Public Disclosure Authorized

Public Disclosure Authorized

Document of
The World Bank

FOR OFFICIAL USE ONLY

Report No: PAD1088

INTERNATIONAL DEVELOPMENT ASSOCIATION

PROJECT APPRAISAL DOCUMENT

ON A

ON A PROPOSED CREDIT
IN THE AMOUNT OF SDR 88.0 MILLION
(US$130.0 MILLION EQUIVALENT)

AND A PROPOSED GRANT
IN THE AMOUNT OF SDR 60.9 MILLION
(US$90.0 MILLION EQUIVALENT)

AND

A PROPOSED GRANT FROM THE MULTI DONOR TRUST FUND FOR HEALTH RESULTS INNOVATION
IN THE AMOUNT OF US$6.5 MILLION EQUIVALENT

TO THE

DEMOCRATIC REPUBLIC OF CONGO

FOR A

HEALTH SYSTEM STRENGTHENING FOR BETTER MATERNAL AND CHILD HEALTH RESULTS

November 25, 2014

Health, Nutrition, and Population Global Practice (GHNDR)
Africa Region

This document has a restricted distribution and may be used by recipients only in the performance of their official duties. Its contents may not otherwise be disclosed without World Bank authorization.

CURRENCY EQUIVALENTS

(Exchange Rate Effective October 31st, 2014)

Currency Unit	=	Congolese Franc
CDF 920	=	US$1
US$1	=	SDR 0.67643895

ABBREVIATIONS AND ACRONYMS

ACTs	Artemisinin-based Combination Therapies
ACV	*Agence de Contractualisation et Vérification* (Performance Purchasing Agency)
AECID	Spanish Agency for International Development Cooperation
ACVE	*Agence de Contre-Vérification Externe* (External Evaluation Agency)
AG	Auditor General
ANC	Antenatal Care
ART	Anti-Retro-Viral Treatment
AS	Audit Statement
ASLO	*Association Locale* (Local Organization)
ARI	Acute Respiratory Infections
AWP	Annual Work Plan
AWPB	Annual Work Plans and Budgets
BCC	Behavior Change Communication
BEmONC	Basic Emergency Obstetric and Neonatal Care
BoD	Burden of Disease
CAG	*Cellule d'Appui et de Gestion* (Coordination and Management Unit)
CAGF	*Cellule d'Appui et de Gestion Financière* (Financial Management and Coordination Unit)
CBA	Cost Benefit Analysis
CBO	Community Based Organization
CCT	Conditional Cash Transfer
CD	Communicable Diseases
CDMT	Medium Term Expenditure Framework
CDR	*Centrale de Distribution Régionale* (Regional Distribution Store)
CFAA	Country Financial Accountability Assessment
CFAF	*Franc de la Communauté Financière Africaine* (African Financial Community Franc)
CGPMP	*Cellule de Gestion des Projets et Marchés Publics* (Procurement Management Unit)
CHW	Community Health Worker
CIFA	Country Integrated Fiduciary Assessment
CPIP	Country Procurement Issue Paper
CNLS	*Conseil National de Lutte contre le SIDA* (National Council Against AIDS
CNCS	*Comité national de coordination et suivi* (National Committee for Coordination and Monitoring)
CNTS	*Centre National de Transfusion de Sang* (National Blood Transfusion Center)

CODIR	*Comité de Direction* (Regional hospital community co-management committee)
COGE	Community Health Committee
COGES	*Comité de Gestion pour l`Hopital de Base* (First Referral Hospital Community Co-management Committee)
Cordaid	Catholic Organization for Relief and Development Aid
CPIA	Country Policy and Institutional Assessment
CPIP	Country Procurement Issue Paper
CPA	Complementary Package of Activities
CPPSS	Financing and Contracting Committee
CPR	*Cadre de Politique de Réinstallation* (Relocation Framework Policy)
CPS	Country Program Strategy
CQ	Consultant Qualification
CS&E	*Comité de Suivi et Evaluation* (Monitoring and Evaluation Committee)
CTB	Belgian Cooperation
CT-FBR	*Cellule Technique -Performance Based Financing* (Technical PBF Unit)
DA	Designated Account
DAF	Directorate of Administration and Finance
DALYs	Disability Adjusted Life Years
DC	Direct Contracting
DEP	*Département d'Etude et de Plannification* (Directorate of Planning)
DFATD	Department of Foreign Affairs, Trade, and Development (Canada)
DFID	UK Department for International Development
DGAF	Director General for Administration and Finance
DGAP	Director General for Administration and Planning
DGE	*Direction Générale de l'Environnement* (Director General for the Environnent)
DGS	*Directeur Général de la Santé* (Director General of Health)
DHIS	District Health Information System
DHS	Demographic and Health Survey
DL	Disbursement Letter
DP	Development Partners
DPHLM	Directorate of Pharmacies, Laboratories and Medicines
DPI	*Direction du Plan et d'Investissement* (Department of Planning and Investment)
DPS	*Direction Provincial de Santé* (Provincial Health Directorates)
DPT	Diptheria, Pertussis, Tetanus
DRC	Democratic Republic of Congo
DRE	*Direction Régionale de l'Environnement* (Regional Directorate for the Environment)
DRH	Directorate of Human Resources
ECZS	*Equipe Cadre de Zone de Santé* (Health Zone team)
ECOM	*Enquête Congolaise auprès des Ménages* (Living Standards Measurement Survey)
EVD	Ebola Virus Disease
EmONC	Emergency Obstetric and Neonatal Care
EOI	Expression of Interest
EPI	Expanded Program of Immunization
ESMF	Environmental and Social Management Framework
EU	European Union

EUP	*Etablissement d'Utilité Publique* (Performance Purchasing Agencies)
EVD	Ebola Virus Disease
FB	Fixed Budget
FHD	Family Health Directorate
FM	Financial Management
FMA	Financial Management Assessment
FP	Family Planning
FTP	Financial and Technical Partners
GARPR	Global AIDS Response Progress Reporting
GAVI	Global Alliance for Vaccines and Immunization
GDP	Gross Domestic Product
GFAMT	Global Fund for AIDS, Malaria and Tuberculosis
GIBS	*Group Intra-Bailleurs de Santé* (Technical and Financial Partners for Health)
GPN	General Procurement Notice
GOC	Government of Congo
GRO	Grassroots Organizations
HAT	Human African Trypanosomiasis
HAU	Health Administration Unit
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HCW	Health Care Waste
HCWMP	Health Care Waste Management Plan
HGR	General Reference Hospital
HIV/AIDS	Human Immunodeficiency Virus-Acquired Immunodeficiency Syndrome
HIPC	Heavily Indebted Poor Countries Initiative
HMIS	Health Management Information System
HNP	Health, Nutrition & Population
HR	*Hôpital de Référence* (Referral Hospital)
HRH	Human Resources for Health
HRIS	Human Resource Information System
HRITF	Health Results Innovation Trust Fund
HSS	Health Sector Services
IA	Internal Audit
IC	Individual Consultants
ICB	International Competitive Bidding
ICR	Implementation Completion Report
ICT	Information Communication Technology
IDA	International Development Association
IE	Impact Evaluation
IEC	Information Education, Communication
IFC	International Finance Corporation
IFI	Internationally Funded Projects
IFR	Interim Financial Report
IGA	Income Generating Activities
IGF	*Inspection Générale des Finances* (General Fiduciary Regulation)
IMCI	Integrated Management of Childhood Illnesses

IMF	International Monetary Fund
IMR	Infant Mortality Rate
IP	Indigenous Peoples
IPP	Indigenous People's Plan
IPF	Investment Project Financing
IPPF	Indigenous Peoples Planning Framework
IPT	Intermittent Preventive Treatment
ISA	International Standards on Auditing
ISDR	Integrated Disease Surveillance and Response
ISN	Interim Strategy Note
ISR	Implementation Status and Results Report
ITN	Insecticide Treated Bed Net
JAR	Joint Annual Review
JICA	Japanese International Cooperation Agency
KAP	Knowledge Attitude and Practices
LB	Live Births
LBW	Low Birth Weight
LCS	Least-Cost Selection
LIB	Limited International Bidding
LLINs	Long-Lasting Insecticidal Nets
M&E	Monitoring and Evaluation
MAP	Multi-Country HIV/AIDS Program
MCH	Maternal and Child Health
MDGs	Millennium Development Goals
MEB	Marginal Excess Burden
MFEB	Ministry of Finance, Economy and Budget
MICS	Multiple Indicator Cluster Survey
MOPH	Ministry of Public Health
MIS	Malaria Indicator Survey
MOF	Ministry of Finance
MOU	Memorandum of Understanding
MSF	*Médecins Sans Frontières* (Doctors Without Borders)
MPA	Minimum Package of Activities
MTEF	Medium-Term Expenditure Framework
MTR	Mid Term Review
NC	*Niveau Central* (Central level)
NCB	National Competitive Bidding
NGO	Non-Governmental Organizations
NHA	National Health Accounts
NHDP	National Health Development Plan
NHP	National Health Policy
NO	Non Objection
NPV	Net Present Value
NRM	National Road Map
ONG	Non-Governmental Organization
OP/BF	Operational Policy/Bank Financing

