICEF. The Central Medical Store will deliver the products to the facilities through the national supply chain structure.

Table 6. Examples and Estimates of Critical Supplies and Equipment to Be Procured

Items	Unit cost	Quantity	Total estimated amount in areas that the project covers (Kankan and Kindia)	Observations
Drugs, consumables, and contraception for health facilities in areas project covers	5,093	117	595,982	Unit cost based on average cost of PASSP CS during quantification of USD5,093
Medical equipment, medical furniture, instrumentation for health facilities in areas project covers	6,000	117	702,000	Unit cost based on average cost of PASSP CS during quantification of USD6,000
Management tools for health facilities in areas project covers	3,000	117	351,000	Unit cost based on average cost of CS PASSP during quantification of USD3,000
Publishing and printing financial management tools for deconcentrated health facilities	12,414	5	62,068	Average cost per year of health center of USD165.61 (USD96,879 for 5 years of 117 CS)
Small biomedical waste management equipment	150	117	17,550	Flat fee of USD150 per CS (USD17,550 for 117 CS)
Vitamin A supplements (100,000 IU)	72	232	16,704	Unit cost of box of 500 tablets USD72
Vitamin A supplements (200,000 IU)	192	1,238	237,696	Unit cost of box of 500 tablets USD192
Agreement with Pharmacie Centrale de Guinée to support distribution of medicines and medical devices	117,000	1	117,000	8% of estimated total amount of drugs, consumables, medical equipment
Total			**2,100,000**	

5. Improve access to water at health center and district hospital level (USD2 million IDA): Investments will address a critical barrier to service delivery in many primary health facilities in Kankan and Kindia—lack of running water. Drawing on the experience of the interventions supported during the Ebola response, this subcomponent will finance water wells or boreholes at primary health facilities, addressing a basic need of many facilities. It is planned to engage UNICEF to assist with building these wells and drills. Table 7 provides details on the proposed water access support, and table 8 on the estimated budget.

Table 7. Initial estimates for Water Wells construction

Objective	Improve access to drinking water in 90 health facilities (45 in Kankan, 45 in Kindia)
Beneficiaries	Patients and health care staff in the 45 targeted health facilities, including communities near the health facilities
Project cost	USD2,000,0000
Project description	• 76 mechanical wells and boreholes will be built, of which 70 will have human-operated pumps and 6 will be for drinking water connection in 76 health facilities in the Kindia and Kankan region (68 in health posts, 8 in health centers). • 20 solar-powered drinking water supply networks will be constructed and connected to delivery rooms and care units, with 8-tap stand-posts for people living on the riverside (18 in health centers, 2 in district hospitals). • Capacity of 90 hygiene committees to adequately and sustainably manage the works that the project makes available will be strengthened.
Main activities	• Construction of 76 water points equipped with human-operated pumps • Construction of 20 Water Supply points (AEPs) in 18 health centers and 2 district hospitals • Training of 90 hygiene committees and public service water management units for more sustainable management of works • Organization of workshop on how to capitalize on project achievements
Implementation strategy	Regional and district-level health authorities will identify beneficiary health facilities, based on an objective needs assessment and in collaboration with health facilities and local elected officials. AEP drilling and construction work will be entrusted to specialized companies with technical and financial capabilities through a tender or call for public bids. A commemorative plaque will be installed to highlight the World Bank's financing of this infrastructure. Control, supervision, and execution of the works will be entrusted to a technical study bureau. The National Service for Developing Water Points is charged with implementation and training of hygiene committees and public service water management units. UN Children's Fund personnel are in charge of monitoring and evaluating project activities. At the end of the project, a capitalization workshop will be organized in the project area.
Expected results	• Health personnel and patients in the 90 targeted health facilities will have permanent access to drinking water infrastructure. • Women and children who frequently use these 90 health facilities will improve their basic hygiene habits, such as washing hands. • People near rivers will have access to water through the 8-tap stand-posts. • 90 hygiene committees and established public service water management units will have the knowledge to sustainably manage hydraulic structures under their respective responsibilities.

Note: AEP refers to "*Approvisionnement en eau potable" in french, or " water supply points" in english.*

Table 8. Estimated Budget

Designation	Unit Cost (USD)	Quantity	Amount (USD)
Construction of well equipped with a human-operated pump	12,230	76	929,480
Construction of mini-drinking water supply network	30,984	20	619,680
Supervision of works and stakeholder capacity strengthening	90,000	2	180,000
Monitoring and evaluation (per diem) and operational cost (gas)	29,999	2	59,998
Technical assistance, staffing	40,000	2	80,000
Project subtotal			**1,869,158**
Indirect support cost (7%)	65,421	2	130,842
Total			**2,000,000**

6. Improve access to electricity at health center and district hospital level (USD1.9 million GFF): Investments will address a critical barrier to service delivery in many primary health facilities in Kankan and Kindia—lack of electricity at the health center and district hospital level. A recent assessment by UNICEF of health facilities in Kankan and Kindia exposed an urgent need for investment in this area. According to the report, an estimate of more than 60 percent of health facilities at the primary level in Kankan and Kindia do not have access to sufficient and reliable electricity. Drugs and commodities in many facilities are stored in conditions without electricity, which is not favorable for their storage. Lack of electricity and inability to connect computer hardware and/or charge mobile phones is sometimes considered an impediment to patient referral efforts of health centers. Drawing on the ongoing experience elsewhere, installation of solar panels at primary health facilities will be financed under this subcomponent, significantly improving access to electricity in many facilities. It is planned to engage UNICEF to coordinate and oversee implementation of solar panels in an estimated 66 health centers and five district hospitals in Kankan and Kindia (almost half of all health centers and district hospitals in the two regions).

Subcomponent 1.2: Strengthening district-level capacity to recruit, and improve the competencies of, health workers (USD4 million)

7. Overview: This subcomponent will increase the availability and competency of health workers at the health post, health center, and district hospital level (e.g., *agents techniques de santé* (ATSs), health assistants, nurses, midwives) to deliver basic RMNCH health services. The project will strengthen the financial and technical capacity of district health directorates (*Directions préfectorales de la santé* (DPSs)) to fill critical health workforce gaps, supporting district authorities with local recruitment efforts (currently done centrally), and financing the contracting of health workers to fill staffing needs (ATSs, nurses, midwives, doctors) at district hospital, health center, and health post levels. The project will finance recruitment of an estimated 400 health care staff over the 5 years of the project. Such health workers will already be in the targeted districts, but not on the government payroll and currently offering their services privately, who will be recruited as contractors to the public sector. In addition to financing their recruitment, the project will aim to strengthen their RMNCH competencies, drawing on a recent needs assessment for district health workers that the Ministry of Health (MOH) conducted with the support of KIT. This will include expanding the innovative district-level training and mentoring scheme developed in Faranah and Labé under the existing health project, which provides continuous, team-based, horizontal skills upgrading and mentoring to all district health workers that an expanded,

trained district health team organizes and delivers (rather than nongovernmental organizations (NGOs), as is often done).

8. District-level recruitment of health workers (USD2.5 million): Providing support for flexible recruitment of health workers to districts will help address the immediate need for health workers at the district level and below in the two project target regions. Although fundamental long-term reform is needed to increase availability of health workers, gaps in health worker staff at the periphery of the health system must be addressed if services are to be delivered in project facilities. According to the norms, a minimum of one midwife and one nurse should be present at the health center level and one ATS at the health post level. District hospitals should have doctors, nurses, midwives, and ATSs, depending on their size. Financing will be provided to address availability gaps of these providers. Although the project will cover the initial cost of recruiting these district health workers locally (up to 400 total – see table 9), discussions will be held to ensure that the cost of the recruitment of contractors will be incrementally transferred to the government until it is absorbed fully by the end of the project period. The project will request a signal from the government towards the end of the project that it is prepared to absorb the required costs, and continue the local recruitment and training of health workers.

Table 9. Number of District Health Workers to Be Recruited Locally and Average Cost

	Year 1	Year 2	Year 3	Year 4	Year 5	Total Cost
Number to hire	0	100	200	300	400	
Cost based on yearly remuneration (average) of USD2,500 per year (USD)	0	250,000	500,000	750,000	1,000,000	2,500,000

9. Improving RMNCH competencies of district health workers (USD1.5 million). With USD1.5 million, the project will support implementation of an institutionalized district-level training model and curricula to address the lack of continuous skills development and mentoring for new and existing district-level health workers. This will build capacity at the subnational level to provide continuous training and support and to strengthen the horizontal skills and competencies of district health workers to better deliver services at this level. Regional and district-level trainers will be responsible for delivering an ongoing horizontal training curriculum and mentorship program to health workers at the health post, health center, and district hospital levels. The training will be a combination of theoretical training (in existing district-level facilities) and practical training, which will be on-the-job training, with some modules on maternal health also provided at the district hospital level (in maternity wards). Once the minimum training has been provided, district level trainers (and supervisors) will continually mentor health workers. Specifically, the project will fund training of trainers, training of district hospital, health center staff and health center posts in relevant RMNCH modules, per diem expenses of staff and trainers, and all costs related to mentoring and formative supervision. The following provides additional details about the training strategy and the estimated costs are summarized in table 9.

10. **Objective of Training Program:** The objective of the proposed training program is to support a decentralized, government-administered training program that will strengthen the skills of newly recruited heads of health posts, health centers, and district hospitals and of current staff who provide RMNCH and primary care services but have not

had the opportunity to upgrade the core competencies that the heads of health facilities have identified as necessary. The specific objectives include strengthening provider knowledge and skills in reproductive health and nutrition; strengthening the skills of health workers in prevention, immunization, and public hygiene for better coverage of preventive interventions; management of resources (medicines, personnel, equipment, finance) in health facilities; micro-planning, monitoring, and health information system monitoring in health centers and health posts in the project area; integrated surveillance of disease and response; prevention of infection; improving health workers' knowledge of national health programs and the organization and functioning of the MOH; and increasing the capacities of an existing pool of operational actors in formative supervision.

11. **Content of Training:** Implementation of the district-level training strategy will be adapted to the specific district context based on a detailed assessment of training needs, given that training needs vary widely (individual, team (learning how to work in a team)) and in different areas (technical (clinical tasks), management). The training program will draw on the integrated training strategy that the MOH developed in 2011 and covers six modules: general information on primary health care; prevention, immunization, and hygiene; reproductive health and nutrition; disease control; resource management; and planning, monitoring and evaluation (M&E), and health information.

12. **Provision of Training:** Professionals in the field with expertise in training, who are available in both regions, will provide training on RMNCH. Training will be provided as close as possible to the field. District-level staff will train health center and district hospital staff in selected training centers at the district level. Health post staff will be trained in the chief town in the sub-district at the level of their health center. Training will target successive cohorts of staff to allow for continuity of service in health facilities and will initially target the heads of health facilities. The health workers expected to be recruited under the project will be trained once they are integrated into the system, as will staff newly recruited to public service once they have joined the targeted health facilities.

13. Training of Trainers: Given the existence of a pool of district-level trainers (and if needed, regional-level trainers), a pedagogical orientation and training of these trainers will be organized to prepare training sessions in the two regions. A pool of national trainers from the relevant central directorates and national programs will provide this orientation of trainers with technical support from KIT (an international technical assistance agency) or other technical assistance agencies as deemed appropriate. Additional trainers could be funded and integrated into district management teams that do not have the necessary human resources to form the pool of needed district-level trainers. The project will cover the costs of training the trainers, as well as the training allowances of any additional trained district trainers.

14. Continued Mentoring: Although the value of the initial and refresher trainings for improving the quality of health care provision cannot be overemphasized, these trainings do not translate into improved service delivery if follow-up on-the-job enhancement is not provided. The effective application of the knowledge and skills learned in training involves multidisciplinary teams working together to deliver health care services. This project supports the shift from traditional didactic training to results-oriented approaches; mentorship is one such approach that could bridge this gap by supporting implementation of a decentralized, cascading mentorship structure, with staff at higher-level facilities mentoring staff at lower-level units. In practice, once the initial minimum training has been provided across all modules,

district-level trainers (and supervisors) will continually mentor frontline health workers at the health center level, and individuals at the health center–level (who will have received training in this) will monitor health post staff.

Table 10. Estimated Cost of Continued District Level Training Over 5 Years

	Total (USD)
Health workers to train (and continuously mentor)	
Training of trainers	500,000
Provision of training (per diem for trainees, trainers, cost of training site and materials	500,000
Mentoring of workers	500,000
TOTAL COST	1.5 million

Subcomponent 1.3: Strengthen the District Health Directorates capacity to supervise and monitor RMNCH service delivery (USD4 million IDA, USD3 million GFF*)*

15. Overview: This subcomponent will ensure that the above inputs translate into quality services, delivered largely by strengthening the capacity of DPSs to provide supportive supervision of primary-level facilities. The DPSs will receive financial and technical support in planning and making supervision visits to improve personnel performance and quality of services in health centers. Districts will rely on supportive supervision methods, including quality checklists for supervision. Funding will finance implementation of existing supervision strategies, including training of district health teams, and costs linked to providing supportive supervision. There will also be investment in reinforcing the Health Management Information System (HMIS) (community, health post, health center, district hospital levels) under the subcomponent by expanding DHIS-2, strengthening and linking to the DHIS-2 the CRVS system to report cause of death, and providing support mechanisms to strengthen data quality at all levels. The following provides additional details on what will be financed.

