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

Appraisal Stage | Date Prepared/Updated: 28-Jan-2018 | Report No: PIDISDSA24033

BASIC INFORMATION

A. Basic Project Data

Country	Project ID	Project Name	Parent Project ID (if any)
Guinea	P163140	Guinea Health Service and Capacity Strengthening Project	
Region	**Estimated Appraisal Date**	**Estimated Board Date**	**Practice Area (Lead)**
AFRICA	19-Jan-2018	27-Mar-2018	Health, Nutrition & Population
Financing Instrument	**Borrower(s)**	**Implementing Agency**	
Investment Project Financing	Ministry of Finance	Ministry of Public health and Hygiene	

Proposed Development Objective(s)

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

Components

Strengthen supply of basic RMNCH services in target regions
Strengthen the demand for basic RMNCH services in target regions
Strengthen health financing capacity of the MOH to guide sector reform and long-term transformation
Strengthen project management, implementation, and donor coordination capacity

Financing (in USD Million)

Financing Source	Amount
Global Financing Facility	10.00
International Development Association (IDA)	45.00
Total Project Cost	**55.00**

Environmental Assessment Category

B - Partial Assessment

Decision

The review did authorize the preparation to continue

Other Decision (as needed)

B. Introduction and Context

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, most of them poor, 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 USD531, 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 debilitating 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 4 main drivers of fragility, conflict and violence in Guinea to be exposure to external shocks, youth exclusion and underemployment, weaknesses in the delivery of services, and the political instrumenatlization of ethnicity. Ongoing political instability linked to recurrent tensions over elections, 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% of girls are enrolled in primary school compared to 81% of boys, and 24% of girls are enrolled in secondary school compared to 37% of boys. In 2013, 67% of the female working-age population was part of the labour force, while 80% 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 per cent of girls and women undergo female genital mutilation (FGM), although the government is making efforts to address the problem.

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 for men and 59.8 for women; total life expectancy is 59.0, 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 (95 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), and 3 percent are severely wasted (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 many other nutrition interventions, depend 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—approximately 26 percent of women aged 15 to 19. 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 USD23 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 USD7.58 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

[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).

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 (and finance a greater share). 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 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 GNF23,700 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 to. 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 USD2,200 a year, a nurse or midwife earns less than USD1,700 a year, and a technical health agent earns USD1,400), 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 recoupment 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* (DPSs)) 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 (DHIS2) 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 challenge 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 supply side:* The lack of a regular provision of inputs such as pharmaceuticals, micronutrient supplements (vitamin A, iron, folate, zinc) adds to

[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 factor 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.

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 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), the other finances health facility infrastructure (a remnant of the successful Ebola Recovery Project). In Faranah and Labe, two of Guineas poorest regions, the Bank is providing direct service delivery support through the USD15 million Primary Health Services Improvement Project, and in the Mamou

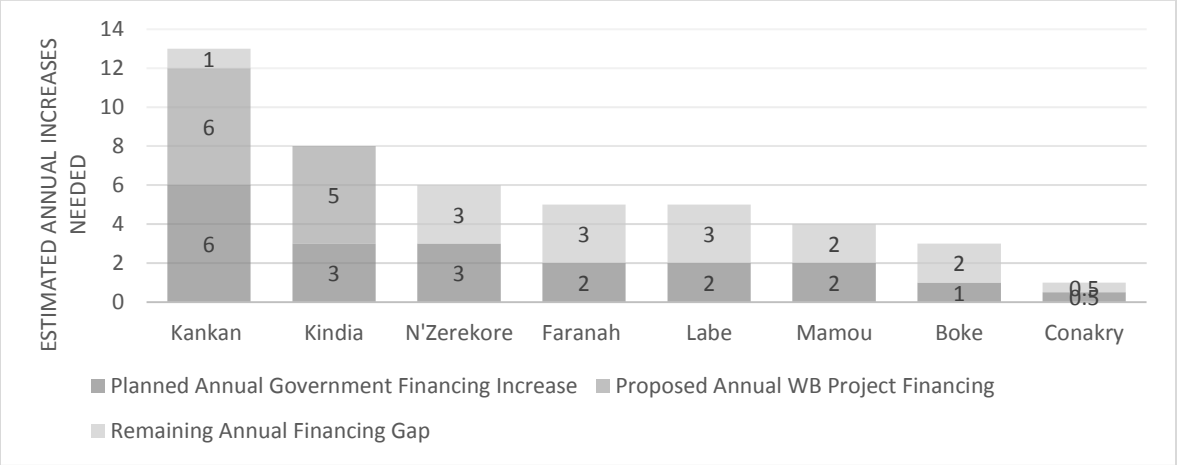
Region, through the USD5 million Mamou Project. Both projects are strengthening the financial and technical capacity of the government to address critical supply- and demand-side barriers to the provision of RMNCH services at primary and community levels of care. Both projects support interventions that 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 the additional financing needs are greatest in Kankan and Kindia, where an additional USD13 million and USD7 million, respectively, are needed annually (on top of already existing government and donor 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 increase 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 USD6 million in Kankan and USD 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 achievements under the PDO (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.