OR	Operations Research
ORAF	Operational Risk Assessment Framework
PARSS	*Projet d'Appui et de Réhabilitation du Sytème de Santé* (Health System Development and Rehabilitation)
PBF	Performance Based Financing
PCA	Complementary Package of Activities
PDO	Project Development Objective
PDSS	*Projet d'Appui des Services de Santé (*Heath System Strengthening Project)
PEFA	Public Expenditure and Financial Accountability
PER	Public Expenditure Review
PFE	*Point Focal pour l'Environnement* (Focal Point for Environment)
PFM	Procurement and Financial Management
PFM	Public Financial Management
PHC	Primary Health Care
PIM	Program Implementation Manual
PIU	Project Implementation Unit
PLVSS	*Projet de Lutte contre le VIH/SIDA et de Santé* (HIV/AIDS Control and Health Project
PMA	*Paquet Minimum d'Activités* (Minimum Health Packet)
PMAE	*Paquet Minimum d'Activités Elargies* (Minimum Package for Enlarged Activities
PMTCT	Preventing Mother-to-child Transmission (HIV)
PNDS	*Programme National de Développement de la Santé* (National Health Development Plan)
PNLP	*Programme National de Lutte contre le Paludisme* (National Malaria Control Program)
PNM	Post Neonatal Mortality
POW	Program Of Work
PPE	Personal Protective Equipment
PPP	Public Private Partnership
PPR	Post Procurement Review
PREM	Poverty Reduction and Economic Management Network
PRSP	Poverty Reduction Strategy Paper
QBS	Quality Based Selection
QCBS	Quality and Cost-based Selection
QoC	Quality of Care
RBF	Results Based Financing
RC	*Relais Communautaire* (Community Health Worker)
RMNCH	Reproductive and Maternal Newborn and Child Health
RH	Reproductive Health
RR	Rate of Return
SANRU	*Santé Rurale* (Rural Health - NGO)
SBA	Skilled Birth Attendant
SBD	Standard Bidding Document
SDC	Swiss Agency for Development and Cooperation
SDI	Service Delivery Indicators
SEP	*Secretaire Exécutif Permanent* (Executive Permanent Secretary)

SGS	*Secretaire Général de la Santé* (General Secretary of Health)
SOE	Statement of Expenditures
SNAME	*Système National d'Approvisionnement en Médicaments* (National Health System of Drug Supply)
SNIS	*Système National d'Information Sanitaire* (Health Management Information System)
SP	Sulfadoxine-pyrimethamine
SPN	Specific Procurement Notice
SRSS	Health System Strengthening Strategy
SSS	Single Source Selection
STI	Sexually Transmitted Infections
SIDA	Swedish International Development Cooperation Agency
SDC	Swiss Agency for Development and Cooperation
TB	Tuberculosis
TF	Trust Fund
TFR	Total Fertility Rate
TOR	Terms of Reference
TSS	Transitional Support Strategy
TT	Tetanus Toxoid
UN	United Nations
UHC	Universal Health Coverage
UNDB	United Nations Development Business
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children's Fund
VCT	Voluntary Counseling and Testing (HIV)
WA	Withdrawal Application
WB	World Bank
WHO	World Health Organization
XAF	Central African Franc
YLL	Years of Life Lost

Regional Vice President:	Makhtar Diop
Acting Country Director:	Jan Walliser
Senior Global Practice Director:	Timothy G. Evans
Practice Manager:	Trina S. Haque
Task Team Leader:	Hadia Nazem Samaha

DEMOCRATIC REPUBLIC OF CONGO
Health System Strengthening For Better Maternal and Child Health Results Project

TABLE OF CONTENTS

PAD DATA SHEET

Congo, Democratic Republic of

Health System Strengthening for Better Maternal and Child Health Results Project (PDSS) (P147555)

PROJECT APPRAISAL DOCUMENT

AFRICA

Report No.: PAD1088

.			
Basic Information			
Project ID P147555	EA Category B - Partial Assessment		Team Leader Hadia Nazem Samaha
Lending Instrument Investment Project Financing	Fragile and/or Capacity Constraints [X] Financial Intermediaries [ ] Series of Projects [ ]		
Project Implementation Start Date 18-Dec-2014	Project Implementation End Date 31-Dec-2019		
Expected Effectiveness Date 01-Jun-2015	Expected Closing Date 31-Dec-2019		
Joint IFC No			
Practice Manager/Manager Trina S. Haque	Senior Global Practice Director Timothy Grant Evans	Country Director Jan Walliser	Regional Vice President Makhtar Diop

.			
Borrower: Ministry Of Finances			
Responsible Agency: Democratic Republic of Congo			
Contact:	Dr. Felix Kabange	Title:	Minister of Health
Telephone No.:	243818000006	Email:	felixkabange@yahoo.fr

.					
Project Financing Data(in USD Million)					
[ ]	Loan	[X]	IDA Grant	[ ]	Guarantee

[X] Credit	[X] Grant	[ ] Other	
Total Project Cost:	226.50	Total Bank Financing:	220.00
Financing Gap:	0.00		

.

Financing Source	Amount
BORROWER/RECIPIENT	0.00
International Development Association (IDA)	130.00
IDA Grant	90.00
Health Results-based Financing	6.50
Total	226.50

.

Expected Disbursements (in USD Million)

Fiscal Year	2015	2016	2017	2018	2019	2020
Annual	8.00	52.00	60.00	60.00	35.00	11.50
Cumulative	8.00	60.00	120.00	180.00	215.00	226.50

.

Institutional Data

Practice Area / Cross Cutting Solution Area

Health, Nutrition & Population

Cross Cutting Areas

[ ] Climate Change

[ ] Fragile, Conflict & Violence

[X] Gender

[ ] Jobs

[X] Public Private Partnership

Sectors / Climate Change

Sector (Maximum 5 and total % must equal 100)

Major Sector	Sector	%	Adaptation Co-benefits %	Mitigation Co-benefits %
Health and other social services	Health	100		
Total		100		

☑ I certify that there is no Adaptation and Mitigation Climate Change Co-benefits information applicable to this project.

.

Themes

Theme (Maximum 5 and total % must equal 100)

Major theme	Theme	%
Human development	Population and reproductive health	30
Human development	Child health	25
Human development	Health system performance	25
Human development	Nutrition and food security	10
Human development	Injuries and non-communicable diseases	10
Total		100

.

Proposed Development Objective(s)

The proposed project development objective is to improve utilization and quality of maternal and child health services in targeted areas within the Recipient's Territory.

.

Components

Component Name	**Cost (USD Millions)**
Component 1: Utilization and Quality of Health Services at Health Facilities through Performance Based Financing.	120.00
Component 2: Improve Governance, Purchasing and Coaching and Strengthen Health Administration Directorates and Services through Performance Based Financing.	65.20
Component 3: Strengthen Health System Performance Financing, Health Policy, and Surveillance Capacities.	41.30

.

Compliance

Policy

Does the project depart from the CAS in content or in other significant respects?	Yes [ ]	No [X]

.

Does the project require any waivers of Bank policies?	Yes [ ]	No [X]
Have these been approved by Bank management?	Yes [ ]	No [ ]
Is approval for any policy waiver sought from the Board?	Yes [ ]	No [ ]
Does the project meet the Regional criteria for readiness for implementation?	Yes [X]	No [ ]

.

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

.

Legal Covenants

Name	Recurrent	Due Date	Frequency
Adoption of the Project Implementation Manual and the PBF Manual		01-Sep-2015	

Description of Covenant

Section V.2. On or before three month after the Effective Date, the Recipient shall adopt the Project Implementation Manual, the PBF Manual and the revised Safeguard Documents all in form and substance satisfactory to the Association

Name	Recurrent	Due Date	Frequency
Recruitment of the External Verification Agency (ACVE)		01-Dec-2015	

Description of Covenant

Schedule 2, Section I.D.2. The Recipient shall hire under terms of reference satisfactory to the Association as further detailed in the PBF Manual and no later than six months after the Effective Date in accordance with the provisions of Section III of the Financing Agreement, as needed, ACVE to conduct independent annual verifications of: (a) the Package of Priority Health Services delivered under Part 1 of the Project; and (b) the performance of implementing agencies (including Health Administration Directorates and Services) under the Performance Frameworks of Part 2 of the Project.

Name	Recurrent	Due Date	Frequency
Financial Management		01-Sep-2015	

Description of Covenant

Section V.3. No later than three months after effectiveness: (a) recruit a procurement specialist, a financial specialist and an accountant to support the management of the Project as well as the

independent auditor for the Project; all with terms of reference, qualification and experience satisfactory to the Association; and (b) install a financial management computerized software for the Project

.

Conditions

Source Of Fund	Name	Type
IDA	The Ebola preparedness plan	Disbursement

Description of Condition

Section IV.B.1.C. Notwithstanding the provisions of Part A of Section IV of the Financing Agreement, no withdrawal shall be made for payments made under Category (3), until and unless the Recipient's Ebola preparedness plan has been adopted by the Recipient in form and substance satisfactory to the Association.

Source Of Fund	Name	Type
IDA	HRITF Grant Agreement Effectiveness	Effectiveness

Description of Condition

Schedule I.V.5.01. The Additional Conditions of Effectiveness consist of the following, namely that the HRITF Grant Agreement has been executed and delivered and all conditions precedent to its effectiveness or to the right of the Recipient to make withdrawals under it (other than the effectiveness of this Agreement) have been fulfilled.

