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Project Information Document/ Integrated Safeguards Data Sheet (PID/ISDS)

Concept Stage | Date Prepared/Updated: 15-Sep-2017 | Report No: PIDISDSC21888

BASIC INFORMATION

A. Basic Project Data

Country	Project ID	Parent Project ID (if any)	Project Name
Guinea	P163140		Guinea Health Service and Capacity Strengthening Project (P163140)
Region	**Estimated Appraisal Date**	**Estimated Board Date**	**Practice Area (Lead)**
AFRICA	Nov 07, 2017	Jan 31, 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 RMNCH health services at primary level in target regions

Financing (in USD Million)

Financing Source	Amount
Global Financing Facility	5.00
International Development Association (IDA)	45.00
Total Project Cost	**50.00**

Environmental Assessment Category	Concept Review Decision
B-Partial Assessment	Track II-The review did authorize the preparation to continue

Note to Task Teams: End of system generated content, document is editable from here.

Other Decision (as needed)

B. Introduction and Context

Country Context

Guinea is a resource-rich country with abundant natural resources, however it is also one of the poorest countries in the world. Guinea is home to a total population of 12.6 million in 2015, and administratively divided into eight regions (see table A1). Its natural resources are vast and the mining sector is an important driver of output growth and exports. However, its legacy of political instability, insecurity, and governance challenges has limited the potential for growth and shared prosperity with respect to Guinea's vast natural wealth. Poor governance, low access to finance by the private sector and lagging infrastructure (especially in roads and electricity) in particular is preventing rapid growth. Economic inclusion is affected by the lack of job opportunities and access to rural infrastructure and services by poor households, low agricultural productivity and low human capital (i.e. health and education). About 80 percent of the population is employed in the agriculture sector, most of them poor, with almost 90 percent of the poor and the extreme poor living in rural areas (i.e. largely referred to as outside of Conakry, and outside the district capitals in each region). With a 2015 per capita GDP of USD 531, the country remains among the poorest in the world, with more than half of its population affected by poverty, and it was ranked 182th out of 188 countries in terms of the Human Development Index (HDI) in 2014.

Table A1: Poverty Indicators by Region

Region	Population (%)	Poverty incidence (%)	Contribution to Poverty (%)	Per Capita Expenditure
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)

Guinea is a country on the brink of fragility because it is significantly vulnerable to internal and external shocks. By the World Bank's definition of "fragile" situations, fragile countries are characterized by a debilitating combination of weak governance, weak policies, and weak institutions. Even though Guinea's Country Policy and Institutional Assessment (CPIA) score is below 3.2 and suffers from factors that tend to generate fragility, Guinea is not on the World Bank's harmonized list of fragile situations because it does not host a peacekeeping or political peacebuilding mission. Nonetheless, under IDA18, Guinea has been classified as "exceptional FCV risk mitigation regime" along with other three countries (Niger, Nepal, and Tajikistan). Ongoing political instability linked to recurrent tensions over political elections, a poverty rate already reaching 55 percent in 2012 and likely higher following the devastating Ebola epidemic (2013-2016), and other external shocks are reasons for concern over Guinea's fragility.

Sectoral and Institutional Context

Guinea has an exceptionally low life expectancy, driven by a particularly high gross mortality. According to the latest WHO data published in 2015 life expectancy in Guinea is: Male 58.2, female 59.8 and total life expectancy is 59.0 which gives Guinea a World Life Expectancy ranking of 162. This is well below the overall world average of (68 years). The gross mortality rate in Guinea is 12 per 1,000 in 2015. The probability of dying between 15-60 years in Guinea is 296 per 1000 population for males, and 273 per 1000 for females (WHO, 2015). The mortality profile in Guinea continues to be dominated by infectious diseases, although non-communicable diseases like cancer and cardiovascular diseases are on the rise. Malaria, diarrhea, and respiratory infections are still far more prevalent than other diseases.

Maternal mortality is still amongst the highest in the region, largely explained by weak service delivery disproportionately evident in rural areas. The 2016 maternal mortality ratio per 100,000 births for Guinea was 550, compared with 743 in 2008 and 1040 in 1990, however it is still high when compared with the regional average of 510 in Sub-Saharan Africa SSA (Source: MICS, 2016, WHO/UNICEF/WB 2015). Table B1 shows that mothers in rural areas are particularly disadvantaged when it comes to service delivery. Around 40 percent of mothers in rural areas receive four pre-natal health consultations (compared to 71 percent in urban areas), around 46 percent have their births delivered by skilled attendants and around 43 percent deliver in health facilities (as opposed to 94 and 84 percent in urban areas, respectively). Nationally, almost 50 percent of women of reproductive age are anemic, which may be attributed to 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).