16. Strengthening District-Level Supervision Capacity (US$1 million IDA): A number of constraints prevent district teams from adequately supervising health centers. In Guinea, the role of the district is to supervise health centers (in addition to district hospitals) and ensure adequate performance and motivation of staff. Some of the barriers to this are lack of a clear action plan for supervision despite general consensus on its importance; lack of a specific budget allocation for supervision; inadequate skills for supportive supervision, with most district managers with clinical, medical, or nursing training not having had adequate training in health management to enable them to provide effective supervision (district health teams comprise doctors, nurses, and midwives); lack of motivation, with most district health managers, like other health workers, not motivated to perform supervisory functions because of low salaries, limited incentives, and limited opportunities for career development as managers; lack of transportation and logistics, with district health managers often having limited access to transportation and other logistics that they need to make frequent supervisory visits in their districts; and heavy workload, with many district managers performing clinical roles (because they have clinical backgrounds), which leaves them little time to perform their managerial and administrative functions.

17. To address these constraints, the subcomponent will help the government strengthen district health teams in the following ways:

- Financing the action plan for supportive supervision, which identifies the purpose of supervision, the implementation process (including the responsibilities of managers undertaking the supervision), the frequency of supervision, and the role of staff being supervised, that has been produced under the current health project: The project will initially support these funds, but the government is expected to eventually absorb and earmark these funds; develop personnel management skills of district managers.
- Providing adequate transportation and logistics: The project will support the districts in this, mainly by identifying vehicles that were purchased during the Ebola response operation. These vehicles will be located and allocated to the districts, if needed.
- Assessing the clinical workload of managers: District health managers with clinical backgrounds who perform dual roles as clinicians and managers will have their workloads assessed, and adjustments will be made to ensure that they have time for their supervisory and managerial functions.

18. The project will support 13 district health teams (eight in Kankan, five in Kindia) consisting of four to five persons each: doctors, nurses, midwives and provide supervision for 117 health centers. A well-designed checklist is critical to the supervision program. The PCU (in conjunction with regional health authorities) will closely support the district team.

19. Strengthen DHIS-2 System and Expand to Community Level (USD1.5 million IDA, USD1.5 million GFF): The government has invested in a district-level HMIS system (DHIS-2) to increase the availability of reliable monitoring data from the health post, health center, and district hospital levels. The project will strengthen the capacity of district health teams and encourage quality reporting of service delivery indicators (SDIs) at the health post, health center, and district hospital levels. The subcomponent will strengthen DHIS-2 in the target districts and where applicable, linking data with the civil registration and vital statistics (CRVS) system that the government is developing, supported by a World Bank social protection project, and with the two districts where project-based financing (PBF) will be introduced. The MOH has chosen the DHIS-2 software as the unifying tool to build a national health information system (HIS)[6]. The objective is to have all actors use DHIS-2 and ensure the application of tools that are interoperable with that software to reduce the cost of data collection and ensure better use of information for monitoring and decision-making.

20. DHIS-2 is being used in all regional and district offices and district hospitals. Health centers and health posts still send monthly paper reports to the districts, but the *Bureau de Stratégie et Développement* (BSD) is working on finding technical solutions to overcome the challenges of poor connectivity in rural areas. The project will provide support in this area, as well as in the following priority domains:

- *Strengthen data quality.* Although no systematic review of data quality has been undertaken so far, there is some evidence from the PBF pilot that the quality of data as recorded in DHIS-2 might be weak. The MEASURE Evaluation project, moreover, funded by the United States Agency for International Development, has further indicated that much

[6] The National Strategic Plan to Strengthen the National Health Information System 2016-2020 (Plan stratégique de renforcement du système national d'information sanitaire 2016-2010) was adopted in February 2016.

more investment is needed to strengthen the HMIS foundation. Support will be provided to design and implement effective mechanisms to check and ensure the reliability of data collected, beyond the automated checks built into DHIS-2 and the supervision visits by BSD staff. The project will draw on the recommendations from a data quality review that will be conducted with the Bank's support at the end of 2017[7].

- *Support development of HIS at the community level.* The indicators and architecture, as well as the implementation and operationalization of the HIS at the community level requires support, and the government is seeking investments for development of the HIS at the community level; the project will provide such support as part of its engagement in development of the government's community health strategy.

21. Strengthening CRVS (USD1.5 million IDA, USD1.5 million GFF): Even though Guinea produces some vital statistics from civil registration, their use is limited to administrative purposes, if at all. The statistics derived from birth and death inform us about the age, sex, and occupation, among other things, of the person when the vital event occurred, but for the purposes of real-time planning, cause of death is necessary. The project will support integration of cause of death into the CRVS system, redesign of quality and security forms and registers, and any relevant training and capacity building required. Real-time disaggregated data from the CRVS system can contribute to better planning for health programming. Investments will be made to implement the recommendations that come out of the current assessment of the CRVS system.

Component 2: Strengthen the demand for basic RMNCH services in target regions (USD11 million IDA, USD2 million GFF).

22. This component will address some of the demand-side barriers to use of RMNCH services (even when health workers and relevant inputs are available) that occur because of financial and sociocultural inaccessibility of services. Although the supply-side improvements under component 1 are expected to increase health center use, component 2 will further increase use by reducing the financial burden of services on the poor and engage CHWs in outreach and demand-generation activities (in line with the CHW plan that the country has developed and is looking to implement). The component is organized into two subcomponents.

Subcomponent 2.1: Implementing an innovative district-level fee-financing scheme to mitigate out-of-pocket expenses for the indigent poor (USD8 million IDA).

23. Overview: This subcomponent will address a critical barrier to accessing health services—the fact that the poorest individuals often cannot afford even the smallest user fees charged at the health facility level. To cover the poorest people, the project will support implementation of an indigent safety net program that has been developed and piloted under the existing health project. The program focuses on a community-driven process to identify indigents, verification of such indigents by local NGOs, development of an electronic database of the indigents, and provision of verified indigents with an indigent health card that will allow them to access RMNCH services free of charge at the primary level.

[7] Module added to the SARA census carried out with World Health Organization, Global Fund, and Bank support in 2017.

The facilities providing services to the indigent population bill the central government (the project) for any services rendered. The activities to be financed under this component will focus on the community selection and NGO verification process, administrative expenses related to management of the database, issuing cards, training and communication activities, and reimbursement to health facilities for services rendered to indigents.

24. Background: The 2012 Limited Poverty Evaluation Survey reports that 55.2 percent of the Guinean population (6,212,748 individuals) are considered to be poor (earning less than GNF8,815 per person per day) (64.7 percent in rural areas, 35.4 percent in urban areas); 18.4 percent of the population is categorized as living in extreme poverty (22.2 percent in rural areas, 9.6 percent in urban areas) and 8 percent as destitute (3.8 percent in urban areas, 10.5 percent in rural areas). In 2012, the regions of Kankan, Kindia, and Conakry accounted for 46.9 percent of the country's population. The 2012 poverty map shows that the regions of Kankan (12 percent) and Kindia (18 percent) had the highest contribution to national poverty. The poorest people have the greatest difficulty accessing health services and are often not able to afford even the small user fee that patients are expected to pay.

25. The country has made great strides in identifying poor and vulnerable persons. Adequately and accurately identifying indigents, a precondition for any target program, is challenging. Progress has been made on a number of fronts; the Bank's Productive Social Safety Net Project (P156484) has supported a small social safety net program pilot based mainly on conditional cash transfers. Poor households living in the targeted subdistricts register at the subdistrict headquarters (self-targeting) in a register that accredited NGO managers keep. The rural council in each subdistrict sets up a targeting committee to analyze and identify the poverty level of each household, which is then recorded using tablets configured with a proxy means test tool. The Fund for Social Development and Solidarity is a government-funded administrative establishment with a mandate to help improve Guinean living conditions by implementing social safety net projects. They have developed tools and strategies for indigent selection (a questionnaire with weighted variables to identify poor people), community-level verification, data management, and household ranking based on overall vulnerability. Drawing on these ongoing initiatives and capacities and taking into account lessons learned from these approaches, the Bank supported the government design of a mixed targeting approach to identify indigents. Using many of the facilities established under the Fund for Social Development and Solidarity, the Primary Health Services Improvement Project in Faranah and Labe supports a system of pre-identification of potentially destitute households by the communities themselves and a proxy means test household survey with weighted variables to determine a poverty score for each surveyed household. The government has requested that the identification approach be expanded into the Kankan and Kindia regions. The following provides detailed information on proposed indigent identification.

26. Community pre-identification of indigents: Community targeting committees (CTCs) set up in each village and made up of community leaders that the communities appoint on the basis of their integrity, their knowledge of village groups and subgroups, and especially their involvement in development actions at the local level pre-identify beneficiaries. The CTC includes the president of the village council, one representative per sector, a female representative of the women's association, a representative of the youth association, and two religious figures. The number of members on each CTC depends on the number of sectors in the village. A local NGO chosen to set up the CTC coordinates community targeting and trains CTC members. Once the committee has been set up, it draws up a provisional list of heads of extremely poor households in each sector and presents it to the NGO managers, who check that these households fit the criteria for

extreme poverty.[8] This check is conducted following the extremely poor household preselection guide, after which the individual preselection sheets are submitted a second time for CTC validation, which is designed to ensure that no eligible household has been forgotten. If a household has been mistakenly omitted, the NGO managers correct the list.

27. Verifying and registering indigent status: The proxy means test is an indirect household means evaluation survey based on a small number of easily observable characteristics (e.g., sex, type of building, household size). Data are collected from all potential beneficiary households that the communities in the villages and districts pre-identify. It will be used to build a more comprehensive database on the households that will be integrated into and saved in a management information system to calculate household scores and rank the households from most to least poor. In Guinea, the Fund for Social Development and Solidarity manages the national database (single register) and makes its staff (controllers) available to conduct the surveys (Productive Social Safety Net Project and the Primary Health Services Improvement Project). Smartphones or tablets are configured for the surveys to take photos of household heads and their dependents.

28. Issuing cards and indigent access to health care: The list of beneficiaries in each village (household heads and dependents) is printed from the management information system, laminated, and distributed to health facilities so that they can check beneficiaries before providing care. One health care card will be produced and provided to each person that will enable him or her to obtain free health care at a health center. The free health care channel that extremely poor people can access is part of the health system's normal operating procedure and structure. Extremely poor people will use the same system and health care channel as other people and be served in a nondiscriminatory manner. Care should therefore be taken to avoid creating specific (stigmatizing) extreme poor data media. To access health care, indigents must present their health care card, which bears their photograph, confirms their status, and entitles them to receive health care free of charge. The card production system will be developed so as to ensure that cards are secure, weather resistant, and suited to specific needs. Once the service provider has checked and confirmed the card's authenticity, the person is checked in and a medical file opened in his or her name.

29. Administering health care to indigents and invoicing for services: Indigents are treated the same as all other people and are to respect the order in which patients are seen. When examinations or prescribed drugs are not available on site, health facilities are responsible for finding them from third-party facilities and paying on behalf of the indigent patient, including drugs from third-party pharmacies. Any other treatment that the individual requires will be conducted in the same way. The expenses that such treatment generates from an external entity and that the health facility pays for are included on the invoice that the health facility issues. Invoicing consists of establishing the price for treatment, drugs, and commodities provided to the patient. It is an important step in the health care process for extremely poor people.

[8] Major extreme poverty criteria are visible observable elements that justify the choice of the household head as extremely poor (e.g., chronic illness, slum dwelling, no means of transportation, hole-in-the-ground toilet or open defecation, traditional source or river as drinking water).

30. Verifying health care provision and reimbursing facilities for care: Verifying and validating health services delivered to extremely poor people is the responsibility of a verification body. This stage is conducted after the health care provider invoices and declares cases. The procedure is as follows: verification of eligibility of the indigent person, verification of the health care provided, and community verification conducted after treatment on samples of beneficiaries by external auditors to confirm that the care provided was effective. The project's financial departments will analyze the invoices and make payments by quarterly bank transfer to the health facility's account, which is shown on the invoice.

31. Costs of the indigent care component: The overall cost for the subcomponent (health care for destitute households) is USD7,004,592 (USD10 per person over 4 years (table 11). Approximately USD1 million will be used to cover administrative expenses (table 12).