Team Composition

Bank Staff

Name	Title	Specialization	Unit
Helene Barroy	Economist	Economist	GHNDR
Leonardo Cubillos-Turriago	Senior Health Specialist	Senior Health Specialist	GHNDR
Faly Diallo	Financial Officer	Financial Officer	CTRLA
Saidou Diop	Sr Financial Management Specialist	Sr Financial Management Specialist	GGODR
Angelo Donou	Financial Management Specialist	Financial Management Specialist	GGODR
Gyorgy Bela Fritsche	Senior Health Specialist	Senior Health Specialist	GHNDR
Abdoulaye Gadiere	E T Consultant	E T Consultant	GENDR
Sariette Jene M. C. Jippe	Program Assistant	Program Assistant	GHNDR
Olga Kadima	Operations Analyst	Operations Analyst	AFCC2
Luc Laviolette	Sr Nutrition Spec.	Sr Nutrition Spec.	GHNDR
Antoine V. Lema	Senior Social Development	Senior Social	GSURR

	Specialist	Development Specialist	
Philippe Mahele Liwoke	Senior Procurement Specialist	Senior Procurement Specialist	GGODR
Eric Christian Thibaut Mallard	Senior Health Specialist	Senior Health Specialist	GHNDR
Tazeem Mawji	Consultant	Consultant	GHNDR
Isabella Micali Drossos	Senior Counsel	Senior Counsel	LEGAM
Michel Muvudi	E T Consultant	Consultant	GHNDR
Jeannine Kashosi Nkakala	Team Assistant	Team Assistant	AFCC2
Hadia Nazem Samaha	Senior Operations Officer	Task Team Leader	GHNDR
Gil Shapira	Economist	Economist	DECHD
Lanssina Traore	Procurement Specialist	Procurement Specialist	GGODR

Non Bank Staff

Name	Title	City

.

Locations

Country	First Administrative Division	Location	Planned	Actual	Comments

I. STRATEGIC CONTEXT

A. Country Context

1. **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 annually from 2010-2012. It reached 8.5 percent in 2013 and is projected to reach more than 10 percent in 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 was under 15 in 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.

2. **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 jeopardized by its lagging human development indicators. The recent economic growth has not translated into consistent improvements in human development outcomes; DRC is currently tied with Niger for the lowest position (187/187) on the 2013 Human Development Index (HDI). Sixty-three percent of the population is estimated to be poor, living on less than $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 plan for the future. Poverty is also 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 percent, retention, the achievement of learning outcomes remains challenging.

3. **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 destruction of the social fabric of the society 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 debilitated 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.

4. **In order to generate further economic growth in DRC, a strong focus on human development, especially in the health sector, 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.

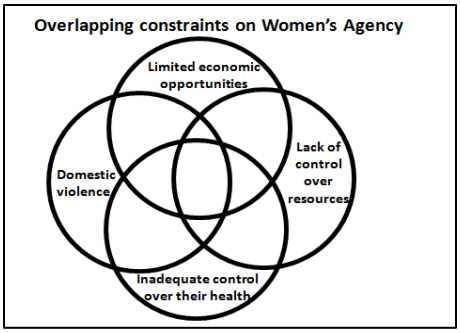
B. Sectoral and Institutional Context

Poor progress on health outcomes

5. **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. In recent years, DRC has made considerable progress in reducing the under-five mortality rate from 148 per 1000 live births in 2007 to 104 in 2013 (DHS). However, infant and maternal mortality rates remain high and the average 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[1]). 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 (1-2-3 poverty survey), 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.

6. **Gender inequalities are also prevalent; DRC ranks 148 out of 157 countries on the Gender-related Development Index.** However, greater women empowerment will not necessarily translate into greater reproductive choice if women do not have access to needed reproductive health services. It is therefore important to ensure that health systems provide a basic package of Reproductive Health (RH) services, including family planning (FP), which is one of the key priorities of the Ministry of Public Health (MOPH) as reflected in the new National Health Development Plan (NHDP) for 2011-2015. In addition, the second Poverty Reduction Strategy Paper (PRSP) identifies "population policy and family planning" as one of the Government's priorities for the next five years; the Government of Congo considers rapid population growth to be one of the four key "threats" affecting its development prospects.

7. W**omen are among the most vulnerable groups in the Great Lakes Region.** They face multiple and mutually reinforcing constraints including high levels of violence, inadequate control over their health, limited economic opportunities, and lack of control over resources.[2] The severity of the constraints varies widely across countries. For example, in DRC 97 percent of



[1] DHS 2013-2014 has been released in October 2014 and data in the PAD relies on the official DHS-2013-2014 data.
[2] The World Bank Gender Group has generated estimates of different constraints on women's agency that can arise at the same time, using Venn diagrams to demonstrate these overlapping constraints. Using questions from the latest round of Demographic and Health Surveys (e.g. experience with sexual or physical violence; lack of control over household decisions; ability to refuse sex; and current employment status) composite scores have been made for each source of vulnerability for several countries, including for DRC.

women face one or more of these constraints; 42 percent are affected by both domestic violence and inadequate control over their health and 25 percent by three key constraints (domestic violence, lack of control over their health, and inadequate control over resources).

8. **DRC is not on track to achieve any of its 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[3] (per 100,000 live births). DHS-2014 data compared with the 2010 MICS shows a net decrease to 104 (per 1000) from 148 (per 1000) [4] for the under-5 mortality rate; infant mortality rate has also decreased from 92 (per 1000) to 58 (per 1000). Despite this major progress, decreasing maternal, infant, and child mortality rates will require greater improvements in both the quantity and quality of reproductive and child health services; specifically 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 two-thirds of births (80 percent) take place in a health facility, the high rate of maternal mortality is directly correlated to the low levels of quality of care, inadequate preparedness for obstetric emergencies and limited availability of effective referral systems. Additionally, other factors (e.g. poor access to facilities, socio-cultural impediments, and financial barriers) also adversely affect the high mortality rate.

9. **The nutritional status of women and children in DRC presents an alarming situation that has severe consequences for current 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 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-2014), 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, at both the household and community levels.

10. **Neglected tropical diseases (NTDs) contribute significantly to Congo's burden of disease**. Two conditions in DRC (Leprosy and Human African Trypanosomiasis (HAT)) are estimated to have the highest prevalence of any NTDs globally. Seventy-five 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 prevalent, and likely to be some of the underlying factors contributing to the burden of disease linked to malnutrition in DRC. The HAT program is in transition, with novel changes such as a new rapid test and a new oral treatment to be launched by the end of 2015. The country's NTD program collaborates with the Gates Foundation which is financing the fight against HAT.

11. In recent months, the Ebola outbreaks in Liberia, Guinea and Sierra Leone have been of great concern; DRC is addressing its own Ebola epidemic in the Province of Equateur which has

[3] DHS 2013-2014
[4] MICS 2010

resulted in 66 confirmed cases and 49 deaths. With a major outbreak in West Africa and the fear of its spread to major cities such as Kinshasa and Lubumbashi, the Government of DRC has developed a preparedness plan to enable them to be better equipped in case such a spread occurs in DRC. With Ebola, there is a clear link between an effective response to an Ebola virus disease (EVD) outbreak and an effective and well-functioning health system. Faced with this potential crisis, the Government of DRC has asked the international community to assist in efforts to increase the country's overall level of preparedness.

12. **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 mother to child transmission care (PMTCT). It is also among the 27 countries with 85 percent of the global burden of disease for multi-drug resistant tuberculosis (MDR-TB) (WHO 2013). TB is the leading opportunistic infection for HIV/AIDS in DRC (Report of NACP Survey 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 2013). In 2012, the incidence of TB was 327 new cases per 100,000 inhabitants.

13. **The epidemic of HIV infection in the DRC is generalized with a prevalence of 1.2 percent in the general population (Preliminary Report DHS-DRC II, 2013-2014).** The prevalence of HIV infection was 3.5 percent (sero monitoring 2011) among pregnant women attending Pre-Natal Consultations (PNC). DRC ranks among the countries with a high-burden of TB/HIV co-infection with an estimated prevalence of 16% of TB patients infected with HIV, and an incidence of 25 per 100,000 inhabitants (TB WHO Global report 2013). In 2013, the World Health Organization (WHO) estimated 42,300 deaths from TB, thus a mortality rate of 63.7 per 100,000 inhabitants. According to the Spectrum 2013, the HIV-related mortality has decreased from 33,000 in 2008 to 30,000 in 2013. This reduction is likely to be due to the increase in access to antiretroviral therapy (ART) (24,645 in 2008 vs. 79,978 in 2013) (Report GARPR 2014).

Health system challenges

14. **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, the Government spends only approximately US$1 per capita/per year (draft World Bank Public Expenditure Review, 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 compared to 2007 levels ($1.5 per capita). Government health expenditures (from domestic resources) oscillated around 4 percent of the budget between 2006 and 2010. Based on the latest National Health Accounts data (NHA-2010), total health expenditures per person/per annum 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. The majority of health expenditures are financed by out-of-pocket spending by households (37 percent) and financial and technical partners (FTPs) (47 percent).