Children in Guinea are particularly disadvantaged, disproportionately so in rural areas. Although the child mortality rate has decreased from 156 per 1,000 live births in 2002 to 94 per 1,000 live births in 2015, the rate remains high when compared with the rest of the region (World Bank, 2016)[1]. At the same time, there are huge variations by region – the under 5 mortality rate in Kankan for example was the highest at 194 per 1000. Indeed, Kankan is largely a rural region, and Table B1 shows that children in rural areas are particularly disadvantaged, and are almost twice as likely to die as their urban counterparts. Post-natal examination coverage of babies is only 43 percent in rural areas (as opposed to 84 percent in urban areas), and complete vaccination coverage before the first birthday of children is only 19 percent in rural areas (39 percent in urban areas). The prevalence of malaria parasites is another significant problem, with malaria the leading cause of morbidity and mortality in health facilities today. While more than two thirds of children (73 percent) are sleeping under an Insecticide Treated Net (ITN) in rural areas (which is 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 contribute to waterborne illnesses frequency and is the cause of the diarrhea and subsequent dehydration. The percentage of children under 5 who are treated for diarrhea is only 30 percent in rural areas (and 45 in urban areas).

[1] World Bank Development Indicators, 2016

Table B1: Select Maternal and Child Health indicators, 2016

Maternal health service delivery Indicators	Guinea	Rural	Urban
Percentage reported having four pre-natal health consultations	51%	40%	71%
Percentage of births attended by skilled birth attendants	63%	46%	94%
Percentage of births delivered in a health care facility	57%	43%	84%
Child Mortality Indicators (per 1000)			
Child mortality rate: Probability of dying between birth and first birthday	44‰	28‰	16‰
Juvenile mortality rate: Probability of dying between the first and fifth birthdays	46‰	57‰	23‰
Under-5 mortality rate: Probability of dying between birth and fifth birthday	88‰	104‰	52‰
Child health service delivery Indicators			
Percentage of babies having received at least one postnatal examination	57%	43%	84%
Percentage of children aged 12-23 having received all recommended vaccinations according to the National Vaccination Program before their first birthday (measles before their second birthday)	26%	19%	39%
Percentage of children under 5 years having slept under an ITN the night before the latest survey	68%	73%	58%
Percentage of children 6-59 months who received Vitamin A supplementation			
Percentage of children under 5 years having suffered from high fever in the last two weeks who have received treatment in accordance with national guidelines	17%	14%	24%
Percentage of children under 5 years treated for diarrhea using Oral Rehydration Salts (ORS)	34%	30%	45%
Percentage of children under 5 years treated for diarrhea using zinc	28%	24%	35%
Percentage of children under 5 years treated for diarrhea using ORS **and** zinc	16%	14%	22%

(MICS, 2016)

Child malnutrition is a serious health problem in Guinea Stunting, a measure of chronic malnutrition, poses the greatest public health burden. Stunted children have an increased risk of morbidity and mortality, impaired cognitive development (often irreversible), and poor educational outcomes. Nearly 32 percent of children in Guinea under the age of five show signs of delayed growth and development height for age <2SD), and nearly half of this group, about 15 percent, are severely stunted (MICS, 2016) – the averages again masking significant rural/urban differences. Stunting is a preventable condition directly linked to inadequate food intake (quantity and quality) and repeated episodes of infectious disease. According to the 2016 MICS survey only 35 percent of children 0-5 months are exclusively breastfed and only 1.4 percent of breastfed children 6-23 months receive a minimum acceptable diet. Malnourished children are more likely to get sick. According to the 2016 MICS, more than 19 percent of children under 5 years had fever and 10 percent had diarrhea in the past two weeks (MICS, 2016). Children that are sick often are more likely to become malnourished, thus perpetuating the cycle of malnutrition.

Reproductive health indicators are equally problematic. Women's fertility rate declined slightly from 5.5 to 4.8 children per woman on average between 1999 and 2016, however there are big regional differences in fertility rates, ranging from 3.6 (Conakry) to nearly 7.0 (Kankan). Currently, only 27 percent of demand for

contraception in Guinea is satisfied by modern methods (MICS, 2016) – there is thus high unmet need and relatively low effectiveness in the current method mix. High rates of early pregnancy in Guinea are also present with 37 percent of women aged 20-24 reporting having given birth at least once before the age of 18. The country also possesses one of the highest rates of adolescent fertility in the region – around 26 percent of women aged between 15-19 years.

