INTEGRATED SAFEGUARDS DATA SHEET
APPRAISAL STAGE

Report No.: ISDSA1017

Date ISDS Prepared/Updated: 26-Oct-2014

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I. BASIC INFORMATION

1. Basic Project Data

Country:	Congo, Democratic Republic of	**Project ID:**	P147555
Project Name:	Health System Strengthening for Better Maternal and Child Health Results Project (PDSS) (P147555)		
Task Team Leader:	Hadia Nazem Samaha		
Estimated Appraisal Date:	08-Oct-2014	**Estimated Board Date:**	18-Dec-2014
Managing Unit:	GHNDR	**Lending Instrument:**	Investment Project Financing
Sector(s):	Health (100%)		
Theme(s):	Population and reproductive health (30%), Child health (25%), Health system performance (25%), Nutrition and food security (10%), In juries and non-communicable diseases (10%)		
Is this project processed under OP 8.50 (Emergency Recovery) or OP 8.00 (Rapid Response to Crises and Emergencies)?	No		

Financing (In USD Million)

Total Project Cost:	230.00	Total Bank Financing:	220.00
Financing Gap:	0.00		

Financing Source	Amount
BORROWER/RECIPIENT	0.00
International Development Association (IDA)	110.00
IDA Grant	110.00
Health Results-based Financing	10.00
Total	230.00

Environmental Category:	B - Partial Assessment
Is this a Repeater project?	No

2. Project Development Objective(s)

The proposed project development objective is to improve utilization and quality of maternal and child health services in targeted areas.

3. Project Description

The project will be implemented in 132 health zones (HZ) reaching 16.55 million people or 23.5 percent of the population. The project will target 4 provinces: Equateur (58 HZ), Bandundu (52 HZ), Maniema (14 HZ) and Katanga (8 HZ). The direct beneficiaries include women and children under 5.

The project will have three components. i) Component 1: Improve utilization and quality of health services through Performance-Based Financing; ii) Component 2: Improve Governance of the Health System; and iii) Component 3: Strengthen Health Financing and Health Policy Capacities.

Component 1: Improve utilization and quality of health services through Performance-Based Financing. Total costs including contingencies US$132 million of which IDA = US$117 million and HRITF = US$15 million.

This component would be supported by IDA and the HRITF as well as through parallel 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 (EUP's: Etablissement d'utilité publique). The institutional framework for implementing PBF will build on extending the EUP model, which has been designed and implemented for PBF operations in the North Kivu, Province Oriental and the two Kasai since 2009. The model has shown to be an effective and efficient model for successful PBF which strengthens national capacity for service delivery in even the most challenging contexts.
This component aims to increase the volume and quality of health services, with a specific focus on maternal and child health interventions, through PBF in selected health zones. Specifically, performance-based incentives will be used to support: (a) increased utilization of targeted services related largely to MNCH (PMA and PCA – see annex 2); (b) improved clinical practice and health worker motivation (both intrinsic and extrinsic); and (c) structural improvements (e.g. availability of drugs and commodities, equipment, etc.). Performance payments can be used for: (i) health facility operational and capital costs (e.g. including maintenance and repair, drugs and consumables, outreach activities (e.g., for transport, performance payment to community workers, and demand-side incentives); and, (ii) financial and non-financial incentives for health workers according to defined criteria. Notably, performance based incentives will be additional to existing financing at target facilities. .
The PMA and PCA respond to the burden of disease in DRC. According to the Global Burden of Disease study 2010, the burden of disease in DRC is predominantly related to communicable, maternal, neonatal and nutritional conditions: the first ten conditions with the highest Years of Life Lost (YLL) lead to 70 percent of all YLL in DRC. Among the top nine of conditions causing the highest burden of disease in DRC in order of magnitude are malaria; diarrhea; lower respiratory tract infections, protein energy malnutrition, measles, preterm birth complications, HIV/AIDS, TB and neonatal encephalopathy.
Further work on the detailed design and initial implementation will be done during project preparation; this will be supported through a Project Preparation Advance (PPA), which has already been discussed with the Government. An important element of this component, as well as the PPA, will be both capacity building and communication, including training on PBF concepts and procedures, behavior change education, information, education and communications related to

demand generation and other strategic communication related to the PBF program.
Component 2: Governance, purchasing, coaching and strengthening health administration units through Performance-Based Financing. Total costs including contingencies US$69.7 million of which US$64.7 million from IDA and US$5 million from the HRITF.
Contract management and verification: an innovative purchasing arrangement will be created covering each of the four provinces. The project will aim at cov ering two provinces in its entirety (Equateur and Bandundu), as well as supporting the health zones covered by the PARSS in Maniema and Katanga. An innovative strategy will be followed to build local capacity in PBF contract management and verification functions through the EUPs. These local organizations will be created bottom-up drawing from existing local human resources and experts that have worked on PBF over the past 14 years. The EUPs will be under a performance contract with the MOPH in which the timely and correct execution of their tasks will be measured and rewarded through a quarterly performance framework applied by a third party.