15. **Since 2010, despite a rapidly growing economy, the country has struggled to mobilize additional domestic resources for health.** The DRC exhibits strong growth rates due to the growth of the mining sector. The growth had reached 7.4 percent on average in 2010-2013 with a peak of 8.5 percent in 2013. However, the growth in the mining sector and in natural resources does not translate into an increased mobilization of revenues for the Government (13% of GDP in 2013). The revenue shortfall does not provide the country the means to increase its investments in human development, the social sectors and in particular in the health sector. It is estimated that the DRC has the potential for increasing its revenues (to 29% of GDP), if the macro-economic stability (including a controlled inflation) is maintained, and for increasing its fiscal space for health (up to 3.5 % of GDP).

16. **User fees in Government health facilities are relatively high and are comparable to the private sector; in part this is due to limited Government subsidies to the health sector.** This means that health facility budgets are insufficient to cover the actual costs of care. The Government has adopted a cost-recovery policy for medicines in its health facilities, except for a few selected generic medicines, which the Government distributes for free to treat malaria and other illnesses. In DRC user fees are collected for curative care in Government health facilities and they are also applied to essential preventive services such as growth monitoring for children under five, institutional deliveries and antenatal and post-natal care. Field observations in various provinces document that financing of health activities at the frontline occur mostly in kind, so that virtually all health workers' income is from out-of-pocket payments. The plethora of health workers in facilities compounds this problem and leads to a vicious circle of increasing costs for services, leading to even higher financial barriers to access services.

17. **DRC has a strong dependency on financial and technical partners not only to finance the health sector and deliver health services but also to pay the wages of health staff.** In 2011, financing from development partners represented 47 percent of the total health expenditure in DRC. Much of these funds supported the service delivery pillar through financing at the health zone level for the basic package of health services (including related medicines, rehabilitation, training, etc.). Much of the resources for the basic package is provided by financial and technical partners. This financing has been mostly in kind, with some funds being used to pay 'bonuses' to a select cadre of health workers. The main partners financing these interventions include Canadian Department of Foreign Affairs, Trade and Development (DFATD), 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 Agency for International Development Cooperation (AECID), Swedish International Development Cooperation Agency (SIDA), Swiss Agency for Development and Cooperation, (SDC), 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.

18. **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 poor performance of health workers (absenteeism, clinical quality of care, interpersonal skills), (ii) health facilities have insufficient financial resources to ensure the availability of medicines and medical supplies; (iii) the range of services available at health facilities is limited; and (iv) the inconvenience 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 of services, and financial barriers. Uptake of preventive services is reasonable; for example, 70 percent of households have 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).

19. **A plethora of health workforce exists in DRC, overstaffing of health facilities is common in both rural and urban areas.** Adding to this problem is the fact that 70 percent of the health workforce does not receive a salary. To cover the cost of salaries and offset the insufficient Government allocation, 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 been insufficient to improve results. Important reforms in the health workforce in DRC are required in order to improve the system's efficiency. A critical aspect of this reform will be to reduce the current workforce numbers to match the needs of the system; additionally, the reform must also focus on addressing the lack of worker motivation while enhancing skills.

20. **Availability of medicines at an affordable cost varies across the health facilities in DRC.** Average availability of essential medicines is estimated around 30% but is highly uneven from one province to another and from one therapeutic class to another[5]. A National Essential Medicines Supply System (SNAME) centralizes the purchasing but decentralizes the distribution at the provincial level through the Central Regional Distribution (CDR) units. The country currently has 19 CDRs which store and distribute medicines at the intermediate level. Despite this design, a parallel subsystem for supplying medicines is in place, which poses many problems of coordination, harmonization, quantification, and inability to improve the country's logistics capabilities. This has resulted in: (i) stock-outs in some health zones and over stocking in others causing expiry of medicines and (ii) inefficient transport of medicines and supplies for various subsystems to the same health zones thus increasing logistics costs.

21. **Given the poor performance of the public sector's drug distribution system, health facilities procure medicines from various sources including private sector distributers**. The private pharmaceutical market is not well regulated; the price of medicines on the market is relatively low but in turn very little is known about their quality. Some surveys suggest that there are a very high percentage of substandard or counterfeit medicines in the private market. The lack of motivation of the health facility to use good quality affordable medicines is offset by their necessity to earn virtually their entire salary through out-of-pocket payments. This in turn leads to polypharmacy and irrational use of antibiotics. The WB project on Human Development Systems Strengthening (P145965) will help strengthen the supply chain in DRC along with other

[5] SARA 2012

partners such as USAID, EU, UNICEF, the Melinda and Bill Gates Foundation, and GAVI, all of whom are heavily investing in this area.

22. **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 and an escalating population growth with a fertility rate of 6.6 (DHS-2014) which has increased from 6.3 since 2010. The population is expected to double by 2030, and the country will have to tackle an epidemiological transition (moving more towards non-communicable disease while still having to address a substantial burden of communicable diseases). In order to reap the benefits of the demographic dividend, it is crucial that DRC lowers its fertility rate. Currently, the unmet need for family planning is estimated at 23 percent (DHS-2014), this has increased since the 2007-DHS.

23. **Currently, the country's health system is ill equipped to meet the challenges identified; support of the reforms undertaken by the Government will be critical in ensuring better performance of the health system.** While 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.

24. **Performance-Based Financing (PBF) is a supply-side Results-Based Financing (RBF) approach which has recently been piloted in DRC to address the above mentioned health sector challenges**[6]. PBF is a health reform mechanism which can strengthen the performance of the health sector as it tackles all the crucial aspects of a health system such as 1) financing; 2) payment; 3) regulation; 4) organization/decentralization; and 5) patient satisfaction, to improve the performance of the system while focusing on equity, quality, efficiency, and access. PBF finances results, based on quantity and quality of services produced by health facilities or Health Directorates and Services at all levels of the system. PBF financing 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 EU, Catholic Organization for Relief and Development Aid (Cordaid), USAID, Memisa, and the World Bank.

C. Higher Level Objectives to which the Project Contributes

25. **The proposed project is fully aligned with the World Bank Group's twin objectives of reducing poverty and promoting shared prosperity, with IDA 17 commitments for Fragile and Conflict-Affected States, and with the Africa Regional Strategy which focuses on strengthening governance and public sector capacity.** Furthermore, the national consultations held in February and April 2014 re-affirmed that human development is a priority sector for the Government. The proposed project is consistent with the Government's Poverty Reduction Strategy Paper (PRSP II). The 2012 Government Development Program defines a roadmap of the targets outlined in the PRSP II and aims to, *inter alia*, improve human development.

[6] Musgrove, P. (2011). Financial and Other Rewards For Good Performance or Results: A Guided Tour of Concepts and Terms and a Short Glossary. Washington DC.

26. **The project is an integral part of the World Bank Country Assistance Strategy (CAS) for the period FY13-FY16 (dated May 2013)**. One of the higher level objectives of the CAS, to which this project will contribute, is to improve social service delivery to raise human development indicators. The CAS has identified four strategic objectives including: improved access to health services in targeted areas; this project contributes directly to the third strategic objective of the CAS. This project was specifically mentioned in the CAS.

27. **The higher level objective to which this project would contribute is to increase efficiency and effectiveness in the health system in order to improve human development outcomes.** Improvements in efficiency and effectiveness, in turn, should boost confidence in these systems and may lead to an increase in overall investment in the social sectors.

28. **In addition to linking to the human development operations in the CAS, the project will complement other IDA-financed projects**. These projects include: (i) the Human Development Systems Strengthening Technical Assistance Project that will aim to strengthen the pharmaceutical and HMIS systems, (ii) The Women's Empowerment Project in the Kivus which will aim to strengthen the reproductive maternal and child health system in 13 health zones, and (iii) the Public Financial Management and Accountability Project.

29. **The Government and the Bank considered the option of sectoral budget support operation (or a P4R)**. However, the Bank's assessment is that the MOPH is not yet ready for such streamlined support. The Project will strive to strengthen the MOPH capacities (especially regarding financial management, M&E and a culture of performance management and rewards) so that such an operation may become an option in the future.

II. PROJECT DEVELOPMENT OBJECTIVE

A. Proposed Development Objectives

30. **The project development objective is to improve utilization and quality of maternal and child health services in targeted areas within the Recipient's territory**. The primary focus of the project will be on maternal and child health (MCH) with improvements in health service delivery achieved though the scale-up and strengthening of PBF in the target areas. In addition to improving utilization and quality of MCH services, PBF will also address the above-mentioned health system challenges by improving the health financing and health policy capacities and by focusing on 1) human resources for health outcomes (motivation, distribution, etc.), 2) financial accessibility to health services, 3) availability of quality and affordable medicines; 4) community engagement, and 5) improvement of data availability.

B. Project Beneficiaries

31. **The project will be implemented in 140 health zones (HZ) reaching 17 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 (16 HZ). The direct beneficiaries include women and children under 5.

32. **The four provinces targeted have been selected based on several criteria.** These include: (i) poor health indicators, (ii) lack of access to health services and (iii) ability to align the project interventions with other key partners such as UNICEF, Global Fund, and GAVI. The underlying strategy for this project will be to support the reform process to finance an integrated package of services and strengthen the stewardship of the health system at a provincial level. By harmonizing and aligning the respective interventions of each of the partners, the project aims to serve all the health zones in 2 provinces to address the fragmentation of the health system (see Annex 2 for further description of partners' alignment).