Table B2: Select Child Nutrition and Reproductive Health Indicators, 2016

Child Nutrition Indicators	**Guinea**	**rural**	**Urban**
Percentage of underweight hildren under 5 years -(weight-for-age)	18	21	13
Percentage of stunted children under 5 years - (height-for-age)	32	38	21
Percentage of wasted children under 5 years - (weight-for-height)	8	9	7
Reproductive Health Indicators			
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: percentage of women aged 20-24 reporting having given birth at least once before the age of 18	36.9	40	27
Prevalence of contraceptive methods: percentage of women aged 15-49 using contraceptive methods (traditional or modern)	8.7	7.8	10.2
Unmet contraceptive needs	27.6	26	19

(MICS, 2016)

Overall, the utilization of essential maternal and child health services has not recovered to their pre-Ebola outbreak levels, and are unlikely to recover without targeted interventions. Whereas hard empirical data on this is limited (the last DHS was in 2012, three years prior to Ebola, and a new one does not yet exist), a recent study published in the Lancet in 2017[2], found that service delivery related to RMNCH today is generally worse than during the pre-Ebola period. The study found for example, that during the Ebola Epidemic, fewer women achieved institutional deliveries and received antenatal care coverage than before the epidemic. And in the post Ebola period, overall trends for institutional deliveries and antenatal care stagnated. Similarly, an increasing trend in child vaccination completion during the pre-epidemic period was followed by significant immediate and trend reductions across most vaccine types during the epidemic. And in the post-Ebola virus disease outbreak period, vaccination coverage for polio, measles, and yellow fever continued to decrease. The article stressed that targeted interventions in RMNCH services, particularly at the lowest level of the health system, would be critical in order to reverse trends.

Health Systems and Service Delivery Challenges

Guinea's health sector is organized into three levels: 1) the first level is composed of health posts and health centers that are closest to communities, and are predominantly found in rural areas (catering, in theory, to the

[2] http://www.sciencedirect.com/science/article/pii/S2214109X17300785

poor) 2) the second level (intermediate level) is composed of prefectural (district) and regional hospitals that are respectively the first and second level referral hospitals for health centers. These tend to be located in regional and district urban centers. 3) The third level has two specialized national teaching hospitals: Donka and Ignace Deen. In addition to the two national teaching hospitals, the government of Guinea (GOG) recently built the Sino-Guinéenne hospital. These hospitals cater largely to urban populations and the more economically advantaged.

The epidemiological profile of Guinea is largely reflective of a health system that has been historically underfunded and inefficient. Government spending on health has been historically low and has only recently increased. Before the Ebola crisis, health expenditure funded by the general tax revenues collected by the Guinean state accounted for only 2-3 percent of total public expenditure and only half a percent of GDP. Per capita spending was US$ 23 in 2012 (PER 2014). Following Ebola, 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 $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 Investment Budget (IB) actually spent in 2016 (MOH 2017).

The majority of public health spending is spent on a centralized bureaucracy and salaries and wages of the health workforce, with little financing 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 2764 staff on payroll in 2016). For operating expenditures and the delivery of priority health programs, the percentage stays roughly the same (approximately 6 percent). Since 2005, public expenditures for important health programs including the Expanded Program on Immunization (EPI), Comprehensive Care for Diseases of Newborn and Children (PECIMNE), as well as the Maternal Health Program (MHP), have constituted less than 7 percent of the Ministry of Health budget.

The lion's share of health resources is supported by households (mainly those in Conakry and urban centers), a burden particularly for the indigent poor. Public health expenditures account for only one third of the expenditures on health, compared to 45 percent across the region, and households shoulder a high burden of health expenditures. Of the private expenditures on health, which account for 4.3 percent of GDP (compared to the regional average of 3.5 percent), 92 percent are out of pocket expenditures (compared to 62 percent across Sub-Saharan Africa). Poor households, the majority of which live outside of Conakry and in remoter parts of the country, spend significantly less than the rich (although they finance a greater share). Programs or insurance programs to support the free delivery of certain health services and provide financial protection for the poor are largely non-functioning or not existent. The indigent shouldbe exempted from paying user fees (a budget line has been put in place to compensate providers) but problems of underfunding and identification of the indigent limit effectiveness of this policy.

The distribution of public health spending is heavily skewed towards Conakry, and the hospital level, not justified by poverty criteria. 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 was approximately six times the levels that prevailed in the rest of Guinea. And 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 of 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 of GNF

3,200 (compared with GNF 23,700 in Conakry). The skewed distribution of public resources is largely linked to the dynamics of the health labor market for doctors, nurses and midwives, which disproportionately benefits urban areas (see box 1).

Box 1: Health labor market dynamics can help explain 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, towards funded health posts at the facility level. Most of the doctors, nurses and midwives end up working in urban areas, despite often officially deployed elsewhere, shifting the distribution of resources accordingly. There are no functioning accountability systems to ensure health workers stay where officially deployed to. The predominantly urban job preference of these cadres is not surprising. Per capita salaries are extremely low (for example a nurse or midwife earns less than US$1000 a year, and a doctor less than US$ 1500) and urban areas hold greater potential for health workers to augment their incomes, finance operational expenses, and make ends meet. Most facilities and health workers function as de-facto private providers, dependent on income from formal and informal user fees, using public sector structures. The recent increase in public health expenditure, most of which was spent on the recruitment of yet more extremely low salaried health workers, is unlikely to meet the health worker needs in the periphery. This is not helped by the fact that recruitment was done largely at central level, and of health workers who were largely trained in Conakry. Global evidence shows that in order to increase the likelihood of rural job uptake or retention, health workers *from* remoter areas, should be trained *in* and *for* remoter areas, and subsequently deployed (through funded rural positions) in remoter areas.