[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.

[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).

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 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. Proposed Development Objective(s)

Note to Task Teams: The PDO has been pre-populated from the datasheet for the first time for your convenience. Please keep it up to date whenever it is changed in the datasheet. ***Please delete this note when finalizing the document.***

Development Objective(s) (From PAD)

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, technical and financial capacity at the health facility, district, and central levels. The interventions that the project supports are intended to simultaneously results in a demonstration effect to inform continuous policy dialogue for long-term systemic and transformational change of the entire health system.

Key Results

23. 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

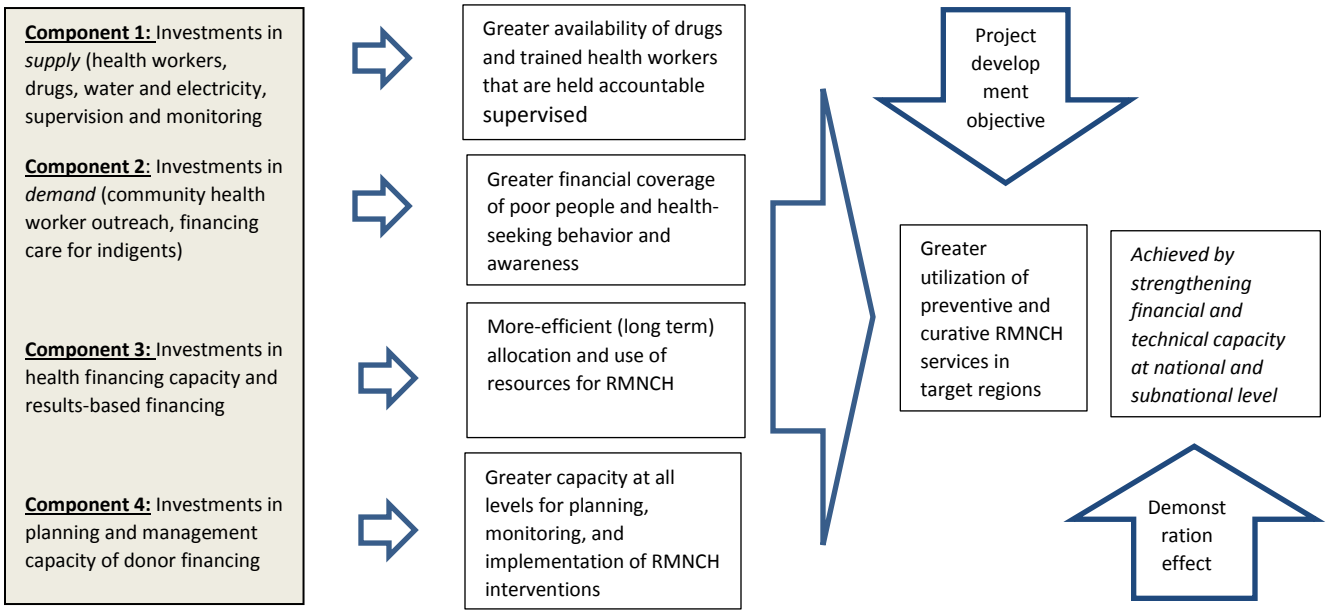
[5] Recent analytical work by the Bank (Ramesh et al. 2016), which assessed post-Ebola response plans and provides guidance to the Ebola-affected countries (Guinea, Sierra Leone, Liberia), emphasizes the need to support interventions that maximize allocative and technical efficiency gains (including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