C. PDO Level Results Indicators

33. The following key indicators will be used to track progress towards the PDOs:

1. Percentage of pregnant women having at least 3 antenatal care visits before delivery[7]
2. Percentage of children between 6 and 23 months receiving preventive nutritional services at least four times per year[8]
3. New curative consultations per capita per year
4. Percentage of children fully immunized[9]
5. Average score of the quality checklist at the health center level [10]

The number of direct project beneficiaries of which female (percentage) would also be part of the PDO level indicators covering both components 1-3.

III. PROJECT DESCRIPTION

A. Project Components Description

34. **The project will have three components**. Component 1: Improve Utilization and Quality of Health Services at Health Facilities through Performance-Based Financing; Component 2: Improve Governance, Purchasing and Coaching and Strengthen Health Administration Directorates and Services through Performance Based Financing; and Component 3: Strengthen Health System Performance Financing, Health Policy, and Surveillance Capacities.

35. **The IDA allocation for this project is US$220 million in addition to a grant of US$6.5 million from the Health Results Innovations Trust Fund (HRITF). Furthermore, an additional US$2.5 million HRITF grant will finance the impact evaluation**. The Impact

[7] It is difficult to provide 4 ANC visits since most women do not come to the health center in the 1st trimester due to many reasons including cultural norms, stigma and lack of awareness of their pregnancy. This figure will be provided as the sum of all ANC visits in one year, divided by three, divided by the target population of pregnant women.

[8] The package of preventive health services will be defined during the project preparation phase but will most likely include services such as growth monitoring and screening for malnutrition, deworming, etc.

[9] The project will also measure fully immunized children under 1 which is a more sensitive and complete measure of correct and timely application of all obligatory immunizations done prior to 11 months of age. This measure is also a proxy of the quality of the EPI program (follow-up on defaulters; quality and effectiveness of outreach and community based programs).

[10] The quality check list is a comprehensive quality assessment of the quality in a health facility, including more than a hundred of items related to the following aspects: hygiene, drug availability, clinical care, equipment availability, drug management, financial management, and laboratory. The checklist can be found on www://nphcda.thenewtechs.com.

Evaluation will be executed and managed by the World Bank. The proposed project will support the health system reform by introducing PBF to finance health facilities in selected health zones[11] to improve quantity and quality of health services and improve governance, transparency and accountability of the health system. The innovative features of this project include: (i) a large supply side financial incentive for household visits; this is a novel demand-generating PBF intervention to improve preventive and curative care as well as health seeking behavior. This will be in addition to the supply-side PBF approach that will include geographical equity adjustments and financing fee-exemptions for the poor and vulnerable;[12] (ii) a clear focus on nutrition[13], HIV/AIDS and neglected tropical diseases in addition to maternal and child health; and (iii) rigorous results monitoring through systematic use of grassroots organizations and third party counter-verification will be combined with rigorous sanctions in the case of fraud.

36. **This project will also be implemented in close collaboration with UNICEF, Global Fund, and GAVI in the targeted areas**. UNICEF will not only contribute to the purchase of quality health outputs, but will also introduce Family Kits [14](both at the household and health facility level) as well as introduce and strengthen their community based interventions in the project targeted areas. The financing of the "household visit" as part of the PBF package of services will strengthen the delivery and the monitoring of the Family Kit approach. Collaboration with UNICEF, which has 510 staff on the ground, will greatly benefit the project and strengthen field support. GAVI and the Global Fund will finance medicines (antimalarial; anti-TB; and HIV medicines, as well as vaccines) and they will finance part of the PBF package of services both at the health facility and health administration level. In addition, GAVI is investing approximately US$53 million to support the distribution of the medicines nationwide. Alignment is an important characteristic of this project (see Annex 2 for further details as to what each partner will contribute to in the 140 health zones).

Component 1: Improve Utilization and Quality of Health Services at Health Facilities through Performance-Based Financing. Total costs including contingencies US$120 million equivalent of which US$115 million from IDA and US$5 million from HRITF.

37. **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 North Kivu, Province Oriental and the two Kasai provinces since 2009. The model has shown to be an

[11] A health zone in DRC is equal to a health district in other countries. Currently, an administrative reform is ongoing which will lead to 26 provinces up from the current 11.
[12] The household visit as per protocol is a comprehensive community based intervention, which is further described in annex 6 'What is PBF'.
[13] 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 collective levels.
[14] This is a UNICEF initiative in support of the Government's "cadre d'accéleration des OMDs 4 et 5" (CAO 4&5) which will make available a kit with essential medicines at the health center and household level to address for instance safe delivery, preventive diseases etc.

effective and efficient model for successful PBF which strengthens national capacity for service delivery in even the most challenging contexts.

38. **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 Maternal Neonatal Child Health (MNCH) (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.

39. **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 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.

40. **At the request of the Government a project preparation advance (PPA) will be made available to finance the design of the project tools as well as the initial implementation activities.** 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 communication and education related to demand generation and other strategic communication related to the PBF program.

Component 2: Improve Governance, Purchasing and Coaching and Strengthen Health Administration Directorates and Services through Performance Based Financing. Total costs including contingencies US$65.2 million equivalent of which US$63.7 million from IDA and US$1.5 million from the HRITF.

41. **Contract management and verification: an innovative purchasing arrangement will be created covering each of the four provinces.** The project will aim at covering two provinces in their 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.

42. **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)*, 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 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/).

43. **The Planning Directorate (DEP - *Département d'Etude et de Plannification*) will coordinate and manage 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 system (HMIS) directorate 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.

44. **Local 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.

45. **In addition, to ensure greater community engagement 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 System Performance Financing, Health Policy, and Surveillance Capacities. Total costs including contingencies US$41.3 million equivalent from IDA.

46. **Component 3 is supporting components 1 and 2; it will focus on institutional capacity building and technical support in various dimensions of health system strengthening that will directly reinforce the investments of components 1 and 2**. This component will reinforce the reform process with a 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 reinforce 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 addressing the inequities across the system. The project aims at having a catalytic role on health system reform through the complementarities of the components.

47. **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 a clear direction on decentralization, the Universal Health Coverage (UHC) agenda, health financing reform and human resource management reform.

48. **Component 3 includes various 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 Directorate, the Health Management Information System (HMIS) Directorate, the Results Based Financing Technical Unit (CT-FBR), the Human Resources Directorate, the Resource Management Unit (*Cellule d'Appui et de Gestion Financière -CAGF)* as well as the procurement unit *(Cellule de Gestion en Passation de Marche Public, CGPMP),* and the monitoring and evaluation unit that is linked to the secretary general. Support will also be provided at the provincial level through the Provincial Health Directorate *(Division Provincial de la Santé –DPS).*

Sub-component 3.1: Support to Improve Health Financing Reform and System Decentralization - Total costs including contingencies US$4.4 million equivalent.

49. **This component will support the Government's reform process to strengthen the health system** with a focus on: (i) better planning and budgeting processes at national and decentralized levels through the use of Mid Term Expenditure Frameworks (MTEFs), (ii) policy dialogue and design of the national health financing and Universal Health Coverage (UHC) strategies, (iii) strengthening of the MOPH leadership on health sector investments with financing coming from national, provincial or external sources, and (iv) institutional support to key entities in the MOPH.

50. **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) commissioning studies to support the policy dialogue.

51. **Given the decentralization reforms underway, this sub-component will support the DPSs**, the decentralized entities in charge of the health system management and stewardship at the provincial level. The Government has recently increased the number of DPSs from 11 to 26. The managers of the 26 DPSs have been recruited through a competitive and transparent process. The reforms include alignment by all partners to fund these DPSs through a "*contrat unique*' (single contract), which consists of one contract with the provincial health directorate, one

performance framework (with some room for provincial adjustments) and one monitoring and evaluation mechanism. The DPS contracts will provide results-based funding to the DPSs by the various partners. This is an innovation in that this would be the first time all partners would provide funding through a common contract to the DPSs rather than paying performance bonuses to individuals, in an attempt to avoid the fragmented funding characteristic of the current system.[15]

52. **There is a lack of clarity as to how and when the Government is willing to initiate decentralization of health workforce management and payment**. When decentralization reform is initiated, the project will support the policy dialogue on human resources management reform at the national and provincial levels. This sub-component will also reinforce the quality of health service delivery by improving the quality of care provided by health workers.

53. **Potential quality of care activities (QoC) to be supported under this sub-component could include:** (i) development of a National QoC Improvement Strategy and operational plan ; (ii) dissemination of clinical practice guidelines and protocols; (iii) development and scaling up of quality assurance and continuous quality improvement modalities; and (iv) establishment and strengthening of professional associations (doctors, nurses, lab technicians) to self-regulate and improve QoC among its members. These QoC activities will complement the pay-for-quality approach of the PBF grants under Components 1 and 2 and will be conducted in collaboration with key partners.

54. **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 three-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) the strengthening of the existing capacity for research and analytical work, as well as strengthening of national institutions such as the statistic bureau, the planning department and other Government entities that will be developed and executed during the project period.

Sub-component 3.2: Health Sector Monitoring and Evaluation (M&E) Strengthening and Project Management- Total cost including contingencies US$16.9 million equivalent.