Performance frameworks will also be introduced at all levels of the health system. These contracting mechanism will hold Provincial Health Directorate (DPS – division provincial de santé)) and Health Zone Teams (ECZS- équipe cadre de zone de santé) and regional drug distribution outlets (CDR – central de distribution régional) accountable for their results through strong incentive mechanisms. Internal performance frameworks contracts will clearly outline the expected performance of the different DPSs and ECZSs vis-à-vis their roles in the health system and lead to successfully scaled up PBF approaches. Results from the organizational performance will be benchmarked on a publicly visible website (http://www.fbrsanterdc.cd/).

The Planning Unity (DEP - Département d'Etude et de Plannification) will coordinate key aspects of the project in close collaboration with the various technical units with the MOPH most notably with the PBF technical unit Cellule-Technique –Results Based Financing (CT-FBR). The DEP and the CT-FBR will be strengthened by a mix of government staff and consultants recruited through a merit-based process. The DEP, apart from managing the project related components, will also be the fund-holder for PBF output-payments. The health management information department (HMIS) will have the responsibility to maintain the PBF web-enabled application database. The DEP, CT-FBR and HMIS unit will all be under performance contracts.

This component in addition to financing PBF grants for strengthening the health administration units at all levels will also finance the provision of goods, consultant services, training and operating costs to support project monitoring, evaluation and management, with an aim to ensure efficient, effective, transparent and accountable delivery of this project. Internal performance contracts will be established between the DEP Unit and the technical units in the Ministry of Public Health to incentivize timely and quality delivery of project activities. The component will also finance the project communications strategy.

Local Health Committees will be involved in the performance based approach through their participation and oversight in: (i) health facility committees (COSA) and health area development committees (CODESA); (ii) fund utilization at the health facility to achieve business plan targets; (iii) discussions and negotiations with the heads of health centers regarding user fee levels; and (iv) community verification of existence of users and assessment of patient satisfaction.

In addition to ensure greater community engagement in order to achieve behavior change in the target population and improve the levels of citizen participation in the management of health, the project will: i) develop and implement an information, education and communication strategy; ii) put

in place the household visit (see Annex 2 for further details) to increase demand of health services and improve healthy behaviors at the household level; and iii) engage the community in the planning and management of health activities including those aimed at enhancing transparency and accountability in the delivery of services.

Component 3: Strengthen Health Financing and Health Policy Capacities. Total costs including contingencies US$18.3 million

Component 3 is supporting components 1 and 2 as it will put the focus on institutional capacity building and technical support in various dimensions of health system strengthening that will directly reinforce and echo the investments of components 1 and 2. This component will reinforce the reform process with specific focus on policy dialogue on health policies and health financing which will support the sustainability of the investments and approaches covered in components 1 and 2. It will also provide opportunities to improve data collection and hence reinforcing the ability of policy development to be based on reliable data. Finally, the technical work and various interventions will strengthen the capacity of the Government to respond and better define more equitable policies and interventions hence addressing the inequities across the system. The project aims at having a catalytic role on health system reform through the complementarities of the components.

This component would be supported by IDA resources. Its aim is to support the development of a medium term strategic vision that would lead to more sound policy making, effective harmonization, and better allocation of resources in the sector. This strategic vision would include clearer orientations in terms of the decentralization, on Universal Health Coverage (UHC) agenda, the health financing reform and the human resource management reform.

Accordingly, component 3 includes different complementary interventions. The project will provide institutional, financial, and technical support to the various entities at the national level that are leading major reform processes (i.e. DEP), the Primary Health Services Direction, the Health Management Information System (HMIS) Unit, the Results Based Financing Technical Unit (CT-FBR), the Human Resources Direction, the future directions of resource management (Direction des affaires financières -DAF), and the monitoring and evaluation unit that is linked to the secretary general. Support will also be provided at the provincial level through the support to the DPS.

Sub-component 3.1: Support to improve health financing reform and system decentralization - Total costs including contingencies US$4.4 million.

