

PROJECT INFORMATION DOCUMENT (PID) CONCEPT STAGE

Report No.: PIDC7724

Project Name	Health System Strengthening Project (P147555)
Region	AFRICA
Country	Congo, Democratic Republic of
Sector(s)	Health (100%)
Theme(s)	Child health (25%), Health system performance (25%), Nutrition and food security (10%), Population and reproductive health (30%), Injuries and non-communicable diseases (10%)
Lending Instrument	Investment Project Financing
Project ID	P147555
Borrower(s)	Ministry of Finance
Implementing Agency	Ministry of Health
Environmental Category	B-Partial Assessment
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Concept Review Decision	

I. Introduction and Context

Country Context

The Democratic Republic of Congo (DRC) is one of Africa's most rapidly growing economies. Since 2010 economic growth has exceeded the average for Sub-Saharan Africa by two percentage points. Real GDP growth has averaged more than seven percent from 2010-2012, it has reached 8.5 percent in 2013 and is projected to reach more than 10 percent by 2015. The implementation of sound macroeconomic policies and significant progress in restoring security in most of its territory has enabled this economic growth trajectory. DRC's large (71 million) and young population (46.3% of the population is under 15 (2010)), its vast natural resources and large agricultural potential position it well for continued growth. Given DRC's strategic location in the Great Lakes Region bordering nine countries, the country's development trajectory could have a positive impact on the entire sub-region.

Human development outcomes in DRC remain some of the poorest in the world. Despite DRC's current economic growth trajectory, its future growth looks bleak due to its lagging human development indicators. The recent economic growth curve has not translated into improvements in human development outcomes; the country ranks second to last (186/187) on the 2013 Human Development Index and sixty-three percent of the population is estimated to be poor, living under \$1.25 per day.

DRC's weak institutions delay progress on social and economic growth. Four decades of conflicts and mismanagement have severely weakened the country's institutions and infrastructure. This turmoil has plunged the population into acute vulnerability due to displacement, loss of economic livelihoods, and destroyed the social fabric impacting the DRC as well as its neighbors. These four decades of conflict and unstable governments have severely weakened the country's administration, eroded public accountability, and undercut publicly funded services. This decline is reflected in the inability of the administration to transform its economic growth into better access to basic services and improved social outcomes for the majority of the population. In addition, policy implementation suffers from low administrative and managerial capacity at the local level. Mindful of the need to modernize public administration and its human resources, the Government of DRC has initiated a civil service reform (including deconcentration) and allocated additional resources to the civil service apparatus. Despite these efforts, public administration remains dysfunctional partly due to outdated laws and regulations, unclear institutional mandates and structures, skills mismatch, low managerial capacity, and inadequate remuneration.

In order to generate further economic growth in DRC, a strong focus on human development, especially health, is imperative. Despite some recent progress, improving public sector capacity and efficiency, especially in the HD sector remains one of the country's challenges and the key to unlocking the economic potential and quelling the country's rampant poverty.

Sectoral and Institutional Context

Poor progress on health outcomes

Despite improvements in some human development indicators, considerable challenges remain. With a Human Development Index ranking of 186 out of 187 countries listed in the 2013 Human Development Report, the DRC has some of the worst health and nutrition indicators in the world. Life expectancy is 49 years (for men and 47 years and for women 51), with crude mortality rates an estimated 40% higher than the average for Africa (and 60% higher in the east of the country). One in seven children dies before the age of five and one in eleven infants dies before their first birthday (DHS- 2007). Chronic malnutrition among children under five is estimated at 45% (DHS) and almost half of children under five are moderately or severely anemic (43.7% and 4.2% respectively). The vast majority of the population, about 97%, lives in malaria-endemic areas with children suffering an estimated 10 episodes of malaria each year.

DRC is not on track to achieve any of the Millennium Development Goals (MDGs), especially those related to Maternal and Child Health. The main maternal and child health indicators remain very poor. The maternal mortality ratio is 670 (per 100,000 live births), the infant mortality rate is 97 (per 1,000), and the under-five child mortality rate is 158 (per 1,000). Decreasing maternal mortality and infant and child mortality rates will require improvements in both the quantity and quality of reproductive and child health services. Indeed, while 85 percent of pregnant women receive some antenatal care by trained professionals and that two-thirds of births (70 percent) take place in a health facility, the high rate of maternal mortality is an outcome directly affected by the

low levels of quality of care, inadequate preparedness for obstetric emergencies and limited availability of effective referral systems. Other causes for maternal mortality include a lack of access to emergency obstetric care, with long delays in obtaining timely care for obstetric emergencies being the norm rather than the exception.