- Number of pregnant women who received antenatal care
- Number of children (0-11 months) fully vaccinated
- Number of children (0-1) receiving vitamin A supplementation every 6 months

D. Project Description

24. The project intends to achieve the PDO by strengthening RMNCH service delivery and uptake at the district and primary level 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: 1) strengthening the supply of district RMNCH services in target regions; 2) strengthening demand for district RMNCH services in target regions; strengthening health financing capacity for long-term reform; and strengthening project management, implementation, and 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



E. Implementation

Institutional and Implementation Arrangements

25. As with the *Projet d'Amélioration des Services de Santé Primaire* (PASSP) and Mamou region project, 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. Day-to-day management of the project will be the responsibility of the PCU that existing Bank projects use. The PCU will be expanded to ensure regional reach in the two target regions.

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

The specific locations and specific details of the proposed project interventions are not as yet known but will are expected to be nationwide. The physical footprint include activities under component 1-2. The project intends to support the availability of critical supplies, commodities and basic infrastructures for the delivery of a basic package of RMNCH services at the level of health facilities and posts, the project will aim to invest in equipment, supplies (including bed-nets and contraception), micronutrient supplements, and drugs and fund the installation of water wells and solar panels to operationalize the proposed health centers and health posts. . It is not anticipated that the negative impact will be large in scale.

G. Environmental and Social Safeguards Specialists on the Team

Emmanuel Ngollo, Environmental Safeguards Specialist
Cheikh A. T. Sagna, Social Safeguards Specialist
Emeran Serge M. Menang Evouna, Environmental Safeguards Specialist
Awa Gueye, Social Safeguards Specialist

SAFEGUARD POLICIES THAT MIGHT APPLY

Safeguard Policies	Triggered?	Explanation (Optional)
Environmental Assessment OP/BP 4.01	Yes	This policy is triggered as the activities under component 1-2, intends to support the availability of critical supplies, commodities and basic infrastructure for the delivery of a basic package of RMNCAH services at the level of health facilities and posts, the project will aim to invest in equipment, supplies, micronutrient supplements, and drugs and fund the installation of water wells and solar panels to operationalize the proposed health centers and

		health posts. These activities may have environmental and social adverse impacts. It is not anticipated that the negative impact will be large in scale, but rather site specific and thus easily manageable, typical of category B operations. Since proposed projects activities footprints won't be known by project appraisal, the Borrower prepared an Environmental and Social Management Framework (ESMF) assorted with an Environmental and Social Management Plan (ESMP). In addition, to properly handle the waste generated from the health facilities, two regional waste management action plans were prepared for Kandia and Kankan. Both the ESMF and the MWMP were consulted upon and publicly disclosed.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.Both waste management plans were published in a newspaper in Guinea on January 15, 2018, and disclosed at the Bank on January 16, 2018.
Natural Habitats OP/BP 4.04	No	This policy is not triggered as the project will finance no activity that could have any negative impacts in the natural habitats.
Forests OP/BP 4.36	No	The policy is not triggered as the project does not anticipate to finance activities that will have negative impacts on the health and quality of forests or the rights and welfare of forest- dependent people and their level of dependence upon or interaction with forests resources.
Pest Management OP 4.09	No	The project activities is not expected to procure pesticides which could have negative social, environmental and health impacts.
Physical Cultural Resources OP/BP 4.11	Yes	The project intends to support digging activities such as construction of water wells and also construction of basic infrastructures. To accommodate the policy's core requirements, the ESMF includes chance find procedures that Borrower will comply with to effectively handle cultural artefacts encountered/found during the construction of water wells or other basic infrastructures that required land movement.
Indigenous Peoples OP/BP 4.10	No	The Policy is not triggered because no such a social group living in Guinea.