This component will support the Government’s reform process to strengthen the health system focusing on: (i) better planning and budgeting process at national and decentralized level through the use of Mid Term Expenditure Framework (MTEFs), (ii) policy dialogue and design of the national health financing and Universal Health Coverage (UHC) strategy, (iii) strengthening of the MOH leadership on health sector investments both financed by national, provincial or external sources, and (iv) institutional support to key entities of the MOHP

In 2013, the government initiated the development of both a new health financing strategy and a Universal Health Coverage Law (UHC). This project will support the national dialogue on the health financing strategy and on UHC. Activities will include (i) technical consultations and discussions with other ministries such as budget, finance, and social protection, (ii) technical and financial support to the teams in charge of the health financing strategy, the health financing reform and the UHC roadmap, (iii) high level consultations with government and parliament members as well as

external partners, and (iv) specific studies that will support the policy dialogue.

Given the decentralization reforms underway, this sub-component will support the provincial health directorate (DPS- Division Provinciale de la Santé), the decentralized entities in charge of the health system management and stewardship at provincial level. The government has recently increased the number of DPS from 11 to 26. The managers of the 26 DPS have been recruited through a competitive and transparent process. The reforms include alignment by all partners to fund these DPS through contrat unique' (single contract), which embodies one contract type with the provincial health directorate, one unique performance framework (with some room for provincial adjustments) and one unique monitoring and evaluation mechanism. The DPS contracts will serve to provide institutional funding to the DPS by the various partners. This is an innovation as it would be the first time all partners would provide institutional funding through a common contract to the DPS, hence addressing the fragmentation of funding the DPS.

There is a lack of clarity of how and when the government is willing to initiate the decentralization of the health workforce management and payment. In case decentralization reform is initiated, the project will support the policy dialogue on Human Resources management reform at national and provincial level. This sub-component will also re-enforce the quality of health service delivery by improving the quality of care provided by health workers.

Potential quality of care activities (QoC) to be supported under this sub-component could include: (i) development of National QoC Improvement Strategy and operational plan development; (ii) dissemination of clinical practice guidelines and protocols; (iii) development and scaling up of quality assurance/ continuous qual ity improvement modalities; (iv) establishing and strengthening professional associations (doctors, nurses, lab technicians) to self-regulate and help improve QoC among its members. Such QoC activities will complement the pay-for-quality approach in the PBF grant under Component 1. These activities will be done in collaboration with other key partners.

Finally, this sub-component would build capacity in health policy and management. The pervasive lack of knowledge regarding health policy concepts, management skills, and regional and global best practices limits government's ability to strengthen its health system. Along with the appropriate counterpart endorsements, partnerships, and the use of national training institutions, this sub-component will finance: (i) a five-year training program for policymakers, and health managers, from the central and provincial levels. The training materials in health policy and management will be adapted from those currently available from the World Bank Institute's Flagship Program for Health System Strengthening; and (ii) strengthen existing capacity for research, analytical work, institutional strengthening of national institutions such as the statistic bureau, the planning department and other government entities which will be developed and executed during the project period.

Sub-component 3.2: Health Sector Monitoring and Evaluation (M&E) Strengthening and Project Monitoring- Total cost including contingencies US$13.9 million.

The weaknesses of the DRC health information system results in inadequate monitoring and evaluation (M&E) of health sector performance and therefore an inability to use data for decision making. Since 2013, the government with the support of external partners decided to migrate its access based HMIS system to a web based DHIS2 platform. A new web based Human Resources Management software is being piloted in two provinces. Web-based Performance Based Financing and Open Data software have been implemented to manage performance based financing and

enhance accountability and transparency in five provinces.

The project will support the HMIS Unit and CT-FBR in the rollout of the DHIS2 and the PBF IT system. It will support the interoperability of web based IT systems and strengthen the HMIS unit in the development of an integrated e-health architecture. This sub-component is fully aligned with and will build upon the work that will be achieved in this field through the HD Systems Strengthening Project (P145965).

The combination of DHIS2, PBF IT systems and an Open Data layer is part of the efforts for setting up data driven health systems supported by performance based financing. Verified and purchased results including the results for the health administration will be visible on the public website whereas the raw data will be downloadable from the website. Benchmarking both the quantity and quality of health facilities and the public health administration will lead to a powerful tool to employ results monitoring and better governance. Introducing an ICT sub-component to the project to build the capacity of the MOPH will allow the health facilities to systematically keep track of funding and payments, record data, and use this data at both the facility and central level to make informed management and policy decisions to improve the health system of DRC. Performance contracting with the health administration at health zone and province levels will include tasks related to epidemic disease surveillance.

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

The geographical areas where the new project will be implemented will cover 132 Health Zones reaching 16.55 million people or 23.5 percent of the population. The project will target 4 provinces: Bandundu, (52 HZ) Maniema, (14 HZ), Equateur, (58 HZ) and Katanga (8HZ) The direct beneficiaries include women and children under 5.