When not supported by donors, service delivery utilization in remoter parts in particular suffers from significant supply and demand side constraints. Where operational[3], health facilities at the periphery of the health system are often staffed by technical health agents called *Agents Technic de Sante (ATS)*, a frontline cadre trained over two years across Guinea in basic service delivery. In the absence of other health workers, most take on all functions of a nurse, midwife, or doctor. ATS are sometimes complemented by other auxiliary cadres, as well as volunteer community health workers at the health post level and in the community itself. Without external support; however, few of these frontline providers receive the funding, supervision, mentoring, and continuous training needed for the appropriate delivery of RMNCH health services. The lack of critical inputs including pharmaceuticals, micronutrient supplements (vitamin A, iron/folate, zinc) and clean water are all adding to these constraints. The Central Medical Store seems to function (following support received by the EU), but delivers only as much as supply can be funded (the main constraint). From the demand side, when supply exists service, utilization is constrained by issues of financial inaccessibility (by the poorest of the poor). In theory, the government supports free antenatal care and delivery in all public health facilities through the provision of delivery kits, including supplies for cesarean section. In actual fact, the lack of financing, transparency, accountability and support to this program, renders these programs non-functional. Other demand side constraints include long distances, cultural taboos, and perceptions of bad quality (which grew with Ebola).

Strengthening Service delivery and utilization on RMNCH at the community and primary level is highly dependent on donor support, commitment to which has been growing. Since Ebola, the government and partners have committed themselves to strengthening service delivery for RMNCH, particularly at the

[3] Anecdotal evidence suggests that up to two thirds of health posts and health centers in some districts are not operational without donor support

community and primary level. The National Health Plan 2015-20 (PNDS), developed jointly following the Ebola crisis, outlines the government's aim to achieve a set of conservative RMNCH indicator targets in each of the eight administrative regions by 2024. Partners today, including the EU, USAID, and the Global Fund are providing support to one or more of the eight administrative regions in Guinea, to strengthen both the supply of, and the demand for, RMNCH services. International funding and technical assistance amounts to about one third of all health expenditures in Guinea, most of which supports health systems strengthening and RMNCH. At the same time, little of this financing is currently channeled through the MOH. Most partners are relying on and financing their own implementation units, contractors, and NGO's to implement their support programs. Less than 5 percent of donor funding is estimated to be channeled directly through the MOH, highlighting in part the capacity constraints at the central level that exist to date.

The Bank is currently providing critical support towards health systems strengthening as well as service delivery capacity at the community and primary level in three out of eight regions. Two regional operations are currently active, one providing some support towards disease surveillance capacity strengthening (REDISSE Project), the other financing health facility infrastructure (Ebola Recovery Project). In addition, the Bank is providing support to strengthen RMNCH service delivery capacity at community and primary levels in the Faranah and Labe Region (through the US$ 15 million PHSIP project, which became effective in December 2015) and the Mamou Region (through the US$ 5 million Mamou Project, which became effective in December 2016). Both projects are strengthening the financing and technical capacity of the government to address critical supply and demand side bottlenecks to the utilization of RMNCH services at primary and community levels of care. Both projects are supporting interventions that move away from business as usual, including an institutionalized and continuous training and mentoring program for auxiliary (ATS) and community health workers, building capacity for supportive supervision, funding a small scale Results Based Financing experiment, and launching a system to identify and finance the costs for the indigent poor to access basic services.