Involuntary Resettlement OP/BP 4.12	No	Despite the activities that will be supported under Component 1.2 no land acquisition will be needed as the project will support the investments that are located in the public land.
Safety of Dams OP/BP 4.37	No	The project is not anticipating financing any new dam that is above the threshold or use an existing dam.
Projects on International Waterways OP/BP 7.50	No	The project is not anticipating any irrigation schemes that will increase the use of international water.
Projects in Disputed Areas OP/BP 7.60	No	The project activities will all be implemented outside of any disputed areas as defined by the policy.

KEY SAFEGUARD POLICY ISSUES AND THEIR MANAGEMENT

A. Summary of Key Safeguard Issues

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

The 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.

Medical waste management and nosocomial diseases were identified to be the most adverse impacts and risks associated with the project. Specific mitigation measures were proposed including installation of incinerators in selected health centers. Specifics health centers staff training will be organized to create awareness among the staff on nosocomial diseases and specifics actions that are needed to be taken to reduce such risks.

2. Describe any potential indirect and/or long term impacts due to anticipated future activities in the project area:

No indirect and long term impacts are anticipated.

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

not relevant

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

The following environmental safeguards instruments were prepared for the purpose of the project: An Environmental and Social Management Framework (ESMF) and two regional (Kankan and Kindia) Medical Waste Management Plans (MWMP).

The updated ESMF was updated, discussed, 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.

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, a specific medical waste management action plan accountable to the project was prepared, reviewed and disclosed. This plan also covers specific measures to prevent nosocomial diseases. As Kankan and Kindia are the two regions that will host the project activities, two specific regional Medical Waste Management actions plans (NSWP) were prepared are consistent with the national waste management plan prepared in 2015. The actions plans identified the main weaknesses related to medical waste management in each targeted region and proposed relevant mitigation measures. Both waste management plans were published in a newspaper in Guinea on January 15, 2018, and disclosed at the Bank on January 16, 2018.

Institutional arrangement to manage environmental and social safeguards: 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. He will ensure that the project implement in the satisfactory manner environmental and social commitments of the project. In addition, the PCU will ensure that National Environmental and Social Agency (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.

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 actions plan which will describe the consultation approach, targets, locations and reports disclosure strategy.

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

The key stakeholder that were identified are mostly the team involved in the health centers in two targeted regions (Kindia and Kankan), local and national NGOs assisting the government of health care, local administrative and political authorities and BGEEE regional staff. As indicated, each year a consultation action plan will be prepared and reports disclosure strategy proposed. The PCU will use participatory approach during the consultation.

B. Disclosure Requirements

Environmental Assessment/Audit/Management Plan/Other

Date of receipt by the Bank	Date of submission for disclosure	For category A projects, date of distributing the Executive Summary of the EA to the Executive Directors
19-Sep-2016	20-Sep-2016	

"In country" Disclosure

Guinea

21-Sep-2016

Comments

The ESMF that will be used was updated, discussed, and disclosed in Guinea on September 21, 2016, and the Bank website on September 20, 2016.

C. Compliance Monitoring Indicators at the Corporate Level (to be filled in when the ISDS is finalized by the project decision meeting)

OP/BP/GP 4.01 - Environment Assessment

Does the project require a stand-alone EA (including EMP) report?

Yes

If yes, then did the Regional Environment Unit or Practice Manager (PM) review and approve the EA report?

Yes

Are the cost and the accountabilities for the EMP incorporated in the credit/loan?

Yes

OP/BP 4.11 - Physical Cultural Resources

Does the EA include adequate measures related to cultural property?

Yes

Does the credit/loan incorporate mechanisms to mitigate the potential adverse impacts on cultural property?

Yes

The World Bank Policy on Disclosure of Information

Have relevant safeguard policies documents been sent to the World Bank for disclosure?

Yes

Have relevant documents been disclosed in-country in a public place in a form and language that are understandable and accessible to project-affected groups and local NGOs?

Yes

All Safeguard Policies

Have satisfactory calendar, budget and clear institutional responsibilities been prepared for the implementation of measures related to safeguard policies?
Yes

Have costs related to safeguard policy measures been included in the project cost?
Yes

Does the Monitoring and Evaluation system of the project include the monitoring of safeguard impacts and measures related to safeguard policies?
Yes

Have satisfactory implementation arrangements been agreed with the borrower and the same been adequately reflected in the project legal documents?
Yes

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