Table 11. Cost of Components of Indigent Care

Region	Prefecture	Estimated numbers of destitute persons				Health care cost (USD)			
		Population	Total households	Destitute households	Total destitute persons	Number of destitute persons	Annual cost per person	Number of years of cost	Total
KANKAN	KANKAN	473,359	46,867	3,937	19,684	19,684	10	4	787,366
	KEROUANE	207,547	27,838	2,338	11,692	11,692	10	4	467,678
	KOUROUSSA	268,630	29,148	2,448	12,242	12,242	10	4	489,686
	MANDIANA	335,999	22,760	1,912	9,559	9,559	10	4	382,368
	SIGUIRI	687,002	64,044	5,380	26,898	26,898	10	4	1,075,939
	Subtotal	**1,972,537**	**190,657**	**16,015**	**80,076**	**80,076**	**10**	**4**	**3,203,038**
KINDIA	COYAH	263,861	35,892	3,015	15,075	15,075	10	4	602,986
	DUBREKA	330,548	45,650	3,835	19,173	19,173	10	4	766,920
	FORECARIAH	242,942	32,716	2,748	13,741	13,741	10	4	549,629
	KINDIA	439,614	62,872	5,281	26,406	26,406	10	4	1,056,250
	TELIMELE	284,409	49,153	4,129	20,644	20,644	10	4	825,770
	Subtotal	**1,561,374**	**226,283**	**19,008**	**95,039**	**95,039**	**10**	**4**	**3,801,554**
Grand total		**3 533 911**	**416,940**	**35,023**	**175,115**	**175,115**			**7,004,592**

Source: Based on the General Population and Housing Census (Destitute persons = 8.4 percent of the population, destitute household size = 5)

Table 12. Estimated Details of Administrative Costs

Recruitment of two local nongovernmental organizations for the indigent identification process for the health districts of the two regions (Kankan and Kindia)	Consulting services	720,000
Recruitment of a computer scientist or statistician to develop a computer application to manage data collected on indigents (implementation of forms, configuration of forms in tablets, data processing)	Consulting services	80,000
Printing membership cards for indigents	Services other than consulting services	200,000
Total administrative costs for scheme		**1,000,000**

Subcomponent 2.2: Supporting the Direct Health Directorates recruitment, training, supervision, and mentoring of Community Health Workers for outreach and basic service delivery (USD2 million GFF, USD2 million IDA)

32. Overview: This subcomponent will provide support to the government in implementing the community health plan currently being developed. This includes support to operationalize its vision to recruit and better and more strategically use CHWs to generate demand and basic service delivery functions at the community level. In line with the CHW plan, such support will strengthen the financial and logistical capacity of district health authorities to recruit and provide continuous training to CHWs and strengthen local capacity to supervise and mentor CHWs (with support from health centers). The support provided under this subcomponent would expand current efforts in Guinea to move away from the sporadic, non-standardized, vertical training programs that NGOs provide and institutionalize into the public sector horizontal training of community lay workers in RMNCH promotion and basic service delivery at the community level, drawing on recently developed training modules developed with support from KIT and the Johns Hopkins Program for International Education in Gynecology and Obstetrics. The component will fund costs linked to basic salaries of CHWs (according to the CHW strategy), district-level training of CHWs (including training of trainers), and continuous mentoring and supervision. The following provides more details on this subcomponent.

33. CHWs are widely accepted in Guinea, and global evidence supports their potential in demand generation and service extension. The Poverty Expenditure Report (2014) found that CHWs were particularly helpful in raising awareness and mobilizing women to obtain clinical care before the Ebola outbreak. CHWs are a diverse group often categorized into full-time paid workers with formal preservice training and volunteer part-time workers with short training (1–3 weeks) with or without payment or incentives. Both types are found in Guinea. Global evidence suggests that, although the former group is preferable overall, both groups have potential to generate demand and extend basic services into the community if adequately trained, supervised, provided with incentives, and integrated into the health system (WHO 2014). The integration of CHWs into the health system and support of their expansion and training is a core priority of the Minister of Health.

34. Who are the CHWs? Historically, program priorities and interests of various donors and NGOs have largely determined the training that CHWs in Guinea receive. Training has usually been short (1–3 weeks) and provided by NGOs or partners with a focus on developing vertical competencies. Training and supervision has seldom been linked to or integrated with existing public health system facilities, and remuneration and supervision arrangements have varied significantly. Many CHWs were drawn into the Ebola response effort, and non-Ebola-related training efforts of NGOs and non- Ebola community-level services largely ceased. Guinea had a history of training health extension workers (ATSs), a health worker cadre trained over 2 years in decentralized health training institutions and formally integrated into the service delivery structure and payroll. Although such workers were trained to fill critical gaps at the lowest level of the health system, lack of incentives and supervision has resulted in few working at the community level. The new community health plan of the MOH envisions ATSs and CHWs (those who can read and write) engaging in outreach, health promotion, and basic service delivery at the community level. According to existing planning efforts by the MOH, there should be one CHW covering 650 people within a community.

35. This subcomponent will support the district by recruiting CHWs and expanding their role and competencies in delivering key RMNCH services at the community level. In addition to financing their recruitment, the subcomponent will ensure that CHWs receive continuous training in vertical RMNCH competencies, are supervised by health post and health center staff rather than NGOs, and provide critical maternal and child health promotion and services to communities much in need. The following provides additional details on the support provided for their recruitment and their continuous training and supervision.

36. Finance and recruit CHWs for RMNCH tasks (USD1 million GFF): The project will cover the initial cost of deployment of CHWs for RMNCH tasks. Remunerating and providing incentives for CHWs has been identified as critical to their effectiveness. The government norm for how many CHWs should be linked to each health center is 10; the project will fund five per health center (with the government or other partners expected to fund the rest directly). With 117 health centers in the two project target regions, the project will support the financing of 585 CHWs by year 5 (table 13). The project will also support technical assistance in development of strategies for career progression.

Table 13. Number of Community Health Worker (CHW) Recruitments per Year and Associated Costs

	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Number of CHWs	0	100	300	400	585	585
Cost based on yearly remuneration of USD720*	0	72,000	216,000	288,000	421,200	997,200

*Based on fees paid to CHW volunteers during the Ebola outbreak. *Agents Techniques de Santé* are expected to earn this amount once they are stationed in the community.

37. Set up a continuous district-level training and supervision arrangement to strengthen the competencies of CHWs (USD1 million GFF): This will involve providing continuous district-level training to newly hired and existing CHWs and upgrading their competencies related to maternal and child health service delivery and promotion (see box 2 regarding competencies), as well as continued professional development, supervision, and mentoring once they are posted. The project will draw on the pool of district-level trainers to organize continuous training sessions and supervision arrangements for CHWs. Specifically, the project will finance finalization of a training and supervision strategy for each district and subdistrict, in line with the CHW plan; training of trainers (this will be the same team as the frontline training team); costs associated with the training sessions (per diem payments for trainers and trainees and other costs associated with training); and costs related to regular supervision visits and arrangements. Training will be delivered in monthly phases, be largely practical in content, and closely involve on-site team based training (including other frontline workers). Once all initial modules are completed, continuous refresher training will be provided in combination with continuous mentoring and supervision arrangements (by the health center team and the district team).

Box 2. Example of Community Health Worker Tasks

The World Health Organization recommends the use of lay (community) workers to promote appropriate care-seeking behavior and antenatal care, companionship during labor, sleeping under bed nets, birth preparedness, skilled care for childbirth, adequate nutrition and iron and folate supplements, monitoring of children's growth, reproductive health and family planning, HIV testing, exclusive breastfeeding, postpartum care, immunization according to national guidelines, kangaroo mother care for low-birth-weight infants, and basic newborn care; administer misoprostol to prevent postpartum hemorrhage; and provide continuous support for women during labor in the presence of a skilled birth attendant. Promoting behavior against Gender Based Violence and Female Genital Mutilation may also be part of the package.

38. Flexible allocation to support implementation of the CHW strategy (USD 3million IDA): This is a flexible allocation as specifically requested by the Ministry of Health. It will support the further implementation of a National Community Health Worker Strategy, which has yet to be fully finalized and costed. Activities to be supported will draw on international best practice and take into account the fiscal realities and challenges facing Guinea related to the implementation of any reform plan. Ultimately however, the flexible financing under this component will be allocated towards elements related to the training, recruitment, supervision, mentoring and monitoring of community health workers as will be detailed in the new strategy and supporting planning documentation. Strengthening CHW systems is a core priority to the Minister of Health.

Component 3: Strengthen the MOH's health financing capacity to guide sector reform and long-term transformation (USD17 million IDA, USD2 million GFF)

39. This component will support the government in developing and implementing comprehensive medium- and long-term strategies on health financing and service delivery reform. It will do this by supporting the introduction of RBF mechanisms at the health center and community levels in two districts in the target regions and supporting capacity building and evidence generation on health financing and service delivery at the central level to support the policy dialogue and vision for more comprehensive health financing reform in the health sector. This component is organized into two subcomponents.

Subcomponent 3.1: Enhancing the quality of RMNCH services and the quantity of RMNCH services for recipients in selected districts (through Results Based Financing) (approximately USD17 million IDA)

40. Overview: Building on the experience of a small pre-pilot RBF experiment that was supported under the existing World Bank project in the Mamou region, this subcomponent will support implementation of an expanded RBF model at the health facility and community levels in four districts in the target regions, where funding will be linked to quantity- and quality-related performance indicators of RMNCH. The existing pre-pilot has garnered interest in a larger introduction of RBF using government facilities to administer the scheme. Whereas an outside technical agency (Health Focus) is implementing the small pre-pilot, which covers just a few health centers and does not cover the community

level, this project will cover all health centers and their catchment areas in two districts, strengthening district and public sector capacity for implementation and monitoring. For such an output-based financing (OBF) model to realize its potential as a driver of long-term systematic change, the BSD, which is in charge of health financing at the central level, will be heavily involved in the design, monitoring, and evaluation of the schemes. A simple process evaluation (before-and-after study) will also be funded to generate lessons to help drive the policy dialogue toward more systemic change.

41. The following provides more detail related to the set-up of the RBF program, including areas that the project's RBF covers, cost of the RBF, players and institutional set-up, quantitative and qualitative indicators, verification and evaluation, and community RBF. Further detail, in particular related to the RBF governance, will be developed as part of the Project Implementation Manual (PIM).

42. What is RBF? RBF is a bottom-up approach to helping health systems move to greater accountability and OBF while keeping results the central driving force. A challenge in the Guinea health system is how to channel more resources to front-line services in rural areas. Input-based financing (IBF) mechanisms do not readily allow funding to go to primary levels and are crowded out by secondary and tertiary care, infrastructure, and salaries. RBF can initiate a paradigm shift by changing the fund flow, channeling more resources to primary care facilities, and linking resources to actual results.

43. RBF takes the form of a performance contract stipulating that financial resources will be paid to service providers in accordance with the quantity and quality of services provided based on predefined indicators. Key components of a successful RBF scheme include:

- Separation of functions **(**regulation, service provision, contracting, verification, payment of funds)
- Sufficient autonomy of health care providers in management and provision of incentives to staff and deciding on investments to increase the quantity and quality of services and in purchasing medical supplies and drugs from independent, competing government-accredited distributors
- Independent verification of results
- Community involvement to assess service quality
- Cash-based OBF

44. The fee-for-service structure that RBF implies is appropriate only for preventive services for which the risks of overprovision is minimal, such as skilled birth attendance, pre- and postnatal care visits, family planning, growth monitoring and promotion, immunization of children, nutrition counseling, micronutrient supplementation, and prevention of mother-to-child HIV transmission. Quality is measured using composite quality indices constructed from quality norms and standards in Guinea.

45. Why RBF: The RBF approach chosen in this project has the potential to serve the dual purpose of improving key service delivery outcomes and initiating discussions on how to move toward OBF and improve donor alignment. RBF can function as a stepping-stone to more general strategic purchasing—especially in contexts such as those in Guinea, where line-item budgets do not easily allow for OBF. Furthermore, RBF can strengthen the capacity to monitor provider performance, take corrective action, and create a platform through which other donors can potentially (virtually) pool resources to purchase a basic package of services.

46. Targeted districts: The project will implement RBF in four health districts (or prefectures): the Dubreka and Telimele districts in Kindia and the Kouroussa and Mandiana districts in Kankan. The four districts cover approximately one-third of the population in these regions, corresponding to approximately 1.3 million inhabitants. The scale of the RBF is kept relatively small to allow for a gradual process of capacity building and continuous learning before expanding. Some key statistics on the supply side in these four districts are provided in table 14 below.

Table 14. Key Statistics on Dubreka, Telimele, Kouroussa, and Madiana

District		**Dubreka**	**Telimele**	**Kouroussa**	**Mandiana**	**Total 4 districts**
Population		359,680	308,130	286,867	363,126	**1,317 803**
Health facilities	Number of hospitals	1	1	1	1	**4**
	Number of IHC and LMC	2	0	0	0	**2**
	Number of health centers	8	14	12	12	**46**
	Number of health posts	35	0	55	66	**156**
	Number of inhabitants per health center	35,968	22,009	23,906	30,261	**27,454**
Health workers	Number of doctors	16	3	2	7	**21**
	Number of state-registered nurses	25	5	10	5	**40**
	Number of state-registered midwives	22	2	2	2	**26**
	Number of healthcare technicians	73	22	46	51	**141**
	Number of community health workers	482	0	469	546	**951**
	Skilled worker coverage	56.7%	15.6%	31.4%	26.9%	**26.0%**

47. Availability of facilities in these districts lags international recommendations and Guinea's own targets. The World Health Organization recommends one health center per 10,000 inhabitants to ensure accessibility to essential health services. Guinea's own targets, as specified in the PNDS, are one health post per 3,000 inhabitants, one health center per 5,000 to 10,000 inhabitants in rural areas, one health center per 20,000 inhabitants in urban areas, and one health improvement center per 50,000 inhabitants in major cities. Table 13 presents official statistics, and considering problems with retention, it is questionable to what extent these health workers are actually present in facilities. Qualitative fieldwork before project implementation (supported by GFF) will assess the accuracy of these figures. Additional data on supply will also become available through the Service Availability and Readiness Assessment (SARA) and SDI surveys that will be conducted from late 2017 to early 2018. Both will be censuses (SDI will survey all facilities in these two districts) and therefore allow for a detailed assessment of supply-side readiness in the specific pilot districts before starting RBF.