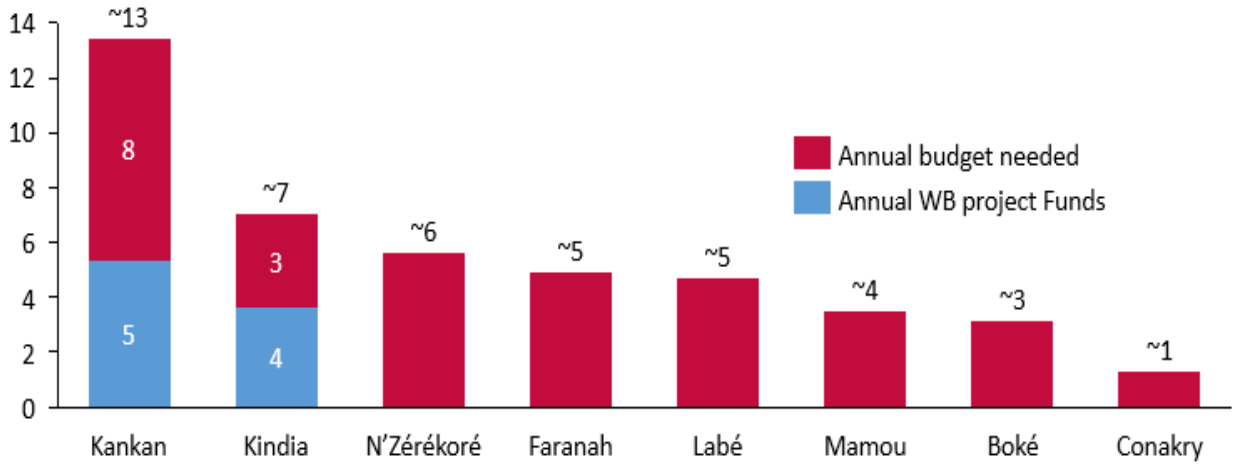
Much more support is now needed to achieve the targets set in the PNDS, with a financing gap for RMNCH particularly evident in the regions of Kankan and Kindia. The costing to reach the PNDS targets in each region was completed using the one health tool, which went hand in hand with an exercise to prioritize the most-high impact interventions needed. The recently developed investment case for RMNCH, produced with support of technical assistance from the Global Financing Facility (GFF)[4] further prioritized key interventions. The investment case highlighted that the annual financing gap by region, to reach the costed RMNCH targets set in the PNDS, remains substantial. The biggest gap is currently evident in the regions of Kankan and Kindia, where US$13 million and US$7 million, respectively, are still needed annually, to meet the conservative RMNCH indicators of the PNDS. Both regions have large populations, particularly high incidence of poverty, problematic health outcomes, and insufficient financing from other sources[5]. The government has

[4] Guinea has been selected for support from the Global Financing Facility (GFF) end 2016. An investment case has been developed that outlines the key priorities and funding gap for reaching the PNDS targets and a workplan for strengthening capacity in health care financing and evidence based policy making has been identified.

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

requested the Bank to support to close this gap. Proposed annual financing of 5 million in Kankan and 4 million in Kindia over the next five years, could reduce this gap significantly, although not eliminate it. Many lives can nonetheless be saved with RMNCH intervention support in these two regions with a focus on the community and primary level particularly in rural and underserved areas.

Figure 1: The annual budget needed to reach RMNCH targets by 2020, as specified in the PNDS - by region (U$ Million)*



Source: Donor mapping cost analysis – GFF Investment Case, 2017. **The amount indicates the funding gap (i.e. for example USD 13 million annual in Kankan, and USD 7 in Kindia, for these regions to meet the 2020 RMNCH targets set in the PNDS.*

While there is critical need to support Guinea cover the two priority regions, capacity also needs to be built to pave the way towards more systemic reform in the longer term. There needs to be a gradual shift towards more pooled government funding, increased decentralized financing (including funding health worker positions tied to the facility level rather than the health worker), and more autonomy and financial management for community and primary level facilities. There also needs to be a shift from the disproportionate financing of salaries of health workers towards the financing of other operational costs and inputs. For this shift to occur, data and information is needed as well as central level capacity on health financing. Currently, public financial management and a strategic vision for longer term health financing reform is constrained by the lack of a functioning health financing unit and related capacity in the MOH. National Health Accounts are produced with large delays, and the MOH is unable to track health expenditures accurately and effectively. At lower levels, despite a move towards decentralization in theory, sub-national authorities including regional and district level health authorities (prefectures) all lack the funding, incentives and staff motivation to be effective. Sub-national administrative bodies and health facilities are headed by civil servants, tied to government process rigidities with little capacity.

Accordingly, the proposed project will address both the critical financing needs in Kindia and Kankan, whilst simultaneously strengthen health financing capacity for longer term reform. In Kindia and Kankan, the proposed project aims to expand some of the innovative demand and supply side interventions to improve

RMNCAH[6] utilization, that are currently being implemented by the current support operations in Faranah, Labe, and Mamou. Progress made to date in the existing project in a context of limited capacity makes the continued use of implementation strategies and tools to date ever more important. With the proposed new project, the Bank would be supporting service delivery for RMNCAH in a total of five of the eight regions in Guinea, working towards improving the lives of more than half of the population in Guinea who are dependent on community and primary level for their services. And to pave the way for policy dialogue and increased capacity towards more systemic reform in the longer term, the project will seek to strengthen health financing budgeting, monitoring, and allocation capacity at the central level, including through a demonstration effect around decentralization of financing and a focus on results.

All interventions will be closely aligned with national planning documentation and the support provided by the Global Financing Facility (GFF). Namely: 1) the health system recovery plan 2015–2017 and a longer National Health Development Plan (PNDS) 2015 – 2024, more narrow sub-sector strategies including a new community health strategy, and a new human resources for health strategy, 2) recommendation of recent analytical work by Ramesh et al, (2016) which assessed post Ebola response plans and provides guidance to the Ebola affected countries (Guinea, Sierra Leone and Liberia)[7] 3) the support provided by the GFF, which aims to bring about more systemic change, by supporting the government improve donor coordination, the allocative and technical efficiency of health sector spending, and overall coordination and prioritization of investments towards achieving RMNCAH results.