55. **The limited capacity of the DRC's health information system results in inadequate monitoring and evaluation (M&E) of health sector performance and consequently an inability to use data for decision making**. Since 2013, the Government with the support of

[15] The contracts are called 'contract unique', and they will be written between the Secretary General of the MOPH and each of the 26 new provincial health teams. Partners are aligning and coordinating with the MOPH who has a high degree of ownership towards this DPS contract as it allows them to do three things: (i) provide structural financing to DPSs of about US$0.4 per capita per year; (ii) implement the health administrative reforms that will create 15 new DPSs in addition to the existing 11 DPSs and (iii) will decrease significantly the vertical and horizontal fragmentation while strengthening the stewardship functions. The PBF portal http://www.fbrsanterdc.cd/ will benchmark publicly the DPS performance which will contribute to enhancing governance.

external partners decided to migrate its MS-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 same platform is used in other provinces by a WB financed PBF program in the Great Lakes region, by a USAID financed pay-for-performance program, the "Contrat Unique" financed by DPSs, and a Cordaid supported PBF program).

56. **This 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 for the development of an integrated e-health architecture. This sub-component is fully aligned with the HD Systems Strengthening Project (P145965) and will complement its work in this area.

57. **The combination of DHIS2, PBF IT systems and an open data layer is part of the effort for setting up data driven health systems supported by Performance Based Financing**. Verified and purchased results including the results for the health administrations 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 provide a powerful tool to employ results monitoring and encourage better governance. Introducing an ICT sub-component to the project to build the capacity of the MOPH will enable health facilities to systematically track funding and payments, record data, and use this data at both the facility and central levels to make informed management and policy decisions to improve the health system of the DRC. Performance contracting with the health administration at health zone and province levels will include interventions related to epidemic disease surveillance such as Ebola and other highly infectious diseases.

Sub-component 3.3: Ebola Preparedness Plan US$20 million equivalent.

58. **Based on the approaches developed in the emergency responses in Liberia, Sierra Leone and Guinea, this sub-component will provide essential equipment, supplies, drugs and vehicles**. The timely provision of these inputs is the first critical step in ensuring that the country is prepared for an EVD outbreak in DRC. Additional community level activities and a nationwide protocol will be carried out as described in Annex 10. It is expected that the equipment and supplies procured under the project will contribute to the overall level of emergency response preparedness in DRC, and be useful for communicable disease outbreaks other than EVD. Close collaboration with other UN agencies such as WHO, UNICEF and some international NGOs such as Médecins Sans Frontières (MSF) will take place. A Memorandum of Understanding with these organizations to procure some goods and services will be considered.

59. **This component will 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**. This sub-component will also finance the project communications strategy.

60. **An Impact Evaluation (IE) financed by HRITF will be embedded in the phased scaling-up of PBF:** The HRITF will fund an Impact Evaluation (US$2.5 million) which will naturally fit into the phased scaling-up of PBF. The Impact Evaluation (see Annex 8) will scientifically evaluate the impact of the PBF intervention on maternal and child health outcomes, quality of care and health service utilization. It will be composed of three main building blocks. The first will evaluate the total impact of the PBF model, the second will focus on quality of care issues and the third will estimate the effects of the community engagement mechanisms that are introduced within the PBF framework to promote demand for health services and preventative health behaviors at the household level.

B. Project Financing

61. The lending instrument will be an Investment Project Financing (IPF), financed under an IDA credit and grant of US$220 million equivalent, and an HRITF grant of US$6.5 million. GAVI, Global Fund, UNFPA and UNICEF's contributions to the output financing in the 140 health zones is estimated at approximately US$90 million. With time, it is expected that counterpart funding will be requested from the provincial budget at the decentralized level. For example, a province like Katanga which has the resources and a motivated Governor may be inclined to co-finance PBF. The Bank support is planned for four years (2015-2019).

The proposed budget breakdown for the project is the following:

Project Components	Project Cost (US$ million)	IDA Credit/Grant Financing	HRITF Financing
1. Improve Utilization and Quality of Health Services at Health Facilities Through Performance-Based Financing.	**120**	**115**	**5**
2. Improve Governance, Purchasing and Coaching and Strengthen Health Administration Directorates and Services through Performance Based Financing.	**65.2**	**63.7**	**1.5**
3. Strengthen Health System Performance Financing, Health Policy, and Surveillance Capacities.	**41.3**	**41.3**	**0**
-Subcomponent 3.1: *Support to Improve the Health Financing Reform and System Decentralization*	4.4	4.4	0
-Subcomponent 3.2: *Health Sector Monitoring and Evaluation (M&E) Strengthening and Project Management*	16.9	16.9	0
Sub-component 3.3 Ebola Preparedness Plan	20.0	20.0	0
Total Project Costs	**226.5**	**220**	**6.5**

Note: Disbursements for all project activities will be made against two categories 1) for PBF expenses; and 2) for good, consultant services, non-consultant services, operational costs, and training.

C. Lessons Learned and Reflected in the Project Design

62. **Lessons learned from the implementation of past projects such as PARSS are taken into account in this project**. Additionally, the project design has also incorporated the experiences of other countries (Cameroon, Burundi, Rwanda, and Nigeria) implementing similar projects.

63. **Effective leveraging of investments from other development partners can enhance results.** The project was developed in close coordination with the development partners that are investing in human development in the DRC. Current and expected investments by other development partners were chosen to complement the Performance-Based Financing approach.

64. **Including a communications strategy into the project design is an effective way to increase stakeholder involvement.** A communications strategy will be integrated into the project to raise the awareness of the community regarding the PBF strategy, to ensure visibility of the projects results, and to showcase and nurture champions who continue to enable reforms. The communications strategy is also expected to be a means to enhance the effectiveness of the systems inputs by creating a mechanism for demand-side governance actions and a process to facilitate coordination with partners.

65. **Strengthening management capacity, a focus on results and promoting innovation are essential to achieving results in low-capacity environments.** Given that DRC is a fragile state, the overall project management capacity is expected to be weak at the outset of the project. In other similar countries, the recruitment of dedicated staff at central and regional levels, the sub-contracting of specific technical and managerial functions to capable agencies and non-Governmental organizations (NGOs), and the focused investment on capacity-building over the initial years of project implementation has resulted in increased capacity at all levels. These lessons will be taken into account in the design of this project and will ensure that those responsible for planning, managing, and delivering services will be fully trained and equipped to perform their functions. While the previous PARSS project used a Project Implementation Unit (PIU), the proposed PDSS project will be using current Government structures for implementation. The DEP will coordinate and manage the project and will be supported by other units within MOPH. This arrangement will be complemented by technical support to be contracted out through the project to strengthen the Government capacity.

66. **The following are lessons learned from the current PARSS project; they focus on both the experience of PBF as well as the experience of project management outside the internal Government structure in DRC.** These lessons were derived from the design and implementation of both Bank and non-Bank operations in Africa. PBF leads to:

a) Improved alignment between resources and maternal and child health priorities by purchasing priority service delivery indicators at higher rates;
b) Improved quality of health services by purchasing services conditional on quality;
c) Creating incentives for health facility managers and health workers to expand the coverage of essential public health interventions and improve their quality by linking facility payments to service delivery and quality indicators, and offering health workers bonuses that are linked to facility performance;

d) Improved governance through better verification and oversight of performance by providing incentives for good performance, by involving the communities for verification of the health facility quality, by involving civil society in assessing health service delivery results and by publishing results on a public website;
e) Reduced financial barriers to improve access to quality health services by the poor; and
f) Enhanced functioning of the public health administration at all levels.

67. **The Haut Katanga PBF Pilot's impact evaluation has yielded key lessons for designing and implementing PBF**[16] which have been used in adjusting the design and implementation arrangements of the PBF strategy of the *PARSS* project targeting 84 health zones in 5 Provinces (Kinshasa, Equateur, Bandundu, Katanga and Maniema). Some of the lessons include:

(i) Increase output budgets for operations in similar contexts from $0.5 to approximately $3 per capita per year;
(ii) Introduce the quality checklist at the health center and hospital level and link performance payments to the quality checklist;
(iii) Introduce health facility management tools (business plans, indices tools, individual performance evaluations);
(iv) Introduce performance contracting for the health administration at all levels;
(v) Strengthen community verification and counter-verification;
(vi) Strengthen the ex-ante verification and coaching;
(vii) Introduce a comprehensive web-enabled data management system (data analysis, reporting, payment);
(viii) Introduce geographic equity bonuses (hardship allowances);
(ix) Introduce investment units to allow facilities to upgrade their quality earlier in the process; and
(x) Strengthen governance through the introduction of a decentralized PBF Steering Committees at the district level.

68. **The above lessons as well as the lessons (both positive and negative) from PBF projects funded by the European Union in Kasai, by CORDAID in South-Kivu**[17] and the growing experiential knowledge on PBF design from other PBF projects globally[18] will shape the thinking of the potential benefits of scaling up PBF in DRC for this new operation.