The nutritional status of women and children in DRC presents an alarming situation that has severe consequences for them and future generations. Malnutrition is the underlying cause of almost half (48 percent) of the deaths of children under five years of age (DHS 2007). Children under five also have high levels of malnutrition, with 43 percent suffering from low height-for-age (stunting, a sign of chronic malnutrition), 10 percent have acute malnutrition, and 24 percent are underweight (MICS 2010). Additionally, 61.1 percent of children under five suffer from vitamin A deficiency. The prevalence of malnutrition among pregnant women and children under five is among the highest in Africa, and is directly linked with poverty, inadequate hygiene and sanitation, both at the individual and community levels.

Neglected tropical diseases contribute significantly to the burden of disease. Two conditions (Leprosy and Human African Trypanosomiasis) are estimated as having the highest prevalence of any NTDs in DRC. In addition, Schistosomiasis, Hookworm infection, Ascariasis, Trichuriasis and Lymphatic Filariasis are also extensively present, and are likely one of the underlying factors contributing to the burden of disease for malnutrition in DRC.

HIV/AIDS continues to be the Government's priority for 2010-2015 as highlighted in the second PRSP. Women continue to be at higher risk of HIV than men. Prevalence rates vary between urban and rural settings. Risk in urban areas is greater than in rural areas. The epidemic in DRC is primarily a function of transmission to and from high risk groups, especially among commercial sex workers. Mother-to-child transmission is poorly understood with only 14 percent of pregnant women understanding that HIV can be transmitted through breastfeeding or that mother-to-child transmission can be reduced through treatment during pregnancy.

Health system challenges

The availability and allocation of resources in the health sector is a major concern in DRC. Despite the fact that health is a key priority for the DRC, the Government spends only approximately US\$2 per capita/per year – one of the lowest levels of health funding in the world. Government health expenditures (from domestic resources) oscillated around 4 percent of the budget between 2006 and 2010. Based on the latest National Health Accounts, total health expenditures per person/per year are US\$14 with the Government's contribution being US\$2 per capita/per year, most of which is used to pay salaries in Kinshasa and a few provinces. While this represents a substantial increase from the 2003 levels of around US\$0.40 per capita, it still remains among the lowest in the world. The majority of health expenditures are financed by out-of-pocket spending by households (43 percent) and development partners (DPs) (34 percent).

User fees in government health facilities are relatively high and comparable to private sector fees, in part due to the limited government spending on the health sector. This means that health facility budgets are insufficient to cover actual costs of care. In addition, the government has adopted a cost-recovery policy for medicines in its health facilities, except for a few selected generic medicines to treat malaria and other illnesses, where government distributes them for free and no cost recovery is allowed. Over 43% of all financing of public sector health worker salaries comes from user fee revenue (NHA 2010). In DRC not only are user fees collected for curative care in

government health facilities but fees are also applied to essential preventive services such as growth monitoring for children under five years of age, institutional deliveries and antenatal and post-natal care.

Utilization rates remain low, which in part can be attributed to poor quality of health services, lack of clear “catchment” areas, and financial barriers to care. Key quality issues are: (i) the performance of health workers (absenteeism, clinical quality of care, interpersonal skills) is weak, (ii) health facilities have insufficient financial resources for ensuring availability of drugs and supplies; (iii) the range of services available at health facilities is limited; and (iv) the availability of services in terms of convenience (operating hours, proximity), and hotel services (such as meals and laundry) are inadequate. Two-thirds of patients in the DRC do not rely on the formal health care system, due to lack of availability of services, distance, poor quality and financial barriers. Uptake of preventive measures is also low. For example, less than 1% of households are estimated to use insecticide-treated bed nets.

A plethora of health workforce exists in DRC whereby overstaffing of health facilities is seen both in rural and urban areas. Adding to this problem is the fact that 70% of the health workforce doesn’t receive a salary. To compensate for no direct salary from Government, health facilities charge high user fees to support their salaries among other costs. Various partners (including the Bank) have paid salary top-ups and financed training of health workers as a motivation bonus, but this has not been sufficient to improve results. Important reforms in the health workforce in DRC will be required in order to improve the system efficiency. A critical aspect of that reform will be to reduce the current workforce to numbers that are more in line with the needs and then focus on addressing barriers to motivation while enhancing skills.

In addition, availability of drugs at an accessible cost is uneven across the health facilities in DRC. This is mainly due to the fact that health facilities procure drugs from various sources, including private sector distributors. However, the private pharmaceutical market is not well regulated and the price of the drugs on the market is relatively high while very little is known about the quality of the drugs. Field visits show that more than half of all drugs and medical consumables present in a government health facility have been procured from the private market, and the remainder are generic products from the Central Agency.