48. Although infrastructure investments will be needed to increase the number of facilities in the long term, the project aims first to upgrade the capacity of the existing infrastructure and demonstrate—through RBF—how they can be

financed to function more efficiently. Incentives will be provided to facilities to deliver the minimum package of services as agreed on in the PNDS and attract more patients and staff through a combination of demand- and supply-side incentives.

49. The design of the small RBF pilot in Mamou relied too heavily on NGOs and therefore offered too little scope for capacity building and strengthening of the existing facilities. The proposed RBF in these two new districts will therefore explicitly use these existing facilities and contract NGOs only for assistance with (counter)-verification.

Who are the key actors and what are their roles?

50. Service providers: To ensure continuity of care, the RBF scheme will contract with health centers, CHWs, and district hospitals. The focus is on services that are in the minimum package of services, as defined in the PNDS. Incentives are set such that CHWs are encouraged to provide mostly preventive and referral services, health centers to treat simple cases and refer to hospitals when necessary, and hospitals to treat these more severe cases.

Coordination structures:

51 RBF National Technical Unit: provide training, write and regularly revise the RBF procedures manual, track the quantity and quality indicators and their prices, draw up contracts and review the performance of the regional health directorates, hold national monitoring workshops with the main players twice a year, organize quantity and quality counter-verification, run the RBF portal, check the invoices and send them to the disbursement agent. This unit should work closely with the BSD and supporting technical assistance agency to ensure timely dissemination of information and lessons learned to key stakeholders within the government and at development partners.

52. RBF Steering Committee: The Ministry Secretary-General chairs the Steering Committee, which comprises the Health Ministry directors; representatives of the Health Ministry's technical and financial partners; and representatives of the ministries of finance, decentralization, local administration, and social affairs. The role of this committee is to examine quarterly reports from the National Technical Unit and to make strategic decisions regarding RBF implementation, expansion, and sustainability. The analytical work in relation to RBF, performed by the BSD, will be discussed in this committee.

53. Regulator: The central directorates and deconcentrated facilities (regional health directorates and prefecture health directorates (PHDs)) of the Health Ministry will be the regulators, defining the required standards for infrastructure, service quality, equipment, and skilled workers; implementing policy in the pharmaceutical sector; monitoring compliance with standards in all areas; defining community healthcare standards; and implementing community health care.

54. Disbursement agent: The PCU will pay invoices, paying for the resources that the health establishments obtained and other structures on performance contracts.

Management structures:

55. The regional health directorates in Kindia and Kankan will coordinate RBF implementation, verifying the quality of the services provided by the PHDs, which will be on performance contracts, attending review meetings at the prefecture and central levels; and organizing review meetings at the regional level.

56. The PHDs will coordinate RBF implementation in their respective prefectures, verifying the quality of services that the health centers provide, attending monthly district RBF validation and coordination committee meetings, organizing regular district review meetings, conducting implementation research in RBF-related areas, and attending regional review meetings.

Verification teams:

57. Teams of verifiers will be put in place in both districts to conduct quarterly verifications of health facilities. Each team will comprise three people from the PHD and one from an NGO or consulting firm. Respective peer teams from the other district will verify referral health facilities. Local community associations will verify community satisfaction with services provided, assisted by NGOs and consulting firms. External teams will conduct counter-verification.

District RBF Validation and Coordination Committee:

58. This committee will consist of PHD representatives, verifiers, city hall representatives, health facility representatives, and representatives of local community associations involved in community-based verification. It will verify quarterly the findings of the verifications; verify quarterly the findings of the patient surveys that the local associations and verifiers from NGOs and consulting firms conduct; and identify, analyze, and solve any RBF implementation problems in the health district, health facilities, local associations, or community.

Health and Hygiene Committee:

59. In addition to their traditional roles, Health and Hygiene Committee members will contribute to RBF implementation by defining and implementing the business plans, freeing up financial resources for business plan activities and bonuses, conducting activities under contract with the health facility, and conducting their community RBF assignment.

60. Budget: The RBF is budgeted based on international experience that suggest a cost of USD2.50 per inhabitant per year. This is probably too high from a sustainability perspective and considering that the project is also providing inputs (supplies and health workers) and fee exemptions for poor people. Additional fieldwork in the two districts (before the start of the project, supported by GFF) will be conducted to obtain a better understanding of the current fund flow at the facility level. Because decentralization is incomplete, and data on public funds and revenue from out-of-pocket payments are unavailable, the size of the operational budget at these facilities is unclear (but expected to be small). The pilot might be extended to more districts if the fieldwork confirms that the budget allows for this. The typical distribution of costs, based on comparable RBF programs, is shown in table 15.

Table 15. Results-Based Financing (RBF) Distribution of Costs

Expenditure line item	Amount (USD)	Proportion (%)
Service structure subsidies and bonuses	1.25	50.0
Community verification (local community associations)	0.08	3.0
Management structure subsidies and bonuses	0.19	7.5
Counter-verification	0.13	5.0
Structures in charge of verification	0.19	7.5
Coordination	0.10	4.0
Miscellaneous (e.g., training, studies)	0.08	3.0
Community worker RBF	0.50	20.0
TOTAL	**2.50**	

61. On this basis of US$2.50 per inhabitant per year, the estimated cost of RBF implementation in the Dubréka, Telimele, Kouroussa, and Mandiana health districts would be approximately US$17,039,687 (Table 16).

Table 16. Estimated Cost of Results-Based Financing (RBF) Implementation

Region	Prefecture	Population	Annual cost of RBF implementation (USD)				Total
			Year 1	Year 2	Year 3	Year 4	
Kindia	Dubreka	359,680	1,079,040	1,132,992	1,189,642	1,249,124	4,650,797
	Telimele	308,130	924,390	970,610	1,019,140	1,070,097	3,984,236
Kankan	Kouroussa	286,867	860,601	903,631	948,813	996,253	3,709,298
	Mandiana	363,126	1,089,378	1,143,847	1,201,039	1,261,091	4,695,355
Total		**1,317,803**	**3,953,409**	**4,151,079**	**4,358,633**	**4,576,565**	**17,039,687**

Note: An annual increment of 5 percent has been applied to factor in demographic growth and improvement in performance of health services owing to implementation of the RBF strategy.

62. RBF funds will be a major source of flexible funding for facilities to cover operational costs. They should be used for activities that are most cost-effective to increase the volume of patients and services and quality of care as laid out in the quarterly business plans that all facilities will be required to provide. Typically, such activities include staff bonuses (usually at a maximum of 40 percent of the total RBF budget), renovation of infrastructure, supplies, and training. At the management structure level (National Technical Unit RBF, regional health directorate, PHD), the use of RBF resources will be at the discretion of each structure's (i.e., health facilities) senior management.

63. Integration of CHWs into RBF: Given the strong commitment of the government to strengthen and implement the Community Health Strategy, CHWs form an integral part of the RBF. Mayors will sign contracts, and the Health and Hygiene Committee will play an important role in monitoring and remunerating CHWs. Staff at health centers will keep track of the number of patients that are accompanied by CHWs, which forms an important component of their remuneration. Incentive payments will be added to payments to health facilities, and the Health and Hygiene Committee

will organize individual payments to CHWs. Because the government is currently drafting its strategy for the Community Health Policy, with support from GFF and other development partners, many questions remain to be answered on how these workers should be selected and on how and how much they should be compensated. The project aims to align with this strategy and will adjust its design as necessary.

64. Combining demand- and supply-side incentives: As described in Component 2, the project will encourage demand for services among the poorest households using a targeted fee exemption scheme in all districts in the four regions. Although the health cards are targeted at households, they are important on the supply side as well because providers know that they will be compensated for providing care to these patients. In the two RBF districts, the exemption scheme will therefore be integrated into the RBF, and reporting, verification, and payment of providers for services provided to the poor people identified will be integrated into the RBF fund flows.

65. Evaluation of RBF: The scale of the pilot (four districts) does not allow for a rigorous comparison of RBF and IBF. To better understand whether and how RBF can be a tool for more-systemwide change, the project will fund a process evaluation to understand where the barriers to implementation are. The evaluation will also examine specific design features of the RBF and try to identify how the scheme can be made less expensive (e.g., lowering the verification needs) and encourage quality (e.g., continuously changing the indicators used in the score), two areas that are not well covered in the RBF literature. In addition, the effects of the community health model will be evaluated to identify whether and how these workers should be individually encouraged. These evaluations will rely as much as possible on survey data that will be collected as part of the activities described in subcomponent 3.2; the SARA (2017) and SDI (2018) will be conducted as censuses in the project areas, and a representative household poverty and expenditure survey will be conducted early in 2018. Follow-up data collection for SARA and SDI and additional data collection are budgeted for in subcomponent 3.2.

Subcomponent 3.2*:* Strengthening the capacity of the MOH in health financing, and development of long-term reform strategies (USD2 million GFF, USD3 million IDA)

66. Overview: This subcomponent will strengthen institutional capacity to shift the health financing paradigm from monitoring inputs to managing results by giving MOH staff the skills and knowledge needed to use new health financing and related budgeting, planning, and monitoring tools. Part of the support under this component (USD3 million in IDA funds) will be for the BSD to recruit full-time, engaged health financing staff and cover costs related to the planning, design, implementation, and dissemination of various studies and evidence-generation activities related to health financing and service delivery strategies and quality of care (e.g., medium-term expenditure framework, NHAs, SDI). The other part (approximately USD2 million) will finance capacity building, technical support, and training for the BSD and Division of Administration and Finance in the MOH on tools needed to strengthen health financing planning, management, and monitoring capacities (including for RBF) and to support the BSD in establishing systematic, long-term reform (focused on decentralized financing, decision-making authority, and accountability systems). This will be performed with the support of an international technical assistance agency with a well-defined term of reference to ensure that there is transfer of knowledge and skills to MOH staff after the contract is completed. The following provides more detail.

67. Objective: The centralized financing system, heavy reliance on IBF, and the large share of funding going to salaries limit the capacity of the system to deliver frontline services. Limited capacity in health financing and lack of accountability are key barriers to systemic change. The demand- and supply-side investments made in this project will be sustainable and drive structural change only if supported by a strong capacity-building component at the central level. The health financing component aims to ensure that key stakeholders—including external partners—share a common vision of how to move to greater accountability and strengthen the link between finance and service delivery and that capacity is being built on realizing this vision.

68. The BSD: The BSD at the MOH is responsible for tasks related to planning and budgeting within the health sector. The BSD consists of two subdivisions: the *Division Planification et Etudes* and the *Système National d'Information Sanitaire*. The main functions of the BSD are to study and define the elements of the *Politique Sanitaire National* in relation to the technical services of the ministry; coordinate and monitor health interventions in accordance with the *Plan National de Development Sanitaire*; and produce, store, and disseminate health information. The BSD lacks the necessary human resources (in terms of quantity and technical capacity) required to deliver on its work program. The capacity of the BSD will be increased through investment in **inputs** (human resources, data, tools) funded from the IDA accompanied by a GFF-funded **technical assistance component to ensure that these inputs are efficiently used**. More detail on these investment areas is provided below, and an overview of the budget breakdown in table 17.

69. Investing in inputs for BSD (USD 3 million IDA)

Hire additional staff. BSD has limited staff, most of whom are quite senior. For reasons of continuity and to increase technical capacity, there is a need for more junior staff who can be trained and gradually take over tasks and drive systemic change.

Collect more and higher-quality data on the demand and supply side of the health system. For current and new BSD staff to plan, budget, and make course corrections, it is essential that the performance of the functions of the health system be transparent. Although data collection regarding service delivery will be strengthened under subcomponent 3.2, this component will support regular data collection on the supply side readiness of the health system (SARA, SDI), on usage and spending patterns from a demand-side perspective (Demographic and Health Survey, out-of-pocket expenses on health), on the overall allocation of public and external resources (NHA, medium-term expenditure frameworks, fiscal space assessments), and on evaluation of specific health financing pilot interventions (RBF, exemption of the poor, providing incentives to CHWs).