69. **The success of PBF has also been well documented outside of DRC.** Experience indicates that PBF approaches can be successful in rapidly increasing the use of cost-effective health interventions. Studies of PBF in Cambodia and Burundi and randomized controlled studies in Rwanda and Zimbabwe have demonstrated its effectiveness. There are promising results from a number of countries in Sub-Saharan Africa that suggest that PBF may be a useful

[16] Robyn, J and Samaha H. (2014): Haut-Katanga Performance Based Financing: Policy Note, Washington DC.
[17] Soeters, R., P.-B. Peerenboom, et al. (2011). "Performance Based Health Financing Experiment Improves Care in a Failed State." Health Affairs **30**(8): 1518-1527.
[18] Fritsche, G., R. Soeters, et al. (2014). Performance-Based Financing Toolkit. Washington DC, © World Bank. https://openknowledge.worldbank.org/handle/10986/17194 License: CC BY 3.0 IGO.

approach to address the types of challenges present in DRC. The Rwandan experience has attracted considerable interest and has yielded results in terms of increasing the proportion of the right skills mix in public sector facilities, increasing financing to the district level, and improving the coverage of quality maternal and child health services. Burundi, which has been implementing a PBF program similar to the DRC scheme, has shown progress towards ensuring the appropriate skilled staff at health facilities; an increase from 37 percent in 2006 to 71 percent in 2010 was observed. Coverage of important health services such as skilled birth attendance has increased from 57 percent in 2006 to 82 percent in 2010, while contraceptive prevalence has increased from 9 to 16 percent.

70. **Unlike the PARSS project which used a project implementation unit (PIU), this new project will be embedded within the MOPH. The project will be housed at the Planning and Research Directorate (*Direction d'Etude et de Plannification, DEP)*.** Despite the challenges with this approach, experience shows that building the capacity of current structures and involving existing stakeholders is essential in ensuring buy-in at all levels. Furthermore, clearly defining the roles and responsibilities within the various units and departments is essential in engaging all those involved in the project execution.

71. **The Bank's fiduciary and operational procedures are complex;** in order to avoid implementation delays it is essential to provide local technical support from the outset of project implementation. It is also imperative to have a strong autonomous coordination and implementation unit within the MOPH to implement this project. Ownership at the highest levels, including the Minister, is vital to the success of the project; however, once this buy-in is achieved, the implementation unit needs sufficient autonomy and authority to execute the project. Along with the independence and control, there are two other elements that are crucial to the success of the project: i) the use of internal performance contracts linked to rigorous performance monitoring and benchmarking of performance, and (ii) solid technical assistance to ensure compliance with fiduciary and operational procedures. This approach has been successful in Rwanda and Burundi and has allowed the Governments to embrace the health reforms while providing the stewardship function needed for PBF to succeed.

IV. IMPLEMENTATION

A. Institutional and Implementation Arrangements

72. **The Ministry of Public Health (MOPH) will implement the project through the Planning Directorate (DEP).** 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 *Cellule d'Appui et de Gestion Financière (CAGF)* (Coordination and Financial Management Unit) and *Cellule de Gestion des Projets et Marchés Publics (CGPMP)* (Procurement Unit) as well as with the Technical RBF Unit (CT-FBR). The CT-FBR will be attached to the DEP to

ensure coordination and integration of PBF activities within the DEP. The DEP will be responsible for overall management and coordination of the PDSS while the CAGF and CGPMP will be responsible for the financial and procurement management.

73. **The CT-FBR will be strengthened to provide the technical assistance required for the various PBF schemes in DRC.** The existing CT-FBR which was set up with the help of the development partner Cordaid, and is being supported by the USAID-financed Management Sciences for Health (MSH) PROSANI project will continue to be strengthened by the project to support the implementation of the PBF activities. The CT-FBR is currently managing the web-enabled application which is the administrative backbone of the PBF program. The project will place the CT-FBR under a performance contract (internal contracting); in addition, it will move the web-enabled application under the management of the central department managing the health management information system (HMIS). This central department will also be placed under a performance contract.

74. **The DEP will report to the National PNDS[19] Steering Committee which is in place for coordinating and implementing the National Health Sector Strategy (PNDS Comité de Pilotage).** The National PNDS Steering Committee is chaired by the Minister of Health and Population and includes representatives from key directorates of the MOPH, the Ministry of Planning and Economy, the Ministry of Environment, the Ministry of Finance, and representatives from the donor community (the Bank will not sit as a member of the committee but only as an observer, to avoid going beyond its mandate). The National PNDS Steering Committee will oversee the implementation of PBF, review the annual PDSS program and approve the budget, and ensure harmonization between the implementation of the PNDS and the PDSS. It will also provide guidance to the CT-FBR, and generate policy direction for the institutionalization of PBF in DRC.

75. **Each quarter, the DEP performance will be assessed through a performance-framework by the CS&E (*Comité de Suivi et Evaluation*) of the Secretary General jointly with the third party counter-verification agent (ACVE).** This performance framework will contain indicators related to (i) timely processing and execution of the PBF payment orders for health facilities, health administration and EUP; (ii) regularity and management of the national PBF steering committee meetings; (iii) maintenance of the PBF web-application front and back-end; (iv) technical support to the EUP-PBF related to contract management, verification activities and strategic purchasing; and (v) capacity building and coordination.

76. **The project policies and procedures will be incorporated in a project implementation manual (PIM), which will be adopted by the MOPH.** It will be complemented by a PBF user manual. The DEP and the Bank will ensure that the PBF manual is consistent with the overall implementation manual. A more detailed description of the implementing arrangements is presented in Annex 3.

[19] PNDS: *Plan National de Développement de la Santé* is the Ministry's National Health Strategy for the next 5 year. A PNDS national steering committee is already in place and hence it was agreed with the Government that the same steering committee would oversee the implementation of the PDSS project.

77. **The DEP/MOPH will create a purchasing arrangement in each province through a non-Governmental entity, a public utility (*Etablissement d'Utilité Publique – EUP)* which will act as the strategic purchaser on behalf of the Government and development partners.** Based on successful experience in DRC in the Kasai Provinces, (Oriental and Occidental) and in North Kivu, public utilities (EUPs) will be created in each of the four project provinces. These EUP-PBFs will have various satellite agencies to effectively cover the target areas. Using the PBF user manual as a guide, the EUPs will negotiate contracts with providers, negotiate business plans, conduct the verification, enter data in the web-enabled application, organize the community client satisfaction surveys, participate in the provincial PBF steering committees, and coach the health facilities and district health teams in enhancing their performance. Facility payments will be made quarterly after service volumes have been verified by the EUP-PBFs and the quality of technical support and care has been assessed by the health district teams, certified by the EUPs, and ratified through special governing boards at the province level. After the quantity and quality of services provided are certified, payment will be released to contracted health facilities via separate fund-holding arrangements.

	Technical Responsibility	**Fiduciary Responsibility**
Component 1: Improve Utilization and Quality of Health Services at Health Facilities through Performance Based Financing		
Performance Payments to Health Facilities	DEP/PBF unit (MOPH)	DEP/CAGF
Component 2: Improve Governance, Purchasing and Coaching and Strengthen Health Administration Directorates and Services through Performance Based Financing		
Performance Payments to Health Directorates and Services	DEP/PBF unit/DPS (MOHP)	DEP/CAGF
Component 3: Strengthen Health System Performance Financing, Health Policy, and Surveillance Capacities		
3.1 Support to Improve Health Financing Reform and System Decentralization	DEP/DGS/PBF unit	DEP/CAGF
3.2: Health Sector Monitoring and Evaluation (M&E) Strengthening and Project Monitoring	HMIS unit / PBF unit	DEP/CAGF
3.3 Ebola Preparedness	DEP/GDS/UN agencies	DEP/CAGF

78. **Verification of the DEP, CT-FBR, HMIS, DPSs, EUPs, and CDR performance will occur each quarter by the ACVE in collaboration with the CE&S in MOPH**. The verified data will be benchmarked on a publicly available website. The ACVE will also counter-verify (using a defined protocol) the quality performance of hospitals and health centers before payments can be made. In case of discrepancies, penalties will be applied.

Partnership Arrangements

79. **The project will be implemented in coordination with development partners that are financing technical assistance and other types of investments in the health sector**. The *Group Inter Bailleurs pour la Santé (GIBS)* is the partners coordinating body in which the World Bank is an active member. The Bank is the leading partner of the Financing Working Group of the GIBS. The GIBS was consulted during identification and preparation of this project and helped set the priority areas. In addition to being consulted, a few key strategic partners have aligned their interventions along the PBF strategy to maximize results. The GIBS will also continue to be consulted during implementation as many of the activities will be delivered jointly with the existing partners. These consultations will provide a sounding board for the project when it faces challenges that would benefit from the inputs of the partners and the partners will in turn benefit from the lessons learned generated from the project.

80. **The alignment between the Global Fund, UNICEF, World Bank and the Reproductive and Maternal Newborn and Child Health (RMNCH) trust fund will ensure complementarity, and ensure the efficient use of resources**. The objective of this partnership is to support the Government's Acceleration Program to Achieve MDGs 4 and 5. This collaborative approach will contribute towards the provision of an integrated package of services implemented through PBF and offered to a larger portion of the population. It is expected that this alignment of development partners will contribute to not only strengthening the health system (efficiency, efficacy and better governance) both from a service delivery and stewardship perspective but will also achieve the intended results in terms of improving utilization and quality of care as well as achieving the anticipated maternal and child health results. Finally this alignment is very much in line with the Ministry of Public Health's objective to reduce partners' fragmentation and ensure harmonization. Discussions for future alignment with GAVI, USAID, UNFPA and the Gates Foundation are ongoing.

81. **Furthermore, other partners such as WHO, JICA, EU, USAID, and DFID are also expected to provide support to strengthen the health system and synergies with these partners are also expected to support this project.** Given the weak capacity in the participating Ministry, this on-going technical and financial support is expected to further enhance project performance. The project team will ensure that capacity is also built within the Ministry at all levels (central and provincial) during implementation in order to reduce technical support over time.