DRC has a strong dependency on development partner (DPs) funds not only to fund the health sector and deliver health services but to also pay the salaries of health staff. In 2011, financing from development partners represented 47 percent of the total health expenditure in DRC. Much of these funds have supported the service delivery pillar through support at the health zone level for the financing of a basic package of health services (including related drugs, rehabilitation, training, etc), with varying levels of financing depending on the development partner. The main partners financing these interventions include Canadian Department of Trade and Foreign Affairs, CTB (Belgian Cooperation), DFID, GAVI, GIZ, Global Fund, USAID, European Union, Spanish Cooperation, Swedish Cooperation, Swiss Cooperation, UNICEF, WHO and the World Bank, as well as several international NGOs. Development partners have taken the approach of “adopting” a health zone and financing the inputs needed to deliver services in that area. Harmonization and alignment between partners to finance health zones has been relatively weak and partner resources have been insufficient to cover the entire country.

Over the next 10-15 years the health landscape of DRC’s population will change significantly and

the country needs to be prepared to respond. DRC is facing rapid urbanization, rapid population growth, and an epidemiological transition moving more towards non-communicable disease while still having to address a substantial burden of communicable diseases.

Currently, the country's health system is ill equipped to meet the above challenges. While low sustainability is intrinsically linked to the extremely low level of financing for health in DRC, it also points to the need to focus on the six pillars of the health system, notably: i) service delivery ii) information, iii) essential medicines, iv) health workforce, v) financing, and vi) stewardship.

Performance-based Financing (PBF) is a supply-side Results-Based Financing (RBF) approach which has been piloted in DRC in the recent past to address the above-mentioned health sector challenges. PBF pays for outputs or results and this is different from classical programs which focus on procuring inputs. In the health sector, outputs or results are predominantly produced by health facilities whereas some results are produced by the health administration. Such outputs or results include quality services produced by health facilities and certain actions by the health administration. Income from PBF is used by health facilities and the health administration to procure necessary inputs and to pay performance bonuses. The DRC has a rich experience in PBF, with pilots being conducted by several development partners including the European Union, Cordaid and the World Bank under the previous health project.

The Haut Katanga PBF Pilot's impact evaluation has yielded key lessons for designing and implementing PBF in DRC which have been used in adjusting the PBF strategy of the current PARSS project targeting 84 health zones in 5 Provinces. Some of the lessons include: 1) the need to have a comprehensive benefit package of 10-15 targeted services, 2) verification needs to be done in a systematic manner and continuously in order to ensure accountability; 3) community engagement and counter-verification is key; and 4) the importance of measuring and paying for quality. These lessons as well as lessons from projects funded by the European Union in Kasai and by Cordaid in South-Kivu will help shape the thinking of the potential benefit of scaling up PBF in DRC for this new operation.

Relationship to CAS

This project is directly related to the third strategic objective of the FY13-FY16 Country Assistance Strategy (CAS) which aims to increase access to social services and raise human development (HD) indicators. Specifically, the CAS outlines that the Government has committed to strengthen service delivery systems in the health sector and to boost the achievement of basic health outcomes in the country. The 2006 Health System Strengthening Strategy focuses on the development of integrated primary health care services at the most decentralized level of the system (Health Zone) and the 2010 National Plan for Health Development provides a robust framework for future directions in the health sector. This project is mentioned explicitly in the CAS as an operation that will look specifically at health systems strengthening, governance and service delivery issues.

II. Proposed Development Objective(s)

Proposed Development Objective(s) (From PCN)

The proposed project development objective is to improve utilization and quality of maternal and child health services in targeted areas. The primary focus of the project will be on maternal and child health with improvements in MCH service delivery achieved through the scale-up and strengthening of Performance-Based Financing (PBF) in the target areas. In addition to improving

utilization of and quality of MCH services, PBF will also address the above-mentioned health system challenges through improving human resources for health outcomes (motivation, distribution, etc.), financial accessibility to health services, community engagement, and availability of material and equipment at the point of service delivery.

Key Results (From PCN)

The proposed set of PDO indicators covers all aspects of the operation. Additional intermediate level indicators for progress monitoring and results reporting will be identified during project preparation:

1. Number of children fully immunized
2. Number of pregnant women having at least 3 antenatal care visits before delivery
3. Number of children aged between 6 months and 59 months receiving preventive nutritional services
4. New curative consultation per capita and per year
5. Average score of the quality checklist

The number of direct project beneficiaries, of which female (percentage), would also be part of the PDO level indicators covering both components 1 and 2.

III. Preliminary Description

Concept Description

The geographical areas where the new project will be implemented will cover 140 Health Zones in 5 provinces (Bandundu, Maniema, Equateur, Katanga and Kasai Oriental). The project will target approximately 24 million people. The provinces have been selected based on criteria such as poor health indicators, lack of access to health services and the ability to build on/expand an ongoing partnership with an international organization. The underlying strategy for this project will be (together with the government and partners) to support entire provinces, when feasible, rather than an unsystematic selection of scattered health zones.