70. Ensuring efficient use of these inputs (USD 2 million GFF)

Strengthen technical capacity of BSD. Training will be delivered on various technical activities: institutionalization of NHA, public financial management, developing Medium Term Expenditure Frameworks (MTFs), and analysis of household and facility survey data. Such training will include not only the technical aspects, but also translation of such evidence into the policy debate and consist of short courses and on-the-job training.

Build long-term technical capacity on health financing. Although training delivered in the short term will address the most pressing needs, long-term efforts are needed to build a cadre of capable young professionals who can find their way to the BSD and other relevant departments in the government and drive sustainable reform. To this end, the project will support development of local capacity by strengthening links with academic institutions—developing and offering modules on health care financing in existing curricula, setting up internships in BSD, and fostering collaboration with an international university.

Strengthen managerial capacity. On-the-job training will be provided to strengthen the capacity of the BSD to manage its activities and staff. This will require that clear roles and responsibilities be established and a process for performance monitoring and investing in tools for better communication be set up.

Ensure policy relevance of capacity being built. The abovementioned efforts will be closely aligned with developing an updated health financing strategy and accompanying implementation plan, which ranks high on the policy agenda. The strategy will need to build on the evidence generated specifically on RBF, the community health strategy, and fee exemptions for poor people and to establish a practical roadmap to sustainable change on each of these aspects.

Improve coordination between all stakeholders. Because Guinea's health sector depends heavily on external resources, BSD can play its role in planning, budgeting, monitoring, and setting out the strategy only if it has clarity on the amount and allocation of external resources. The project will also support setting up a joint donor coordination unit to increase such transparency. The BSD will need to play a critical role in linking to such a unit on a regular basis, and this component will support establishing this linkage in the most efficient way.

71. Ensuring the efficient use of these inputs requires intensive, continuous support on the ground. An external technical assistance agency will be contracted to take on this task. Careful attention will be paid to the incentive structure in such a contract to ensure that capacity is being built in the government rather than the technical assistance agency taking over parts of its function. Furthermore, although the agency can draw on temporary technical experts, it is essential that it have a core team permanently on the ground.

Table 17. Budget for Subcomponent 3.2

Activity	Budget (over 5-year period) (USD)
Institutional strengthening in health care financing and planning	
Expanding workforce of *Bureau de Strategie et Development*	150,000
Training staff	100,000
Dissemination, communication	50,000
Subtotal	**300,000**
Improving evidence-based decision making	
Supply-side readiness survey (service delivery indicator, service availability and readiness assessment)	1,000,000
Household survey to monitor out-of-pocket expenses	500,000
National health accounts	200,000

Health information systems	500,000
Evaluation of results-based financing	500,000
Subtotal	**2,700,000**
In-field support	
Contracting of international organization	2,000,000
Subtotal	**2,000,000**
Total	**5,000,000**

Component 4: Strengthening project management, implementation, and donor coordination capacity (USD2 million IDA, USD1 million GFF)

72. This component will provide support for managing the project and related monitoring and evaluation (M&E) activities through the existing Project Coordination Unit (PCU), and support the possible eventual integration of the PCU into a broader donor coordination unit headed by the Ministry (which is in the planning). Specifically, with USD2 million from IDA, the component will finance the recurrent costs for the PCU team, the same team managing the existing World Bank projects. The current PCU will be expanded to include extra staff at the regional level for ease of implementation. In addition, with a contribution of USD1 million in GFF grant funding, the component will support the ministry in better coordinating overall donor support (including with this project). There are ministry plans to bring all of the project PCUs of different partners (including the existing World Bank PCU) under one roof in Guinea and to have a MOH official lead and coordinate these. The GFF grant will support these efforts, including financing the initial salary of one person to lead the donor coordination unit and any start-up costs for this unit. The following provides more detail on the activities and costs of the proposed support.

73. PCU team support/costs (2 million IDA): The Project will support the costs of the existing PCU team in Conakry, however expand the PCU to the regional level in Kankan and Kindia to strengthen its reach and implementation capacity, coordination, and monitoring of project interventions in the target regions of the project. The need for stronger project management support at the decentralized level (i.e. Regional level) was a key lesson learned from the existing project. Some of the PCU expenses will be complemented with financing from the existing World Bank Projects.

74. Joint Donor Coordination Unit (USD1 million GFF): Recent evaluations, including those that the Global Alliance for Vaccines and Immunization, conducted in 2014 and 2016 and an organizational, institutional, and operational audit in 2016, have revealed significant needs for better programmatic, accounting, and financial management coordination by the MOH. Various partners and organizations finance and implement MOH projects and programs, sometimes through a direct financing and implementation approach by partners (UNICEF, WHO, UN Population Fund, international NGOs) and sometimes through the use of project management units with linkages to the MOH (World Bank, U.S. Agency for International Development, European Union).

75. The government is planning to strengthen the ownership and capacity of the MOH BSD and Division of Administration and Finance (DAF) to harmonize the financing and management of donations, credits, grants, and projects; to improve

oversight of implementation; and to reduce the burden of managing multiple grants and projects in parallel. The idea is to develop a better mechanism to coordinate external assistance programs and improve the financial management and coordination capacities of projects and programs.

76. The effective functioning of this unit would contribute greatly to implementation of the national Compact, which the MOH and its technical and financing partners have signed, within the framework of "health for all." Growth in health investments in the post-Ebola period requires, more than ever, at the level of the state as a whole and particularly at the level of the MOH, coordinated, effective, efficient, transparent management of public finances and health programs. Setting up a programmatic and financial management unit within the MOH is an illustration of the desire of Guinean authorities to succeed in the health governance component of the priority action plan for the post-Ebola recovery of the health system.

77. The MOH, with support from partners and the GFF, is conducting a feasibility study to identify specific design options for a financial and programmatic management unit of donor assistance, with the aim of strengthening the management and coordination of the many funds and programs that partner organizations are implementing—sometimes in parallel and without much oversight. The various donor programs and financing streams need to be brought together under the umbrella of a new management unit in the MOH (or joint donor coordination unit) headed by a director for international cooperation and to move toward greater coordination and allocative efficiency of health sector spending.

78. Under the project, USD1 million in GFF support will fund the design and consultative process of developing this joint donor coordination unit and cover any start-up costs to facilitate its operationalization. This could include investments in software development to harmonize donor aid and programs (linked to the donor mapping that the GFF supports), to finance consultation to fine-tune the design, and to finance office space and technical assistance and training needed to manage such a unit.

All of the interventions in all 4 components take into account, and will benefit, from the complementary activities of partners: The following is a brief overview of partner investments:

79. With a nationwide budget of approximately USD 134 million in 2017, the Global Fund for instance addresses mainly the prevention and treatment of issues related to HIV, Tuberculosis, and Malaria in all regions in Guinea including Kankan and Kindia. GAVI, with commitments totaling around USD 84 million since 2001 for all regions in Guinea, addresses primarily access to vaccination and the strengthening of the health system. USAID, with a nationwide budget of approximately USD 29.3 million in 2016, has been working in both Kindia and Kankan on Ebola prevention initiatives, strengthening community health, and addressing issues of malnutrition. KFW Development Bank is invested mostly in Kindia with a budget of USD 15 million in the area of reproductive and family health, again. Their new financial cooperation program comprises the rehabilitation and extension of health infrastructure especially in peripheral regions, potential plans to support and complement performance-based financing (PBF) mechanism for health services related to pregnancies and childbirths, as well as communication and awareness-raising measures. UNFPA on the other hand is supporting reproductive health services with programs on essential obstetric care, adolescents and youth, family planning and health commodities with a budget of about USD 1 million for the regions of Kankan and Kindia.

80. It is important to note that much of the financing is channeled to NGOs and other implementation agencies and contractors: Helen Keller International (HKI) for example has received financing from USAID and Global Alliance Canada to tackle malnutrition, vitamin A deficiency, and Ebola prevention in the regions of Kankan. Also JHPIEGO, primarily financed by USAID, has been working on strengthening community health through the development of training manuals for community health workers and capacity building workshops.

ANNEX 2: IMPLEMENTATION ARRANGEMENTS

COUNTRY : Guinea
Guinea Health Service and Capacity Strengthening Project

A. Project Institutional and Implementation Arrangements

1. The institutional arrangements needed to prepare and implement the proposed project activities include the following.

2. The Ministry of Health (MOH) will be the implementation agency for the new operation at all levels, in addition to providing technical stewardship at the central level. A steering committee, the same one involved in the existing projects, will provide strategic direction, monitor overall progress of the project, and approve annual work plans and annual and quarterly reports. The Secretary General of the MOH (or possibly an advisor to the Minister of Health) chairs the steering committee, which is composed of MoH and MOF department directors and representatives from UNICEF, the UN Population Fund, and World Health Organization. Each directorate in the MOH will play its administrative role regarding the project.

3. The day-to-day management of the project will be the responsibility of the Project Coordination Unit (PCU), that existing Bank projects use. The PCU consists of a technical unit and fiduciary unit, staffed by technical personnel and headed by a full-time project coordinator. The PCU will be decentralized in the two regions, where a minimum number of staff will be hired—at least one physician, one accountant, and one monitoring and evaluation specialist (to work closely with district authorities). The PCU will work in close collaboration with the BSD (which will support planning efforts) and report directly to the Secretary General (or possibly an advisor to the minister) and is tasked with coordinating project activities; paying performance-based financing (PBF) subsidies under component 1 (closely linked to the health financing staff in the *Bureau de Strategie et Development* in the MOH); providing financial management for project activities under the project components; and preparing consolidated annual work plans, budgets, monitoring and evaluation reports, and the project execution report for submission to the Steering Committee and the International Development Association (IDA).

4. A suitable agency (NGO) for verification of results in the results-based financing (RBF) pilot district will be identified and assessed to determine its appropriateness. The institutional setup for the PBF elements of the project will be detailed in a national manual on PBF. A nongovernmental organization (NGO) will also be identified to verify indigent payments.

5. The UN Children's Fund (UNICEF) will be contracted to construct water wells, equip facilities with solar panels, and procure medications and supplies. The national Central Medical Store, the *Pharmacie Centrale de Guinée* (PCG), will carry out distribution functions related to key pharmaceuticals and commodities funded under this component, The PCG has benefitted from recent technical support from the European Union and MSH/SIAPS.

6. The new operation will comply with the *manual of procedures* and expenses will be included in quarterly financial reports. All project funds will be financially audited following existing audit guidelines. The terms of reference for the existing independent external auditor will be amended to take into account this new operation.

B. Financial Management and Disbursements

7. The Project Coordination Unit (PCU) of the ongoing Primary Health Service Improvements Project (PASSP- P147758) under the oversight of a steering committee chaired by the Minister of Heath or his representative will have the overall fiduciary responsibility of the new project Health Service and Capacity Strengthening Project. The financial management arrangements for this project will be based on the existing arrangements in place under the PASSP (P147758); the Regional Disease Surveillance Systems Enhancement (REDISSE) (P154807); and Post Ebola Support Project (PESP) MAMOU (P158579) managed by the same PCU. The overall performance the PCU was rated Satisfactory following the last FM supervision of PASSP conducted in May 2017. At the time of the FM assessment, the supervision mission of the Post Ebola Support project- MAMOU was ongoing. The primary finding of the mission did not reveal any key issues; the first disbursement to UNICEF, one of the two Implementing entities was made on August 14, 2017.

8. Staffing has remained adequate and proper books of accounts and supporting documents have been kept in respect of all expenditures. The PCU is familiar with the Bank FM requirements. The audit for the year ended December 31, 2016 for the PASSP was submitted on time, and the external auditor expressed unqualified opinion. Most of the recommendations related to the internal control weaknesses have been implemented or are being implemented. Furthermore, the main recommendations of last supervisions related to the last supervision mission of PASS are being implemented mainly the selection of the Internal Auditor. However, the issue of the sharing of the operating costs of the PCU among the different projects managed by the PCU, remains to be addressed. This issue is part of the action plan derived from the FM assessment. The interim un-audited financial reports for the on-going projects are also submitted on time.

9. The overall risk for the Health Service and Capacity Strengthening Project following the FM assessment has been rated Substantial. It is considered that the financial management satisfies the Bank's minimum requirements under Bank Policy and Directive- IPF, and therefore is adequate to provide, with reasonable assurance, accurate and timely financial management information on the status of the project required by the Bank.

10. To mitigate the risks, the following measures will be required**:** In order to maintain the continuous timely and reliability of information produced by the PCU and an adequate segregation of duties, the following staff with qualifications and experiences satisfactory to the Bank will be appointed: (i) one accountant fully dedicated to the accounting and disbursements tasks of this new Project; (ii) a senior accountant to oversee and coordinate the accounting works performed by all the accountants assigned to each project managed by the PCU including at regional levels; and (iii) one accountant for each Regional Office to be set up in Kindia and Kankan. The senior accountant will report to the FM Officer (Responsible Administratif et Financier- RAF) of the PCU. The Implementation Manual including fiduciary procedures will also be updated to include specific arrangements related to the fiduciary aspects of this new project. The existing accounting software will be configurated and customized to include the new project managed by

the PCU. The software will be installed in the regional offices in Kindia and Kankan. A designated account in US$ and a transaction bank account in GNF managed by the PCU, will be opened in a commercial bank on terms and conditions acceptable to the Bank. Interest income on the DA/PA will be deposited into a specific account opened in a commercial bank. Furthermore, two sub-bank accounts will be opened in commercial banks acceptable to the Bank and will be managed by the regional offices in Kankan and Kindia. Finally, the terms of reference of the external auditor will be updated to include this new project in the scope of the audit mission. These mitigation measures are dated covenants and should be implemented within three to four months following the effectiveness of the project. However, the selection of the senior Internal auditor should be completed by project effectiveness.