Relationship to CPF

The interventions under the project remain consistent with, and aligned to, the strategic area of the World Bank Group's Country Partnership Strategy (FY14-FY17), which focuses on improving human development indicators in Guinea, and which also covers basic education, social protection and health. The proposed interventions are also in line with the new Systematic Country Diagnostic (SCD) currently being prepared which emphasizes the critical need to strengthen human capital through education and health, and address high levels of poverty particularly in Kankan and Kindia where the majority of the poor live. In addition, the project also remains fully aligned with the government's PNDS (2015-2024), Community Health Strategy, Health workforce strategy, and the GFF Country Investment case, and will ultimately contribute towards the twin goals of the World Bank Group to 1) end extreme poverty and 2) promote shared prosperity of the bottom 40 percent.

[6] While project aims to increase the availability of RMNCAH services, it acknowledges that the actual uptake of adolescent health services such as family planning requires a multi-sectoral approach which is beyond the scope of the project.

[7] 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 and 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); strategies that improve accountability, decentralization and resource allocations towards results.

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.

Improve the utilization of RMNCAH health services at primary level in target regions

Key Results (From PCN)

The following outcome indicators will be used to measure the achievement of the PDOs in the targeted regions/districts

- Number of children (0-5 years) fully vaccinated (core indicator)
- Number of children under 5 with confirmed malaria who received antimalarial treatment (core indicator)
- Percentage of pregnant women receiving at least 4 antenatal care visits from health provider
- Number of women and children who have received basic nutrition services[8] (core indicator)

D. Concept Description

The project intends to achieve its objective through interventions at the community, primary, and central level that are organized into three complementary components: 1) Strengthening the supply and demand for RMNCAH services at primary level in target regions 2) strengthening health financing capacity for longer term reform 3) strengthen project management and implementation capacity. Table C1 provides an overview of the financing of each component/sub-component.

Table C1: Overview of components and financing by component in US$ million

Project Components	Project cost	IDA Financing	GFF Financing	% Financing
1. Strengthen supply and demand for services at primary level in target regions	**30.0**	**30.0**	0.0	100
1.2. Strengthening Supply of RMNCH services	10.0	10.0	0.0	100
1.2. Strengthening Demand for RMNCH services	20.0	20.0	0.0	100
2. Strengthening health financing capacity and innovation	**15.0**	**15.0**	**0.0**	**100**
2.1 Demonstration effect pilots on health financing	10.0	10.0	0.0	100
2.2. Health Financing Capacity in MOH	5.0	0.0	5.0	100
3. Strengthening project management and implementation	**5.0**	**0.0**	5.0	100
Total Project Costs	**50.0**	**45.0**	**5.0**	**100**

1. Description

[8] This is one of the new core bank indicators and will be defined during preparation, and could include, for example: Vitamin A coverage rate for children 6-59 months; Deworming coverage rate for children 12-59 month; Children with diarrhea who received ORS + Zinc

Component 1: Strengthen the supply and demand for basic RMNCH services in target regions (USD 30 million IDA).

This component will finance the inputs and demand generation activities needed for the delivery of a package of basic services at both the primary and community level in Kankan and Kindia. The interventions expand those currently developed and implemented in Labe, Faranah and Mamou and significantly empower decentralized authorities to implement services. These services will mainly serve the rural population and the basic package of services will address the leading causes of child and maternal mortality as well as the service delivery challenges noted in the problem statement. Together with the ongoing World Bank Projects in Faranah, Labe, and Mamou, the World Bank would be providing support in a total of five out of the eight administrative regions in Guinea.

Sub-component 1.1: *Strengthening RMNCAH supply at primary level through innovative interventions (US$ 10 million IDA):* This sub-component will address the lack of inputs needed for the delivery of a basic package of RMNCAH services at the community and primary level in the two target regions: a) To ensure 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 (including ITNs and contraception), micronutrient supplements, and drugs to revitalize and top up drug revolving funds at the primary level, and fund the installation of water wells and solar panels to operationalize the targeted health centers and health posts. The project will provide financing to the national Central Medical Store (CMS) to deliver these inputs and seek to revitalize self-sustained facility level drug revolving schemes, finance any subsequent funding gaps, as well as capacity strengthening at facility level in the areas of quantification, procurement and management of supplies. b) To ensure the availability of competent health workers at the health center and health post level (including ATS, health assistants, nurses/midwives, etc.), the project will provide financial and technical support to districts to fill critical health workforce gaps, supporting district authorities with *local* recruitment efforts (currently always done centrally) and financing salaries. And to strengthen RMNCAH competencies (drawing on a recent needs assessment carried out by KIT), particularly related to maternal health, the project would expand the innovative district level training and mentoring scheme currently developed in Faranah and Labe. This provides continuous horizontal skills upgrading and mentoring to all health workers at the primary level and is organized and delivered by an expanded and trained district health team (rather than NGOs as often done) c) Finally, the project will support the development and implementation of a supportive supervision program for all health post and primary level facilities. Supervision visits to the health facilities within the project target districts will be incentivized and performed by the District Health Directorates to improve the performance of personnel in the health centers, and quality of services, under their authority. The districts will rely on supportive supervision methods including the use quality checklists for supervision. Funding will include development of the supportive supervision strategies, training of district health teams, and key costs linked to carrying out the supervision.