Institutional capacity building at national level is the focus of the project. Particular attention is given to some of the most “foundational” system building blocks in each sector. No civil works will be undertaken and no adverse environmental or social impacts are expected. The project does not require any land acquisition leading to involuntary resettlement and/or restrictions of access to resources and livelihood. The project is expected to have a positive impact for all beneficiaries including vulnerable groups such as children, women and the poor who are the main target beneficiaries of the project.

This project will cover 4 provinces and hence part of the population targeted will include Indigenous Peoples (IPs). The expected impacts are positive as the IPs do not have access to quality care and hence the project will ensure that quality free care is provided to them to ensure a better health outcome. An Indigenous Peoples Health Needs Assessment has been conducted as part of the current PARSS (P088751) project; this will be used as a starting point in developing the Indigenous Peoples Plan for the project.

5. Environmental and Social Safeguards Specialists

Antoine V. Lema (GSURR)

Abdoulaye Gadiere (GENDR)

6. Safeguard Policies	Triggered?	Explanation (Optional)
Environmental Assessment OP/	Yes	The environmental impacts of the project are

BP 4.01		expected to be minimal. The project will finance the updating of the existing Health Care Waste Management Plan (HCWMP) currently used by the health PARSS project. It will be updated, reviewed, consulted upon and disclosed publicly both within the DRC and at Bank's Infoshop by project effectiveness.
Natural Habitats OP/BP 4.04	No	The project will not affect natural habitats.
Forests OP/BP 4.36	No	The project does not involve forests or forestry.
Pest Management OP 4.09	No	The project does not involve pest management.
Physical Cultural Resources OP/ BP 4.11	No	The project does not involve physical cultural resources.
Indigenous Peoples OP/BP 4.10	Yes	An Indigenous Peoples Plan will be prepared, consulted upon and disclosed in country and at the Infoshop. It aims to ensure that Indigenous Peoples will benefit from social outputs of the project as it will cover indigenous areas. Disclosure is planned by effectiveness.
Involuntary Resettlement OP/BP 4.12	No	The project does not involve land acquisition leading to involuntary resettlement and/or restrictions of access to resources and livelihoods.
Safety of Dams OP/BP 4.37	No	The project does not involve dams.
Projects on International Waterways OP/BP 7.50	No	N/A
Projects in Disputed Areas OP/BP 7.60	No	N/A

II. 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 is not expected to have large scale, significant, or irreversible environmental or social impacts. Project activities are focused on delivery of an integrated package of health services both at the community and health facility level, as well as providing high impact maternal and reproductive health services. Project activities that could potentially cause an adverse impact that will need to be minimized, mitigated and managed include: (i) During the operation of the health facilities the generation of additional quantities of medical waste will increase slightly over the current baseline. (ii) In addition, the health facilities will receive an investment bonus at the beginning of each year, which they can use to do some minor rehabilitation such as painting, opening a window, fixing the rood

etc. These activities may cause noise, vibrations and emissions from vehicles and machinery, generate construction waste and involve potential risks regarding workplace and community health and safety. However, these activities' anticipated impacts will be temporary, site specific and localized, and limited in scope.

The presence of indigenous people (Batwa) in the targeted Provinces was identified and confirmed during project preparation. Batwa constitute a vulnerable and marginalized group in the project area. The risk of social exclusion of Batwa in the context of the project cannot be ignored, to ensure that Batwa will benefit from the project, OP/BP 4.10 has been triggered, and an Indigenous Peoples Plan (IPP) focusing on outreach and inclusion will be prepared.

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

The planned project activities are not anticipated to have long-term or indirect negative social or environmental impacts. The project is expected to increase social cohesion at the family and community level as well as activities to promote gender equality and change negative attitudes and norms towards women and girls. In addition, the project support will provide targeted communities with better access to basic health service. Project investments may strengthen sound environmental and social practices in the construction sector and around health facilities. In addition, the expected impacts on the indigenous people are positive as the Batwa do not have access to quality care and hence the project will ensure that quality free care is provided to them to ensure a better health outcome.

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

Not applicable

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.

At national level, the DRC has legislative and regulatory frameworks which are conducive to good environmental management. In addition, they have signed a number of international treaties and conventions to ensure good environmental governance. At sector level, the DRC has already implement Bank safeguards policies in various sectors. At project level, the beneficiary has agreed to prepare and implement the safeguards policies triggered by the project. In accordance with World Bank policy guidelines, the borrowers will prepare: (i) Medical Waste Management Plans (MWMPs) as well as (ii) an Indigenous Peoples Plan (IPP) will be developed which will focus on outreach and inclusion.