Detailed Financial Management and Disbursement Arrangements

11. A FM assessment of the implementing unit (PCU) of PASSP, REDISSE and MAMOU, identified to manage the project, was carried out in August/September 2017. The objective of the assessment was to determine whether the PCU has acceptable FM arrangements in place to ensure that the project funds will be used only for intended purposes, with due attention to considerations of economy and efficiency. The assessment complied with the Financial Management Manual for World Bank investment projects financing operations, effective December 11, 2014.

12. Arrangements are acceptable if they are capable of accurately recording all transactions and balances, supporting the preparation of regular and reliable financial statements, safeguarding the project's assets, and are subject to auditing arrangements acceptable to the World Bank. These arrangements should be in place when the new project implementation starts and be maintained as such during project implementation. The assessment concluded that the FM of the PCU satisfies the World Bank's minimum requirements under Bank Policy and Directive- IPF and therefore is adequate to provide, with reasonable assurance, accurate and timely FM information on the status of the project required by the World Bank.

13. The overall FM risk rating is assessed as Moderate and mitigation measures proposed (see Table 18) will strengthen the internal control environment and maintain the continuous timely and reliability of information produced by the PCU and an adequate segregation of duties**.**

Table 18. FM Action Plan

Action	Responsible Party	Deadline and Conditionality
Design a mechanism for sharing the operating costs of the PCU among the different projects managed by the PCU; this will allow to reflect the contribution of each project to the overall operating cost of the PCU.	PCU of PASSP	Three months after effectiveness
Update the PIM, including fiduciary procedures to include specific arrangements related to the new project.	PCU of PASSP	Three months after effectiveness
Update the configuration of the accounting software of the PCU and install the software in the regional offices opened in Kindia and Kankan	PCU of PSAAP	Two months after the operationalization of the regional offices
Recruit one Accountant assigned to the new project and with qualifications and experience satisfactory for the World Bank.	PCU of PASSP	Three months after effectiveness

Action	Responsible Party	Deadline and Conditionality
Recruit one Principal Accountant with qualifications and experiences acceptable for the World Bank to oversee and coordinate the accounting works performed by the accountants assigned to each project managed by the PCU.	PCU of PASSP	Three months after effectiveness
Recruit one accountant for the regional office of Kindia and the regional office of Kankan	PCU of PASSP/ Regional Offices	two months following the creation and operationalization of the Regional Offices
Finalize the selection of the Senior Internal Auditor (already on-going under the PASSP)	**PCU of PASSP**	**By effectiveness**
Recruit one assistant (junior) Internal Auditor	PCU of PASSP	Three months after effectiveness
Recruit the external auditor	PCU of PASSP	Four months after effectiveness

14. Internal control system. An FM Procedures Manual is available to define control activities and an internal audit function to carry out ex post reviews and to evaluate the performance of the overall internal control system. Due to the increase in the PCU of PASSP, the need to implement an effective internal audit function is becoming critical. In addition to the selection of the Senior Internal auditor, the selection of an Assistant Internal Auditor to is needed to strengthen the team of internal auditors. To address the weaknesses identified during the implementation of PASSP and other projects managed by the PCU at the Ministry of Health, the composition, the mandate, and frequency of meetings of the Steering Committee will be strengthened to ensure adequate oversight of the project.

15. Planning and budgeting. The PCU of PASSP will prepare a detailed consolidated annual work plan and budget (AWPB) for implementing the project activities. The AWPB will be submitted to the project Steering Committee for approval and thereafter to IDA for no-objection, not later than November 30 of the year preceding the year the work plan should be implemented.

16. Accounting. The prevailing accounting policies and procedures in line with the West African Francophone countries accounting standards—SYSCOHADA—in use in Guinea for ongoing World Bank-financed operations will apply. The accounting systems and policies and financial procedures used by the project will be documented in the project's administrative, accounting, and financial manual. The PCU will customize the existing accounting software to meet the new project requirements as well as to allow for recording of transactions at regional offices of Kindia and Kankan. Accounting documents/ supporting documents of expenditures will be kept in these offices.

17. Interim financial reporting. The consolidated unaudited IFRs will be prepared every quarter and submitted to the World Bank regularly (e.g. 45 days after the end of each quarter) and on time. The IFR will reflect the transactions made at central and decentralized levels as well as any funds managed by UN Agencies. The frequency of IFR preparation as well as its format and content will remain unchanged. The consolidated quarterly IFR for the new project includes the following financial statements: (a) Statement of Sources of Funds and Project Revenues and Uses of funds; (b) Statement of Expenditures (SOE) classified by project components and/or disbursement category (with additional information on expenditure types and implementing agencies as appropriate), showing comparisons with budgets for the reporting

quarter, the year, and cumulatively for the project life; (c) cash forecast; (d) explanatory notes; and (e) Designated Account (DA) activity statements.

18. Annual financial reporting. In compliance with International Accounting Standards and IDA requirements, the PCU of PASSP will produce annual financial statements. These include (a) a Balance Sheet that shows assets and liabilities; (bi) a Statement of Sources and Uses of Funds showing all the sources of project funds and expenditures analyzed by project component and/or category; (c) a DA Activity Statement; (d) a Summary of Withdrawals using SOEs, listing individual Withdrawal Applications by reference number, date, and amount; and (e) notes related to significant accounting policies and accounting standards adopted by management and underlying the preparation of financial statements. The annual statements will reflect the transactions incurred at central and decentralized levels as well as those of the UN Agencies.

19. External Auditing. The PCU will submit audited project financial statements satisfactory to the World Bank every year within six months after closure of the fiscal year. The audit will be conducted by an independent auditor with qualifications and experience acceptable to the World Bank. A single opinion on the audited project financial statements in compliance with the International Federation of Accountants will be required. In addition, a Management Letter will be required. The Management Letter will contain auditor observations and comments and recommendations for improvements in accounting records, systems, controls, and compliance with financial covenants in the Financial Agreement. The report will also include specific controls such as compliance with procurement procedures and financial reporting requirements and consistency between financial statements and management reports as well as findings of field visits (for example, physical controls). The audit report will thus refer to any incidence of noncompliance and ineligible expenditures and misprocurement identified during the audit mission (see Table 19). The project will comply with the World Bank disclosure policy of audit reports and place the information provided on the official website within two months of the report being accepted as final by the team and the World Bank.

Table 19. Due Dates of the Audit Report

Audit Report	Due Date	Responsible Party
Audited financial statements including audit report and Management Letter	(a) Not later than June 30 (2000 + N) if effectiveness has occurred before June 30 (2000 + N-1). (b) Not later than June 30 (2,000 + N+1) if effectiveness has occurred after June 30, (2000 + N-1)	PCU of PASSP

20. Upon credit effectiveness, transaction-based disbursements will be used. The project will finance 100 percent of eligible expenditures inclusive of taxes. A designated account (DA) and a Project Account (PA) or Transaction account will be opened in a commercial bank under terms and conditions acceptable to IDA. The ceiling of the DA will be stated in the DFIL. An initial advance up to the ceiling of the DA will be made and subsequent disbursements will be made against submission of SOE reporting on the use of the initial/previous advance. The option to disburse against submission of quarterly unaudited IFRs (also known as report-based disbursements) could be considered, as soon as the project meets the criteria. Other methods of disbursing the funds (reimbursement, direct payment, and special commitment)

will also be available to the project. The minimum value of applications for these methods is 20 percent of the DA ceiling. The project will sign and submit Withdrawal Applications electronically using the eSignatures module accessible from the World Bank's Client Connection website. Interest income on the DA/PA will be deposited into a specific account opened in a commercial bank.

21. Use of UN Agencies: In the case of payments to UN agencies, the special World Bank disbursement procedures will be used to establish a "Blanket Commitment". The "Blanket Commitment" will be set up for each UN agency for the full amount to be transferred to the UN agency as an Advance. The following UN Agencies will be contracted during the project implementation period: (i) UNICEF for water and solar electricity and; (ii) WHO for capacity strengthening.

22. Payments under Performance Based Financing (PBF): This mechanism will be implemented in two districts in Kankan and two districts in Kindia. For the components under PBF, payments will be made upon verification and approval of the achievements of the agreed results by the Independent Verification Agent (IVA). The IVA certificate (visa) will be provided to support the withdrawal applications prepared by the PCU and submitted to the Bank for payment. The PCU will transfer the funds into a sub-bank account opened in a commercial bank acceptable to the Bank in Kankan and Kindia. The funds transferred will be based on approved annual work plan and budget of each region. Each Regional Office will manage the funds and made payments based on the activities agreed in the annual work plan and budget as well as the results achieved and verified by the IVA (Likely an NGO). The modalities of transfer of funds from the Project account (PA) opened in Conakry to the regional offices will be detailed in the project implementation manual as well as the FM procedure manual. Supporting documents of payments will be kept in the regional offices.

23. Local taxes. Funds will be disbursed in accordance with project categories of expenditures and components, as shown in the Financing Agreement. Financing of each category of expenditure/component will be authorized as indicated in the Financing Agreement and will be inclusive of taxes according to the current country financing parameters approved for Guinea.

24. Support to the implementation plan. FM supervisions will be conducted over the project's lifetime. The project will be supervised on a risk-based approach. Based on the outcome of the FM risk assessment, the following implementation support plan is proposed. The objective of the implementation support plan (see table 20) is to ensure the project maintains a satisfactory FM system throughout its life.

Table 20. FM Implementation Support Plan

FM Activity	Frequency
Desk reviews	
IFRs' review	Quarterly
Audit report review of the program	Annually
Review of other relevant information such as interim internal control systems reports	Continuous, as they become available
On-site visits	
Review of overall operation of the FM system (Implementation Support Mission)	Semester for Substantial risk
Monitoring of actions taken on issues highlighted in audit reports, auditors' Management Letters, internal audits, and other reports	As needed
Transaction reviews	As needed
Capacity-building support	
FM training sessions	Before project effectiveness and during implementation as needed

C. Procurement

25. Procurement rules and procedures. Works, goods, and non-consulting and consulting services for the project will be procured in accordance with the procedures specified in the World Bank Procurement Regulations for IPF Borrowers, dated July 2016 (procurement regulations) and the World Bank Anti-Corruption Guidelines: Guidelines on Preventing and Combating Fraud and Corruption in Projects Financed by IBRD Loans and IDA Credits and Grants dated October 15, 2006, and revised in January 2011 and July 1, 2016, as well as the provisions stipulated in the financing agreement.

26. All goods, works, and non-consulting services will be procured in accordance with the requirements set forth or referred to in Section VI of the Procurement Regulations—Approved Methods: Goods, Works and Non-Consulting Services; consulting services will be procured in accordance with the requirements set fort or referred to in Section VII—Approved Selection Methods: Consulting Services of the Procurement Regulations, the Project Procurement Strategy for Development (PPSD), and the procurement plan approved by the World Bank. The procurement plan for each contract, including its updates, shall include a brief description of the activities and contracts, selection methods to be used, cost estimates, time schedules, the Bank's review requirements, and any other relevant procurement information. The procurement plan covering the first 18 months of the project implementation was prepared and approved before the negotiation date. Any updates to the procurement plan will be submitted for the Bank's approval. The recipient (i.e. PCU) shall use the Bank's online procurement planning and tracking tools (STEP) to prepare, clear, and update its procurement plans and conduct all procurement transactions.

27. Requirements and Actions for National Open Competitive Procurement. When procurement is conducted on the national market, as agreed to in the procurement plan, the country's procurement procedures may be used, with the

requirements set forth or referred to in paragraphs 5.3 to 5.6 related to national procurement procedures. For Guinea, the requirements for national open competitive procurement are outlined in table 22.

Table 22. Requirements and Actions for Competitive Procurement

Requirements	Actions
Open advertising of procurement opportunity at national level	No action needed
Procurement open to eligible firms from any country	Eligibility conditions in Art 51 of the Procurement Code; Project Procurement Strategy for Development (PPSD) needs to reflects this.
Request for bids or request for proposals will require that bidders or proposers submitting bids or proposals present signed acceptance at time of bidding to be incorporated into any resulting contracts, confirming application of and compliance with Bank's anti-corruption guidelines, including without limitation Bank's right to sanction and Bank's inspection and audit	Form elaborated by Operations Policy and Country Services (OPCS) must be added to each contract agreement with bidders or consultants.
Contracts with appropriate allocation of responsibilities, risks, and liabilities	The Country bidding documents are largely based on the Bank's standard procurement documents. They are not assessed by the Bank however require consistency with the new procurement framework.
Publication of contract award information	The Contract award information is stated in Art 12 of Procurement Law and Art 67 of Procurement Code. Publication is required for all contracts awarded using competitive methods. Requirement extends to all contracts.
Rights for Bank to review procurement documents and activities.	Requirement should be included in procurement plan.
Effective complaints mechanism	PCU will refer to Art 123 to Art 132 of Procurement Code.
Maintenance of records of procurement process	Art 15 of Procurement Code requires Public Procurement Regulation Agency (ARMP) to collect and maintain records of all procurements processed. For other actors, requirement not specified. The PCU must spell out practical modalities and appropriate documentation to archive.

