

**PROJECT INFORMATION DOCUMENT (PID)
APPRAISAL STAGE**

Report No.: PIDA11825

Project Name	Health System Strengthening for Better Maternal and Child Health Results Project (PDSS) (P147555)
Region	AFRICA
Country	Congo, Democratic Republic of
Sector(s)	Health (100%)
Theme(s)	Population and reproductive health (30%), Child health (25%), Health system performance (25%), Nutrition and food security (10%), Injuries and non-communicable diseases (10%)
Lending Instrument	Investment Project Financing
Project ID	P147555
Borrower(s)	Ministry Of Finances
Implementing Agency	Ministry of Public Health
Environmental Category	B-Partial Assessment
Date PID Prepared/Updated	23-Oct-2014
Date PID Approved/Disclosed	27-Oct-2014
Estimated Date of Appraisal Completion	09-Oct-2014
Estimated Date of Board Approval	18-Dec-2014
Decision	

I. Project 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 Gross Domestic Product (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 percent 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 (HD) outcomes in DRC remain some of the poorest in the world. Despite DRC's current economic growth trajectory, its future growth could be compromised by its lagging human development indicators. The recent economic growth curve has not translated into consistent

improvements in human development outcomes; the country is tied with Niger for the lowest position (187/187) on the 2013 Human Development Index (HDI) and sixty-three percent of the population is estimated to be poor, living under \$1.25 per day. The country's poverty is more than monetary. It includes a sense of exclusion, economic instability, and the inability to cope with uncertainties and to project in the future. Poverty also is experienced as the lack of economic opportunities and physical and psychological insecurity (World Bank Country Assistance Strategy, 2012). While the primary gross enrollment ratio for education has improved considerably, reaching 101.4%, retention and the achievement of learning outcomes remain challenges.

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

Despite improvements in some human development indicators, considerable challenges remain. With a Human Development Index ranking of 187 out of 187 countries listed in the 2013 Human Development Report, DRC has some of the worst health and nutrition indicators in the world. DRC has made considerable progress in recent years in reducing the under-five mortality rate from 148 per 1000 live births in 2007 to 104 in 2013 (DHS). However, mortality rates remain high and life expectancy is 49 years (47 years for men and 51 for women), with crude mortality rates an estimated 40 percent higher than the average for Africa (and 60 percent 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- 2014). While some of the conditions that typically determine malnutrition have improved (e.g., access to drinking water has increased from 22 percent in 2005 to 50 percent in 2012 (Enquete 1-2-3), chronic malnutrition among children under five is estimated at 43 percent (DHS) and almost half of the children under five are moderately or severely anemic (43.7 percent and 4.2 percent respectively). The vast majority of the population, about 97 percent, 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 estimated at 846 (per 100,000 live births) - DHS 2014 Preliminary DHS-2014 data as compared with the 2010 MICS shows a net decrease to 104 (per 1000) from 148 (per 1000) for the under-5 mortality rate and a decrease from the infant mortality rate from 92 (per 100) to 58 (per 1000). Despite this major progress, decreasing maternal mortality, infant and child mortality rates will require further improvements in both the quantity and quality of reproductive and child health services. Especially the very high maternal mortality ratio which is a sensitive indicator for a functional emergency obstetric care system. While 85 percent of pregnant women receive some antenatal care by trained professionals and while two-thirds of births (80 percent) take place in a health facility, the high rate of maternal mortality is directly driven by the low levels of quality of care, inadequate preparedness for obstetric emergencies and limited availability of effective referral systems in addition to other factors (e.g. poor access to facilities, socio-cultural impediments, and financial barriers).

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) (this indicator hasn't changed based on the DHS-2013), 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 in DRC (Leprosy and Human African Trypanosomiasis (HAT)) are estimated as having the highest prevalence of any NTDs globally. 75 percent of the global HAT cases are in DRC, and 50 percent of all cases in DRC come from one district (Mai-Ndombe in Bandundu province), covered by the project. In addition, Schistosomiasis, Hookworm infection, Ascariasis, Trichuriasis and Lymphatic Filariasis are also extensively present, and are likely to be some of the underlying factors contributing to the burden of disease for malnutrition in DRC. The HAT program is in transition, with major novel changes such as a new rapid test and new oral treatment which will both come available by end 2015. The program collaborates with the Gates Foundation which is involved in financing the fight against HAT.

Human Immunodeficiency Virus-Acquired Immunodeficiency Syndrome (HIV/AIDS) and Tuberculosis (TB) continue to be the Government's priority for 2010-2015 as highlighted in the second Poverty Reduction Strategy Paper (PRSP). TB and HIV infection are two diseases that are accompanied by a heavy economic and social burden. DRC is among the 22 countries most affected by TB and among the 20 countries that support 90 percent of the unmet needs of PMTE. It is also among the 27 countries where we find 85 percent of the global burden of disease in terms of multi-drug resistant tuberculosis (MDR-TB) (WHO 2013). The TB is the leading opportunistic infection of HIV/AIDS in DRC (Rapport of NACP Survey Frequently DRC) and HIV is one of the most important risk factors for TB; it is also the leading cause of death among people living with HIV (UNAIDS global carry-2013). In 2012, the incidence of TB is 327 new cases per 100,000 inhabitants.