The IDA allocation for this project is US\$150 million. A grant of US\$14 million is expected from the Health Results Innovations Trust Fund (HRITF), in addition to a US\$2.5 million grant to finance an impact evaluation. The proposed project will use PBF to finance health facilities at selected provinces and health zones to improve quantity and quality of health services. The innovative features of this project include: (i) a large budgetary allocation for household visits, which is a novel demand-generating PBF intervention to improve preventive and curative health seeking behavior, in addition to the supply-side PBF approach that will include geographical equity adjustments and financing of fee-exemptions for the poor and vulnerable; (ii) a clear focus on addressing nutrition, HIV/AIDS and neglected tropical diseases in addition to maternal and child health; and (iii) rigorous results monitoring through systematic use of grassroots organizations combined with rigorous sanctions in case of fraud. The details of the project components are below.

Component 1: Performance-Based Financing (PBF) to improve the quantity and quality of maternal and child health services

Component 1 aims to support the delivery of a basic and a complementary package of priority health services which respond to the burden of disease in DRC. This component will finance PBF payments to health service providers and health administration units (health facilities and hospitals)

contracted in the target areas. This component would be supported by IDA and HRITF as well as potentially development partner funding from UNICEF, Global Fund and GAVI. PBF will be financed through separate fund holding arrangements, while the purchasing, verification, community mobilization and coaching will be organized through provincial purchasing agencies (EUPs: Etablissement d'utilité publique).

The institutional framework for implementing PBF will extend the EUP model, which has shown to be an effective and efficient model for successful PBF operations in DRC, leading to not only successful implementation of PBF at lower costs (overhead costs of 15 percent for EUP versus 30 percent for international NGOs), but also strengthening national capacity for service delivery in even the most challenging contexts.

Subcomponent 1.1: Performance payments to health facilities

This subcomponent will provide grants for a package of Maternal and Child Health (MCH) services and technical support for PBF implementation. Public, quasi-public and private health facilities, including health centers and first level referral hospitals, will be targeted in rural and urban areas.

PBF grants financed under this component (based on the selected services to be purchased) will be paid to these health facilities in proportion to, and in payment for, achieved results. Facility payments will be based on (i) the quantity of MCH and other services delivered to the targeted population, and (ii) the technical quality of these services. Facility payments will be made quarterly after service volumes have been verified and quality of technical support and care has been assessed and certified by the EUPs, and ratified through special governing boards at the health zone level. After the quantity and quality of services provided are certified, payment will be released to contracted health facilities via the fund-holding entities.

Subcomponent 1.2: Strengthening capacity for Performance-Based Financing implementation

Subcomponent 1.2 will finance: (i) activities to support PBF implementation and supervision (capacity building, verification and counter verification, IT system, etc.) through the use of EUPs for contract management and verification; (ii) performance frameworks that will be introduced at all levels of the health system to hold provincial health administrative units (DDS – division départementale de santé) accountable for services through incentive mechanisms; (iii) internal performance framework contracts with DDS vis-à-vis their roles in the health system and implementation of PBF; and (iv) performance frameworks with the PBF Technical Unit (CT-PBF), who will coordinate key aspects of the project in close collaboration with the various technical units with the MOPH.

This subcomponent will also finance activities related to verification and counter-verification of the DDS, EUPs and drug regulatory authority/MOPH HMIS/MOPH. An external evaluation agency (Agence de Contre-Vérification Externe - ACVE) will assess the performance of the EUP, DDS, HMIS department/MOPH and the drug regulatory authority/MOPH.

Component 2: Strengthening Governance, Health Financing and Health Policy Capacity Building

This component aims to strengthen health care financing policy and practices in DRC, both to improve equity and efficiency in health financing and to pave the way for Universal Health Coverage. This component will be supported by the Government's own funds, IDA resources and the HRITF trust fund. Key activities will include technical assistance for: (i) improving budget

formulation and allocation practices; (ii) developing and implementing of a sound health care financing strategy; (iii) improving regulatory functions for improved health system management at central and provincial levels; and (iv) strengthening the health management information system and monitoring and evaluation tools.

Finally, this component will cover project implementation and general monitoring and evaluation activities.

IV. Safeguard Policies that might apply

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

V. Financing (in USD Million)

Total Project Cost:	150.00	Total Bank Financing:	150.00
Financing Gap:	0.00		
Financing Source		Amount	
BORROWER/RECIPIENT		0.00	
International Development Association (IDA)		150.00	
Total		150.00	

VI. Contact point

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