28. Procurement Risk Assessment and Mitigating Measures. The PCU of PASSP (P147758), under oversight of the steering committee chaired by the Minister of Health or his representative, will have overall fiduciary responsibility for the new Health Service and Capacity-Strengthening Project. Procurement activity management arrangements for this project will be based on the arrangement in place under the PASSP (P147758). The procurement specialist for that project will be responsible for this project's activities. One procurement assistant will be hired to assist with procurement project activities.

29. A procurement assessment conducted in September 2017 as part of project preparation showed that, in the MOH, there is a procurement officer responsible for ministry public procurement activities and a tender committee that will be involved in the project procurement process; that existing staff and tender committee members have limited procurement skills and insufficient experience in Bank procurement procedures; and that, outside the MOH, there are

two actors involved in the public procurement process (*Direction Nationale des Marches Publics (DNMP)*, under the Ministry of Finance, and *Direction du Contrôle des Procédures de Passation et d'Execution des Marchés Publics*); There are significant time delays in the procurement process. The assessment has rated the overall procurement risk as substantial.

30. Project Procurement Strategy for Development. As part of project preparation, the borrower prepared and submitted a PPSD to the Bank on October 9, 2017. The project will finance procurement of medications, medical equipment, information technology equipment, vehicles, sanitation works, and consultant services. The Bank reviewed the PPSD (including procurement plan), which describes how fit-for-purpose procurement activities will support project operations for achievement of PDOs and deliver value for money. The strategy includes a summary of procurement risk, a mitigation action plan, a market analysis, and procurement approaches.

31. Procurement Mitigation Measures. Procurement mitigation measures proposed, based on the PPSD and procurement risk assessment, are listed in table 23.

Table 23. Proposed Procurement Mitigation Measures

Implementation agency	Procurement mitigation measures	By when
MoH (PASSP PCU)	Recruitment of procurement assistant with adequate qualifications and experience	Within 3 months after signing of the financing agreement
MoH and World Bank	Train procurement specialist, PRMP, tender committee in Bank's new procurement framework	Three (3) months after effectiveness
MoH-PCU	Elaborate and submit project implementation manual (PIM), with procurement section, for International Development Administration (IDA) approval	Within 3 months after effectiveness
PASSP-PCU	Set up acceptable filing system in PCU	Needs to be described in project implementation manual

Note: MOH, Ministry of Health; PASSP, *Projet d'Amélioration des Services de Santé Primaire*; PCU, Project Coordination Unit.

32. Frequency of Procurement Reviews and Supervision. Bank pre- and post-reviews will be conducted based on thresholds indicated in the procurement plan. The Bank will conduct implementation support missions every 6 months and annual post-procurement reviews. The Bank may also conduct an independent procurement review any time up to 2 years after the closing date of the project.

D. Environmental and Social (including safeguards)

33. The project will mostly fund procurement of medicines, essential supplies, and equipment to support maternal and child health at the health post and health center level; training and deployment of CHWs to generate demand and deliver basic services in maternal and child health; and health centers with access to water. Activities related to the proposed operation may lead to an increase in health care waste in addition to potential adverse effects associated with water well construction at health centers, but it is anticipated that these potential adverse effects will be limited, site specific,

small in scale, and manageable. This is why the project is rated as environmental assessment category B. **The project triggers two environmental safeguard policies.**

34. Operational Policy (OP)/Bank Procedure (BP) 4.01—Environmental Assessment: Potential negative environmental and social risks and effects related to handling and disposal of medical and health waste (e.g., placentas, syringes, material used for delivery of babies) in health facilities and water well construction are anticipated.

35. OP/PB 4.11—Physical Cultural Resources: Well construction will require land excavations that could result in chance finds. The revised ESMF describes procedures to be followed in this case.

36. Safeguard Instruments: Two main safeguard instruments were prepared for the purposes of the project: an ESMF and two regional medical waste management plans (one for Kindia, one for Kankan).

37. The ESMF has been updated, reviewed, consulted upon and disclosed at the Infoshop on September 20, 2016, and published in a newspaper in Guinea on September 21, 2016, under the Ebola Emergency Response Project. This ESMF was updated to reflect the project-specific components and activities that are different from those of the Ebola project. The revised ESMF contains procedures for systematic environmental and social screening for all activities before selection and implementation, procedures for conducting activity-specific environmental social impact assessments or environmental and social management plans, capacity-strengthening and awareness-raising campaigns targeted at relevant stakeholder groups for better implementation and monitoring of project safeguard measures, establishment and implementation of a consultation framework for environmental control and monitoring, and procedures for handling chance finds.

38. In September 2015, the government prepared and disclosed a national medical waste management plan (NSMWP). Because this project will not be able to finance the whole NSMWP as the government prepared it, it was agreed that a specific medical waste management action plan accountable to the project will be prepared. Two Medical Waste Management Actions Plan were prepared for Kankan and Kindia regions, reviewed and disclosed. They were published in a newspaper in Guinea on January 15, 2018, and disclosed at the Bank on January 16, 2018. These plans cover specific measures to prevent nosocomial diseases. Specific actions will be incorporated in each annual workplan.

39. Institutional Arrangement to Manage Environmental and Social Safeguards: An existing PCU will implement the project. The PCU will hire at least one full time environmental and social specialist with relevant skills on environmental and social medical waste management and nosocomial diseases. The environmental and social specialist will support the PCU during the whole life cycle of the project. He or she will ensure that the project is implemented in the satisfactory manner from an environmental and social commitment perspective. The PCU will also ensure that the National Environmental and Social Agency is fully involved in environmental and social monitoring of the project. Periodic reports will be prepared to provide relevant information on safeguard implementation status.

40. Consultation: The government consulted stakeholders during the update of the safeguard instruments in the target areas, including Conakry. To ensure that stakeholder voices continue to be heard, the project will prepare a stakeholder consultation plan that will describe the consultation approach, targets, periodicity, and reporting.

41. World Bank Support: World Bank supervision missions will include environmental and social safeguard specialists to assist the project implementation unit by providing regular implementation support, conducting field reviews of safeguard implementation, and monitoring safeguard implementation based on periodic progress reports.

E. Monitoring and Evaluation

42. A comprehensive description of the project's results framework and the arrangements for monitoring and evaluation (M&E) are described in Annex 1 (Results Framework and Monitoring) and Annex 3 (Implementation Arrangements), respectively. The results framework will be tracked, and a mid-term review will be used to assess progress and make appropriate mid-course corrections. The Project Coordination Unit (PCU) will be responsible for monitoring the agreed-upon project development objective (PDO) indicators and a set of intermediate outcome indicators during the life of the project.

43. The national Health Management Information System (HMIS), and in particular the District Health Information System (DHIS-2), will be primarily used to collect monitoring data, with the project's M&E team providing additional support to integrate and ensure the quality of primary-level information. The M&E consultant in the PCU will work with government counterparts to strengthen and secure the collection of required quality data at all levels.

44. The Centre of Excellence for CRVS Systems and GFF Secretariat will provide technical support in linking the DHIS-2 and CRVS, leveraging existing work at the country level and the recently developed national CRVS strategy.

45. For PBF specifically, monitoring data will be aggregated for the project's quarterly and annual indicators linked to the national HMIS system (currently reinforced through the strengthened DHIS-2). The RBF project monitoring system will include identification and consolidation of M&E indicators; training and capacity-building initiatives at the national, regional, and local levels; standardized methods and tools to facilitate systematic collection and sharing of information; an independent review by external technical consultants; and annual program evaluations and strategic planning exercises for the RBF component.

46. Fee exempted indigents will be verified as part of the quality checklist supervision visits, combined with independent spot checks, by the District Health Team. An NGO will be contracted for additional verification.

47. The PBF pilot will also include a process evaluation of the implementation of RBF and an evaluation of some key design challenges that influence the scheme's cost-effectiveness and ability to be expanded. More detail on the evaluation approach can be found in Annex 1.

F. Risks

48. Political and Governance (Substantial). The country has poor governance and a fragile political environment. It appears that, after the last presidential election and the advent of a new government, that there is political will to move ahead to achieve better economic management and inclusive development.

49. Macroeconomic (High). The Ebola outbreak and decline in global commodity prices, particularly of minerals, on which Guinea's economy depends, have highlighted the vulnerability of the country's economy to shocks. The government is facing a widening fiscal deficit that is constraining its ability to support investments in service delivery. The Post-Ebola Priority Action Plan has outlined strategic measures to overcome the above twin shocks, including diversification of the economy with strong support from development partners.

50. Sector Strategies and Policies (Substantial). The government is eager to strengthen health service delivery, weaknesses in which hamper economic and human development. This commitment is outlined in the health system recovery plan 2015–2017; the PNDS 2015–2024; and narrower subsector strategies, including a new community health strategy, a new health workforce strategy, and the GFF-supported national investment case for reproductive, maternal, newborn, and child health (RMNCH). The risk of adverse effects from sector strategies and policies nevertheless remains substantial, largely because these strategies are not fully funded, the government contribution to the health sector remains low and varies from year to year, health financing continues to suffer from technical and allocative inefficiencies, and decision-making authority remain extremely centralized, and capacity remains low. This project aims to minimize some of these challenges by supporting district health authorities and, at the macro level, helping the government improve donor coordination, increase the allocative and technical efficiency of health sector spending, and provide overall coordination and prioritization of investments in RMNCH.

51. Technical Design of the Project (Substantial). Project activities involve improving health service delivery to benefit women and children who depend on primary care in remote parts of the country. The project design is based as much as possible on a sound economic rationale, analytical underpinnings, technical soundness, and potential design flexibility to help the operation achieve the PDO. Project design was based on close collaboration with governmental and non-state actors such as UNICEF, UN Population Fund, WHO, the Global Fund, the Global Alliance for Vaccines and Immunization, and bilateral organizations (particularly USAID, AFD and GIZ), which will help greatly in promoting and monitoring PBF results. At the same time, while the project draws on such collaboration and some of the strategies developed under the existing health project in Guinea (which focuses on different regions) and is linked closely to national sector strategies, the development, scale up and replication of some of the health workforce training approaches; the indigent coverage mechanisms; the RBF; and the strengthening in health financing capacity remain ambitious given the lack of capacity (and motivation) at all levels. This warrants the *substantial* risk rating of the design.

52. Institutional Capacity for Implementation and Sustainability (Substantial). The MOH and existing PCU have experience developing health projects, and the new project will draw on the capacity built to date. At the same time, the PCU is implementing three other projects (with this project being the fourth), requiring a high degree of coordination and ability to meet different M&E arrangements. To address this, the project aims to reinforce and strengthen the

existing institutional capacity, including through continuous training and support of the PCU staff and the hiring of a social and environmental staff member. All PCU staff are closely linked to the directorates of the MOH, who take on the main implementation functions in line with their action plans. Governance, financial, and technical capacity weaknesses are common and a concern in most line ministries. Because of these challenges, the institutional capacity for implementation and sustainability risk is substantial.

53. Fiduciary Risk (Substantial). The procurement and financial management risks of the project are rated substantial and high, respectively, reflecting the continued challenges with World Bank fiduciary procedures. At the same time, the project will rely on an existing PCU with substantial prior implementation experience and capacity related to Bank procedures and will draw on a well-qualified procurement specialist and financial management specialist, support continued training and technical assistance for preparation of large procurement documents, and ensure enhanced IDA supervision and annual audits.

54. In addition to these risks, IDA has classified Guinea as an "exceptional FCV [fragility, conflict, and violence] risk mitigation regime," along with Niger, Nepal, and Tajikistan. A Risk and Resilience Assessment that was conducted in 2017 identified the several drivers of fragility, including conflict and violence in Guinea to be exposure to external shocks, youth exclusion and underemployment, as well as weaknesses in the delivery of services. The project's aim to improve the quantity and quality of health service delivery, including by recruiting additional health workers is expected to help mitigate these risks.

ANNEX 3: ECONOMIC AND FINANCIAL ANALYSIS

COUNTRY : Guinea
Guinea Health Service and Capacity Strengthening Project

Introduction

1. The economic and financial analysis in this section will provide an overview of the macroeconomic and fiscal context of Guinea, elaborate on the economic rationale for investing in the health sector in Guinea, investigate the cost efficiency of the proposed project design, and conduct a cost-benefit analysis to assess project feasibility.