Sub-Component 1.2: Strengthening RMNCH Demand at the Community and Primary Care Level (USD 20 million): This sub-component will address the limited demand for RMNCAH services due to financial and socio-cultural inaccessibility to services, as well as the distance of some communities to the nearest health post/center. It will do this by supporting districts to a) manage and implement an innovative fee financing scheme to cover indigents, which focuses on a community driven process to identify (and verify) indigents (carried out by NGOs with district authorities), equip them with identify cards, and allow them to access RMNCAH services free of charge at primary level. The facilities then bill the central level government (the

project) for any services rendered (following NGO verification). In addition, this subcomponent will b) empower district authorities to finance and organize the training of community health workers (volunteers or ATS) to deliver critical outreach services as guided by the government's community service delivery strategy. This would expand current efforts in Guinea to move away from the sporadic, non-standardized and vertical training programs currently provided by different NGOs, and institutionalize the *horizontal* training of community lay workers in RMNCAH promotion and basic service delivery at the community level.

Component 2: Health financing capacity and a demonstration effect to inform longer term reform (USD 15 million)

This component will support pilots using innovative health financing strategies to deliver RMNCAH services in two districts of the target regions (each target region has 5 districts in total), to strengthen decentralized capacity and inform the policy dialogue on longer term reform. This will go hand in hand with strengthening the financial capacity of the Ministry of Health (MoH) to better plan for and account for their limited resources.

Sub-component 1.2: *finance innovative service delivery and financing strategies for a demonstrating effect in two districts (US$ 10 million IDA):* Building on the policy dialogue developed to date through a small experiment (pre-pilot) in the Mamou Region supported under the existing WB project, this sub-component will fully pilot two different innovative financing mechanisms, this time on a larger scale and using public sector capacity, namely (i) a standard Results based Financing (RBF) model in which funding at the primary level is linked to quantity and quality related performance indicators on RMNCH , in one district in Kindia or Kankan; and (ii) a model in which primary level facilities are provided with the same training and supervision but without linking the additional cash to explicit performance indicators, in a second district in Kindia or Kankan. A process evaluation (before/after study) to be funded by the project will provide insights into the "impact" of the pilots as well as the relative cost-effectiveness of different models and help drive the policy dialogue towards more systemic change. As mentioned, the two pilots will build on the small pre-pilot RBF experiment currently financed under the existing project in the Mamou region, which has helped start a discussion around the value of RBF. Whereas the small pre-pilot pilot is currently being implemented by an outside technical Agency (Health Focus) there is now interest for a larger pilot on RBF but also in testing a flexible financing approach, making use of district level government structures. For decentralized output based financing models to realize their potential as a driver for systematic change, and to contribute towards capacity building in the MOH, the Bureau de Strategie et Development (BSD), who is in charge of health financing, needs to be strengthened (supported through GFF TA as well as under sub-component 2.2 below), and will be heavily involved in the design phase and monitoring and evaluation of the schemes.

Sub-Component 2.2: Strengthening the capacity of the MoH in Financing, Planning and Monitoring (US$ 5 million GFF), by building capacity at national, regional and district level in Health Financing. Around US$5.0million in GFF grant will be used to provide technical support to the BSD in the MoH to strengthen health financing, evidence based policy making, and build an environment for larger reform efforts in the longer term. Support will address the specific shortcomings to be identified in an institutional assessment of the BSD (carried out with, but likely activities will include (i) institutional strengthening of the BSD through financing and embedding someone in BSD in a more medium-to-long term role (as opposed to a project-based consultant), (ii) providing training on both technical aspects (e.g. MTEF, PFM) of health care financing and managerial capacities, and providing relevant funding to produce related outputs (iii) support the development of a Health Financing Strategy, (iv) support the (institutionalization of) collection of data (NHA, monitoring of

out-of-pocket payments, supply-side readiness, service delivery indicators, health work force) and (v) support a detailed resource mapping and tracking of the activities of development partners, and (vi) build capacity (and understand and knowledge of) results based financing and other approaches linked to decentralized financing. Based on the lessons learned from sub-component 2.1 (on the financing mechanisms), a strategy will be developed for potential financing reform at the district level in support of the decentralization process, and to generate longer term efficiencies and a reorientation around results.