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\$1 per capita/per year (draft WB PER, 2014) – one of the lowest levels of health funding in the world. While this \$1 per capita represents a substantial increase from the 2003 levels of around US\$0.40 per capita, it is a decrease as compared with 2007 (\$1.5 per capita) and it still remains among the lowest 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 (NHA-2010), total health expenditures per person/per year are US\$12 with the Government's contribution being 12 percent, most of which is used to pay salaries in Kinshasa and a few provinces. While this \$1 per capita represents a substantial increase from the 2003 levels of around US\$0.40 per capita, it is a decrease as compared with 2007 (\$1.5 per capita) and it still remains among the lowest in the world. The majority of health expenditures are financed by out-of-pocket spending by households (37 percent) and financial and technical partners (FTPs) (47 percent).

Utilization rates remain low. This can be attributed in part 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 medicines and medical supplies; (iii) the range of services available at health facilities is limited; and (iv) the convenience of services (operating hours, proximity), and inadequacy of hotel services (such as meals and laundry). 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 reasonable. For example, 70 percent of households are having insecticide-treated bed nets and among those households that have nets, 76 percent of children under five slept under a net the previous night (DHS 2014).

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 percent of the health workforce doesn't receive a salary. To offset the costs of salaries and insufficient Government allocation of funds, health facilities charge high user fees. Various partners (including the World 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 this reform will be to reduce the current workforce numbers to match the needs and then focus on addressing barriers to motivation whilst enhancing skills.

In addition, availability of drugs at an accessible cost is uneven across the health facilities in DRC. A National Essential Drugs Supply System (SNAME) centralizes the purchasing while decentralizes the distribution at the provincial level through the Central Regional Distribution (CDR) units. The country currently has 19 CDR which store and distributes drugs at the intermediate level. Despite this design, a parallel subsystem for supplying drugs is in place, which poses many problems of coordination, harmonization, quantification, and even improving logistics capabilities. This has resulted in: (i) the stock-outs in some health zones or over stocking sometimes causing expiry of these medicines and ii) inefficient transport of drugs and supplies for various subsystems to the same health zones thus increasing logistics costs.

DRC has a strong dependency on financial and technical partners not only to finance 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 medicines, rehabilitation, training, etc.), with varying levels of financing depending on the development partner. This financing has been mostly in kind, with some funds being used to pay ‘bonuses’ to select cadre of health workers. The main partners financing these interventions include Canadian Department of Trade and Foreign Affairs, Belgian Cooperation (CTB), UK Department of International Development (DFID), Global Alliance for Vaccines and Immunization (GAVI), German International Cooperation (GIZ), Global Fund (GF), United States Agency for International Development (USAID), European Union (EU), Spanish Cooperation, Swedish Cooperation, Swiss Cooperation, United Nations Children’s Fund (UNICEF), World Health Organization (WHO), and the World Bank (WB), as well as several international non-governmental organizations (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.

II. Proposed Development Objectives

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

III. Project Description

Component Name

Component 1: Improve utilization and quality of health services through Performance Based Financing

Comments (optional)

Component Name

Component 2: Improve Governance of the Health System

Comments (optional)

Component Name

Component 3: Strengthen Health Financing and Health Policy Capacities

Comments (optional)

IV. Financing (in USD Million)

Total Project Cost:	230.00	Total Bank Financing:	220.00
Financing Gap:	0.00		
For Loans/Credits/Others			Amount
BORROWER/RECIPIENT			0.00
International Development Association (IDA)			110.00
IDA Grant			110.00
Health Results-based Financing			10.00
Total			230.00

V. Implementation

The Ministry of Public Health (MOPH) will implement the project through the Planning and Evaluation Directorate (DEP – “Direction d’étude et de planification”). Strengthening existing structures rather than setting up parallel structures is a strategy embraced by both the counterpart and the Bank. The DEP will be reinforced by a mix of government staff and external technical assistance recruited through a merit-based process. As the current capacity levels for project coordination, financial management, and procurement are weak, the DEP will be strengthened over the long-term through use of local technical assistance for project implementation and PBF coordination. In addition, the entire unit will be placed under a performance contract with the MOPH (internal contracting; part of the PBF approach). The DEP will work in close collaboration with the financial management and coordination unit and the procurement unit (CAG – “cellule d’appui et de gestion” and CGPMP ‘cellule de Gestion des Passation des Marches Publics”) as well as with the Technical PBF Unit. The DEP will be responsible overall for the management and coordination of the PDSS while the CAG and CGPMP will be responsible for the financial and procurement management of the PDSS.

VI. Safeguard Policies (including public consultation)

Safeguard Policies Triggered by the Project	Yes	No
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

Comments (optional)

VII. Contact point

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