2. Investing in Guinea's health sector has the potential for large benefits that fit well into the country's priorities. One of the core reasons why the Ebola epidemic spread rapidly in the country was the absence of a solid health system that could contain such an outbreak. The outbreak then crippled the country, disrupting livelihoods and businesses and resulting in much lower than projected macro-level economic performance. Investing in the health sector goes beyond improving the health system of the country; it is critical for reestablishing trust in the Guinean economy.

3. Investing in RMNCH services as opposed to other services in Guinea presents large marginal benefits. Maternal mortality remains high in the country—550 per 100,000 births. Child mortality also ranks among the worst in the world, at 88 per 1,000 (younger than 5), and this rate is even higher in the two targets districts; younger than 5 mortality in Kankan, for example, was the highest (194 per 1,000) (MICS 2016). Communicable, maternal, neonatal, and nutritional diseases are the leading causes of maternal and childhood morbidity and mortality in Guinea.[9]. These diseases are usually linked to incapacity of the health system to deliver basic things such as prenatal visits, assisted deliveries, vaccinations, insecticide-treated nets, and nutrition services. In rural and remote areas, the supply of these services is even more limited, resulting in worse health outcomes for women and children residing in these areas.

4. By focusing on provision of care at the community and primary care levels, the project is expected to achieve high impact at relatively low cost. Most of the things that affect RMNCH complications can be addressed at these levels. The interventions under the project are intended to prevent complications at the community level, better inform households, bring about behavioral change, better equip health posts and health centers, and maximize the use of existing resources, such as CHWs and nursing assistants, for better delivery of services. The interventions will contribute to greater health equity by increasing provision and use of maternal and child health services in districts where needs are greatest.

Economic Rationale for Investing in Health Sector

5. Private spending by households remains the largest source of funds for Guinea's health care system. Health care expenditures in Guinea collectively accounted for approximately 5.6 percent of Guinea's GDP in 2014 (World Bank 2014). Out-of-pocket expenditures constitute nearly 45 percent of total health expenditures on health in the country. These

[9] For information, see the Institute for Health Metrics and Evaluation Guinea country profile at http://www.healthdata.org/guinea

expenditures support the cost recovery structure, which by one measure accounts for approximately 20 percent of total funds to public health facilities (HER 2014). Cost recovery is greater at higher levels of the health pyramid, and health centers and health posts require more subsidies, especially for non-personnel expenditures, from the central government.

6. Public health care spending in Guinea has been low and variable and has been declining in real value. Public funds for health care account for approximately 1.33 percent of GDP, approximately 8 percent of total government spending in Guinea. Government expenditure on health, as a share of GDP and public spending, is low (in comparison with other sectors) and unstable, and low budget execution rates further exacerbate the low level of spending. Most public health spending is on operating expenses (salaries and non-personnel); capital investments in health are particularly lacking.

7. Although the government of Guinea has increased its capacity to raise revenue and increased the share of the public budget spent on health (to approximately 8 percent), public health expenditures per capita are still far below levels that the international community recommends for provision of a basic package of services. Total spending measured in current dollars is approximately USD30 per capita, which is significantly less than in neighboring countries, including Sierra Leone (USD86), Cote d'Ivoire (USD88), Senegal (USD50), Mali (USD48), Liberia (USD46), and Guinea-Bissau (USD37) (World Bank 2014). Public health spending per capita is only USD7.58. Ebola response efforts have absorbed much of the publicsector capacity and are largely implemented by international organizations and nongovernmental organizations in parallel to the public health system. This reflects the severe capacity constraints of Guinea to deliver services using its own structures. Many health facilities are no longer operational because of desertion and health personnel death and the disruption in supplies and commodities.

Project Efficiency

8. The project aims to improve the utilization of RMNCH at the primary level in target regions. Greater access to the proposed package of services is expected to have a direct impact on the top causes of disability-adjusted life years in the country. As a result, the project will reduce health care costs related to disease treatment by focusing on cost-effective preventive and curative measures and will help reduce the socioeconomic burden related to the extra care needed for preventable diseases. Preventing disease and supporting a healthy population will support the economy in several ways: greater productivity, labor supply, and human capital; greater consumption and production of goods and services that would otherwise not have been consumed and produced; and higher household earnings.

9. The project design is based on well-documented evidence supporting the effectiveness of community-based primary health care services. Evidence of the effect of community-based primary health care interventions on child and maternal mortality indicates substantial benefits of investing in these interventions. A systematic review (Hall 2011) concluded that women counseled in primary care facilities were 5.6 times as likely to breastfeed exclusively as women who were not. The effectiveness of community-based health centers in diagnosing and treating childhood pneumonia (leading cause of under-5 mortality globally) is well established; a meta-analysis of seven published studies from Bangladesh, India, Nepal, Pakistan, the Philippines, and Tanzania demonstrated a reduction in total mortality of 24 percent and in pneumonia-specific mortality of 36 percent in under-5 children (Sazawal and Black 2003). Studies have

also demonstrated that management of childhood malaria in community health facilities reduces overall under-5 mortality by 40 percent and malaria-specific under-5 mortality by 60 percent (Kidane and Morrow 2000; Sirima et al. 2003). Primary care facilities can provide antenatal and postnatal care services, reducing the risk of postpartum hemorrhage and subsequent maternal mortality. Prevention of unwanted pregnancies is one of the four pillars critical to for the prevention of maternal mortality, if the unmet need for contraception was fully met, maternal deaths would further decline by 29 percent (Ahmed et al. 2012).

10. The project will contribute to greater technical and allocative efficiency in the health service delivery system. As institutional capacity strengthens and the availability and quality of key inputs improve, more facilities will be pushed to the production function frontier and will therefore deliver better services at a given cost. Component 1 of the project focuses on primary facilities, which are the most cost-effective modality for providing a defined package of effective services. Countries with robust primary care systems have better population health outcomes for all-cause mortality, all-cause premature mortality, and cause-specific premature mortality from major respiratory and cardiovascular diseases (Atun 2004). More specifically, primary care has been associated with lower infant and maternal mortality (WHO 2008; WB 2010; Cortez et al. 2012; Knaul et al. 2012; Dukpa et al. 2014), which is extremely relevant in the context of Guinea. Finally, the project will support the Guinean health system in being more results focused and obtaining greater value for money. By building capacity and supporting the monitoring and evaluation system, it will enable decision-makers and managers at all levels to be more efficient in planning and implementing activities.

11. The project is also expected to reduce spending and produce economic gains by increasing the utilization of RMNCH services at the primary level in target regions. Greater access to the proposed package of services is expected to have a direct impact on the top causes of disability-adjusted life years in the country. As a result, the project will help reduce health care costs related to disease treatment by focusing on cost-effective preventive and curative measures and reduce the socioeconomic burden related to the extra care needed for preventable diseases. Preventing disease and supporting a healthy population will improve the economy in several ways: increasing productivity, labor supply, and human capital; increasing consumption or production of goods and services that would otherwise not have been consumed or produced; and increasing household earnings.

12. The project will help promote equity in access to health care services and reduce the financial burden on poor households. The evidence shows that primary care, in contrast to specialty care, is correlated with more-equitable distribution of health services: a finding that holds in cross-national and within-national studies (Starfield, Shi, Macinko 2005). Studies from various countries demonstrate that a health care system oriented toward specialist care creates inequity in access, whereas health systems in low-income countries with well-established primary care systems tend to be more pro-poor, equitable, and accessible.

13. The critical role of the MOH in providing affordable RMNCH services justifies public sector engagement. Investments funded through the project will strengthen health service delivery and increase institutional capacity. Public sector intervention is vital to providing health facilities with critical inputs so that they can in turn provide essential health care services to communities, along with free essential drugs. Project interventions are also expected to have

positive externalities for health system resilience, management of epidemiological risk and public health, and important spillovers—all of which are benefits of public sector intervention.

14. The value that World Bank support to Guinea adds is technical input based on international experience in strengthening health systems and managing emergencies and experience from implementation of the previous Primary Health Services Improvement project in Guinea.

Cost-Benefit Analysis

15. An integral part of the economic analysis aim is to contrast expected costs and benefits of the proposed project. This is typically done through a cost-benefit analysis that computes the net present value of the proposed project by subtracting the present value of expects costs from the present value of expected benefits.

16. Although RMNCH services affect, directly or indirectly, health outcomes of the entire population targeted, a major effect on health outcomes is expected primarily for women of reproductive age and children in the targeted districts and regions. The project will support the government in improving the supply and demand of RMNCH services in the regions of Kankan and Kindia. To achieve this, the proposed interventions are organized around four interlinked and complementary components: increasing the supply of basic RMNCH services in target regions by ensuring availability of commodities, supplies, relevant human capital to deliver on the supply side, and appropriate supervision mechanisms; increasing the demand for basic RMNCH services in target regions by supporting the financial coverage of indigents and financing and organizing the training of CHWs to deliver critical outreach services; Strengthen health financing capacity (and a demonstration effect to inform more comprehensive reform), which involves strengthening the capacity of the MOH in financing, planning, and monitoring (GFF grant) and implementing RBF at the primary and community levels in two districts; and strengthening project management and implementation capacity by expanding the existing PCU and supporting efforts to bring all project PCUs together under a MOH official.

17. The cost-benefit analysis will rely on conservative methods to forecast costs and benefits associated with the proposed project. This is particularly important given the uncertainties that govern the magnitude of the effect of the intervention and the implementation efficacy of the project. To monetize the benefit associated with providing RMNCH services, the analysis examines productive life years gained due to reduced mortality by calculating the number of years gained as a result of a project intervention and calculating the economic benefit of these years. Productive life years gained is a modified mortality measure in which remaining life expectancy is taken into account. This method gives more weight to young target populations, because saving the life of an infant yields more life years than saving the life of an older person. Given the nature of the proposed project and its likelihood of having a large effect on children and young adults and hence large gains in terms of future productive life years, this method was seen to be most suitable for this context.

18. Assumptions in the analysis and the rationale behind them are as follows.

a. In estimating present values, the discount rate is assumed to be 3 percent. This estimate is reasonable given available data on Guinea's deposit interest rate, which is currently estimated at 3.8 percent (World Bank 2016). This is also a commonly used discount rate in similar economic evaluations (WHO 2003; Drummond et al. 2005). The discount rate is also assumed to be constant for the project's 5 years.
b. Population growth rate is assumed to be 2.5 percent and constant over the life of the project. This is the latest recorded national population growth rate according to World Development Indicators in 2016. The national population growth rate is applied to the targeted regions' growth rate; it is assumed that the populations of Kankan and Kindia will grow at a rate of 2.5 percent as well (World Bank 2016).
c. It is estimated that half of the total population in the targeted regions could directly benefit from RMNCH services. This is a conservative estimate base on a demographic profile of Guinea that the UN Population Division produced (UN 2017). Of this estimated population, it is assumed that the project will prevent 0.5 percent of deaths per year. This is an extremely conservative estimate.
d. Average gained productive life-years per person is computed to be approximately 20. This is also a conservative estimate given that a large percentage of the targeted population is children and young adults. The average gained productive life-years per person is discounted at rate of 3 percent (as is standard) to give less weight to future than immediate health outcomes.
e. Gross national income per capita is assumed to be constant to 2016 gross national income per capita of USD490 per year. This value is used to monetize productive life years gained throughout the project (World Bank 2016).

19. Taking into account the present value of project costs (estimated at USD50,376,779) and the present value of expected benefits (estimated at USD101,477,596), the net present value of the proposed project is expected to be USD51,100,817. The positive net present value indicates that project benefits outweigh project costs, making this a sound investment. The benefit-cost ratio resulting from the analysis is estimated to be 2.01, meaning that, for each USD1 of investment through the proposed project, a return of USD2.01 is expected. These results are based on extremely conservative assumptions, and it is likely that they underestimate total project benefits. They also fail to account for positive spillovers that will arise from efficiency gains from the project due to greater capacity and infrastructure. For example, health care savings for health systems and households due to reduced morbidity and mortality are not taken into account.

Table 24 Cost-Benefit Analysis

Year	2018	2019	2020	2021	2022
Cost estimates					
Disbursement (USD)	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000
Discount rate (%)	3	3	3	3	3
Present value of costs (USD)	**50,376,779**				
Benefit estimates					
Population of Kankan	473,359	485,193	497,323	509,756	522,500
Population of Kindia	439,614	450,604	461,869	473,416	485,252
Total population in targeted regions	912,973	935,797	959,192	983,172	1,007,751
Estimated population that would directly benefit from RMNCH services	456,487	467,899	479,596	491,586	503,876
Estimated saved persons from RMNCH services	2,282	2,339	2,398	2,458	2,519
Average gained productive life-years per person (present value)	20.00	19.42	18.85	18.30	17.77
Total gained productive life-years (present value)	45,649	45,427	45,207	44,987	44,769
Gross national income per capita (USD)	490	490	490	490	490
Estimated benefit (USD)	22,367,839	22,259,257	22,151,202	22,043,672	21,936,664
Discount rate, %	3	3	3	3	3
Present value of economic benefits (USD)	**101,477,596**				
Net present value of proposed project (USD)			**51,100,817**		
Benefit-cost ratio			**2.01**		

Note: RMNCH, reproductive, maternal, newborn, and child health.