Component 3: Strengthening donor coordination and implementation capacity (USD 5 million)
This component will provide support towards efforts for better coordination of development assistance in Guinea, and strengthen management capacity of this particular project. There are plans to bring all the different project PIUs under one roof in Guinea, and to have these headed by a Ministry of Health official. Accordingly, support under this sub-component will be two-fold: a) Finance the initial salary of one person to head the donor coordination unit, as well as any start-up costs needed for this, and b) finance the recurrent costs for the WB PIU team, the same team currently managing the existing WB projects. The current PIU will be expanded to include extra staff at the regional level for ease of implementation. PIU support towards project management and implementation will include efforts in Kankan and Kindia to strengthen the HMIS system as part ensuring routine collection of HSS data at regional, district and sub-district level to inform project indicators.

Note to Task Teams: The following sections are system generated and can only be edited online in the Portal.

SAFEGUARDS

A. Project location and salient physical characteristics relevant to the safeguard analysis (if known)

Activities with a physical footprint include those under component 1-2. The project 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 (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. The specific locations and specific details of the proposed project interventions are not as yet known but will are expected to be nationwide.

The project will be category B due to activities that will be covered through components 1-2. It is not anticipated that the negative impact will be large in scale.

B. Borrower's Institutional Capacity for Safeguard Policies

Preliminary assessment:
(i)-Policy framework: Article 19 (3) of the constitution states that: "the People has the right to the preservation of his heritage, culture and of its environment ". The environmental policy framework is rooted in the provisions of the Constitution. The Environment code was published on May 28, 1987. In November 8, 1989 the government published a Decree Regulating Impact Studies.

(ii)-Operationalization of policy framework: The national Environmental and Social Assessment and ESIA review process is

under the responsibility of the Ministry of the Environment through the Guinean Bureau of Studies and Environmental Assessment (BGEEE). It implements its mandate through five main phases: (1) validation of the terms of reference proposed by the promoter to serve as a scoreboard for the Environmental and Social Impact Notice (NIES); (2) the admissibility review (AR); (2) the receipt of the ESIA draft reports submitted to the Minister for the Environment; (4) review and judgment on the environmental and social acceptability of the project by the BGEEE; (5) monitoring of social and environmental dimensions of the project. The environmental and Social Impacts reports review requires the participation of relevant ministries to be involved or interested by the activities.

Since March 2013, the Government adopted a General Environmental (and Social) Assessment Guide/Directives. Sectoral guidelines are under preparation.

(iii)-Resourcing: The capacity of the BGEEE to ensure an effective ESMPs monitoring remains very limited. The Project Implementation Unit (PIU) will be hosted within the Ministry of Public Health and Hygiene which is already hosting three ongoing World Bank financed health projects. Given existing capacity shortages, the scope and scale of the project proposed activities, a full time Environmental and Social Safeguards specialist to accompany the project throughout its lifespan will be hired.

(iv)-Practice/outcomes/track record: So far, BGEEE statistics are not published annually and archiving is done through incoming and outgoing mail system; compliance certificates that have been issues are not readily accessible and available.

Despite the Borrower's past experience with implementing World Bank-funded operations and safeguards policies, it's institutional capacity to implement social and environmental requirements in a satisfactory manner remains low.

C. Environmental and Social Safeguards Specialists on the Team

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

D. 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 (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. 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 will thus prepare 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, the Government will prepare a Medical Waste Management Plan (MWMP) based on the 2015 National Medical Waste Management Plan to ensure that only actions that could be implemented by the project would be explicitly identified and funded. Moreover, to accommodate the OP/BP 4.11 core requirements, the ESMF will include chance find procedures 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. Both the ESMF and the MWMP will be consulted upon and publicly disclosed both in-country and at the World Bank Website prior to appraisal.
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 will likely increase the use of chemical pesticides which could have negative social, environmental and health impacts. The Project beneficiaries are likely to adopt integrated pest management practices will be prepared, consulted upon and publicly disclosed both in-country and at the World Bank Website prior to appraisal.
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 will include 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. The ESMF will be consulted upon and

		publicly disclosed both in-country and at the World Bank Website prior to appraisal.
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	Component 1.2 activities are likely to require land acquisition that would result in the loss of access, assets or means of livelihood, with or without physical displacement of people. Since the physical footprint of the project intervention sites are unknown at this very juncture and won't be known by appraisal, the Government will prepare a Resettlement Policy Framework (RPF) well-consulted upon and publicly disclose both in-country and at the World Bank website prior to appraisal.
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.

E. Safeguard Preparation Plan

Tentative target date for preparing the Appraisal Stage PID/ISDS

Oct 02, 2017

Time frame for launching and completing the safeguard-related studies that may be needed. The specific studies and their timing should be specified in the Appraisal Stage PID/ISDS

All required documentation will be prepared in time, over the next few months.

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APPROVAL

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Note to Task Teams: End of system generated content, document is editable from here.