The MWMPs will cover (a) anticipated waste composition and quantity; (b) existing medical waste management system, including free capacity, deviations from, and gaps to BAT, (c) existing regulatory framework and supervision / monitoring arrangements; (d) plan for using the existing medical waste management system, including any measures to upgrade or remedy identified gaps and deviations; and (e) additional arrangements for supervision and monitoring of medical waste management. In DRC, where indigenous people (Batwa) have been identified in the project area, the borrower will prepare IPP and put in place mitigation mechanisms to ensure indigenous people benefit from the project.

As DRC is considered a conflict country the safeguard instruments are prepared under the special policy exceptions and considerations described in paragraph 11 of OP 10.00 (namely, a Category B operation in a fragile and conflict-affected state), which defers their preparation from the project

preparation phase into the implementation phase. The MWMPs and the IPP will not be prepared before appraisal as would be mandated under normal procedures, but will be finalized before actual physical works / footprints occur during the project implementation phase.
5. Identify the key stakeholders and describe the mechanisms for consultation and disclosure on safeguard policies, with an emphasis on potentially affected people.
The preparation of the project has relied on consultations with government officials at relevant levels, provincial officials, donors' community, implementation partners, community and civil society groups, and direct beneficiaries of the project. The implementation of the project will likewise rest on various consultations. The preparation of safeguards instruments (MWMPs, and IPP) will include additional consultations, at local, provincial and national level. Upon review and approval by the government, the MWMPs and IPP will be disclosed by governments in local languages to project-affected groups and NGOs in publicly accessible places for consultations, and by the World Bank, in the Infoshop.

B. Disclosure Requirements

Environmental Assessment/Audit/Management Plan/Other	
Date of receipt by the Bank	20-Feb-2015
Date of submission to InfoShop	20-Feb-2015
For category A projects, date of distributing the Executive Summary of the EA to the Executive Directors	
"In country" Disclosure	
Congo, Democratic Republic of	20-Mar-2015
Comments: Document will be disclosed in country by effectiveness .	
Indigenous Peoples Development Plan/Framework	
Date of receipt by the Bank	20-Feb-2015
Date of submission to InfoShop	20-Feb-2015
"In country" Disclosure	
Congo, Democratic Republic of	20-Mar-2015
Comments: Document will be disclosed in country by effectiveness .	
If the project triggers the Pest Management and/or Physical Cultural Resources policies, the respective issues are to be addressed and disclosed as part of the Environmental Assessment/ Audit/or EMP.	
If in-country disclosure of any of the above documents is not expected, please explain why:	

C. Compliance Monitoring Indicators at the Corporate Level

OP/BP/GP 4.01 - Environment Assessment	
Does the project require a stand-alone EA (including EMP) report?	Yes [ ] No [×] NA [ ]
OP/BP 4.10 - Indigenous Peoples	
Has a separate Indigenous Peoples Plan/Planning Framework (as appropriate) been prepared in consultation with affected Indigenous Peoples?	Yes [×] No [ ] NA [ ]

If yes, then did the Regional unit responsible for safeguards or Practice Manager review the plan?	Yes [×] No [ ] NA [ ]
If the whole project is designed to benefit IP, has the design been reviewed and approved by the Regional Social Development Unit or Practice Manager?	Yes [ ] No [ ] NA [×]
The World Bank Policy on Disclosure of Information	
Have relevant safeguard policies documents been sent to the World Bank's Infoshop?	Yes [ ] No [×] NA [ ]
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 [ ] No [×] NA [ ]
All Safeguard Policies	
Have satisfactory calendar, budget and clear institutional responsibilities been prepared for the implementation of measures related to safeguard policies?	Yes [ ] No [ ] NA [×]
Have costs related to safeguard policy measures been included in the project cost?	Yes [ ] No [ ] NA [×]
Does the Monitoring and Evaluation system of the project include the monitoring of safeguard impacts and measures related to safeguard policies?	Yes [ ] No [ ] NA [×]
Have satisfactory implementation arrangements been agreed with the borrower and the same been adequately reflected in the project legal documents?	Yes [ ] No [ ] NA [×]

III. APPROVALS

Task Team Leader:	Name: Hadia Nazem Samaha	
Approved By		
Regional Safeguards Advisor:	Name: Alexandra C. Bezeredi (RSA)	Date: 26-Oct-2014
Practice Manager/ Manager:	Name: Trina S. Haque (PMGR)	Date: 26-Oct-2014