B. Results Monitoring and Evaluation

82. **Results monitoring, evaluation and feedback are the corner stone of well-designed PBF approaches.** Services are verified on location before they are paid (ex-ante) each month, and in very distant locations every two or three months. Each quarter the quality of each contracted health facility be it health center or hospital, is verified using a rigorous quantified quality checklist. The quantity verification is conducted by the EUPs while the quality performance is assessed by the health zone teams (ECZS) for the health centers, and by the provincial health directorate (DPS) in collaboration with development partners for the hospitals. The combined quantity and quality results are discussed and validated each quarter in the provincial PBF steering committees and the decentralized governing boards for PBF. Once the

data are validated, the fund holder(s) is/are notified to pay providers directly into their bank accounts.[20] All performance information will be benchmarked and publicly visible on a website through a dashboard and all data will be downloadable in an Excel table format.

83. **A third party agency will be contracted to assess the internal contracting arrangements, while grass roots organizations will be engaged to systematically carry out community client satisfaction surveys.** The ACVE will be contracted to assess the performance of the MOPH directorates (DEP, CT-FBR, HMIS) and the EUPs, in collaboration with the internal audit department of the MOPH. The third party agency will also counter-verify (ex-post) the reported quality performance of health centers and hospitals using a defined protocol. Penalties will be applied in case of discrepancies.

84. **The results of the PBF component of the project will be assessed through a full Impact Evaluation (IE).** The policy objectives of the Impact Evaluation are to (i) evaluate the total impact of the PBF model on the outcomes of interest, (ii) focus on quality of care and assess the effects of the indicators that will be used to measure and pay for quality within the PBF scheme and (iii) estimate the effects of the community engagement mechanism that are introduced within the PBF project to promote demand for health services and preventative health behaviors at the household level. It is expected that the results from the Impact Evaluation will be useful to fine tune the design of the national PBF policy in DRC and will also contribute to the larger body of knowledge on PBF.

C. Sustainability

85. **Technical sustainability will be ensured by capacity building and knowledge transfer activities throughout the project**. For Components 1 and 2, capacity-building efforts at all levels of the health sector will be coordinated and implemented by the DEP in collaboration with the CT-FBR and the EUPs. Capacity in the EUPs will be created during the preparatory phase of the project through trainings and on the job coaching. A training of trainers will create a pool of knowledgeable PBF trainers who will then train verifiers, health administrators, presidents of health center committees and health facility in-charges. Grass-roots organizations will also be selected and specific members will be trained as community client survey agents. This capacity transfer and training program will continue throughout the project and will taper off towards the end of the project cycle when capacity has been sufficiently built. Technical sustainability will be enhanced by using and strengthening country systems.

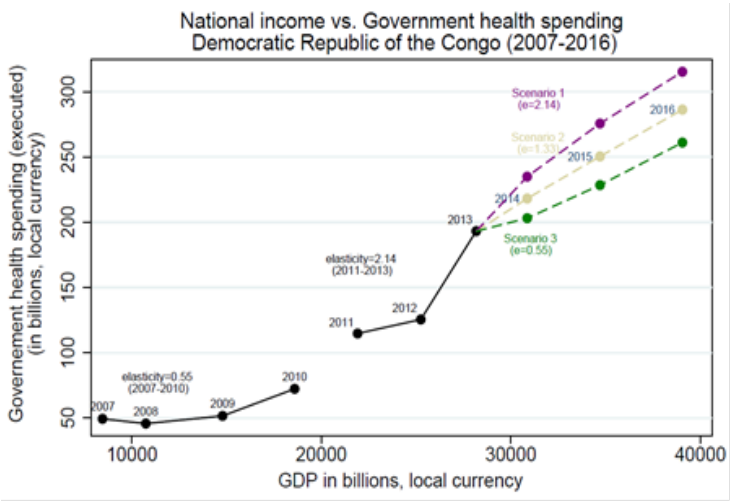
86. **Financial sustainability of PBF can reasonably be achieved given the increased collaboration between key development partners, and given the Government's buy-in and their likelihood to expand the fiscal space for health**. Although financial sustainability needs to be ensured through better alignment between major development partners such as the Global Fund, GAVI and UNICEF, the Government will also have to begin financing PBF to ensure sustainability. Based on recent fiscal space analysis, it is estimated that the Government could double its current low public health expenditures over the coming years by putting in place a

[20] Many health facilities do not yet have bank accounts, and they are being assisted in creating these. It is estimated that around 25% of health facilities, due to being located in very difficult to access regions, will be paid using specialized money-transfer agencies.

technical and allocative efficient health financing mechanism, and by engaging the central and provincial Governments in creating effective health financing strategies. It is envisaged that PBF will be used by the Government to channel its new public investments for health.

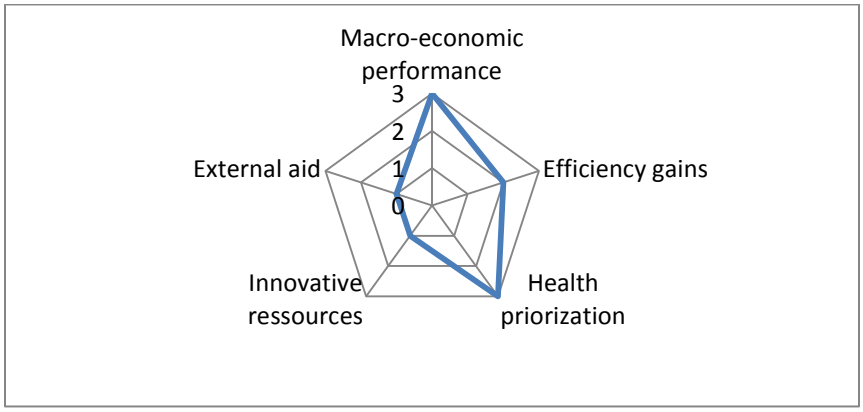
87. **The selection of the project components, especially the PBF and the health systems strengthening approach, creates the conditions for a sustainable investment in the sector.** By boosting the system's reliance on existing health facilities and delivery mechanisms, the project will be directly contributing towards the sustainability of the sector. Also, by spending US$3.6 per capita, per year (including overhead costs), the cost is likely to be affordable and sustainable in the long term. Despite the fiscal fragility of the health sector in the DRC, there is available space to further connect health investments with income growth. The analysis shows that Government health spending has been stagnant on growth from 2011 onwards (e=2.14 from 2011 to 2013, against e=0.55 between 2007 and 2010). This trend (e>2) will be sustained through 2016; Government health spending could further benefit from the robust macro-economic performance in the medium term and exceed 300 billion FC (against 193 billion FC in 2013, in current value) (Fig.1).

Figure 1: Elasticity of Government health spending to income growth, DRC (2007-2016 projection.)



88. The economic situation provides realistic options for sustaining the proposed project's expected results over time in the DRC; the most promising option is the mobilization of domestic resources. In the medium term, there is sizeable room for increasing the fiscal space for health, mainly through (i) a more effective mobilization of Government revenues; (ii) a re-prioritization of Government budget toward health; and (iii) extra gains in technical and allocative efficiency of health spending which could then free-up resources for the sector (PER, World Bank, 2014) (fig.2).

Figure 2: Analysis of the potential sources of fiscal space for health (medium term), DRC



Source: PER, World Bank, 2014

V. KEY RISKS AND MITIGATION MEASURES

A. Risk Ratings Summary Table

Risk Category	**Rating**
Stakeholder Risk	Substantial
Implementing Agency Risk	
- Capacity	Substantial
- Governance	High
Project Risk	
- Design	Substantial
- Social and Environmental	Moderate
- Program and Donor	Moderate
- Delivery Monitoring and Sustainability	Moderate
Overall Implementation Risk	**Substantial**

B. Overall Risk Rating Explanation

89. **The project is embracing new approaches with PBF that are novel to the larger group of stakeholders**. The proposed scaling up from 80 to 140 health zones and the resulting challenges posed by the geographical complexity, the associated issues of access, and the complexities of working closely with development partners to achieve results present a risk which will need to be mitigated. Additionally, the project will attempt to tackle key health system reforms such as user fee policies, pharmaceutical drug costs and drug management, and quality. Given the weak institutional capacity at the country level, the overall risk rating is considered to be substantial. The Government and key development partners are dedicated to

launching new reforms to improve the health status of the population as well as to protect the poor. The Bank ensured that adequate technical assistance was available during project preparation and will be made available during implementation to mitigate the potential risks. The anchoring of the project within the MOPH will be complemented by additional technical assistance for project coordination, management, as well as PBF expertise. Additionally, the web-application will allow a transparent and open way to follow the project achievements; it is expected that with these measures in place, implementation risks in the project would be mitigated.

VI. APPRAISAL SUMMARY

A. Economic and Financial Analysis

90. **Investing in maternal and child health services is critical to improving access to quality services for direct beneficiaries.** The economic justification relies on the disproportionate burden of maternal and neonatal deaths in the DRC and the fact that affordable and cost-effective interventions to prevent these avoidable deaths are well-established. Evidence from low-income countries suggests that improved coverage with a package of interventions targeted to mothers and children is extremely cost-effective ($82-$142 per DALY averted)[21]. The interventions proposed under this project are all considered global "best buys" in this respect.

Table 1: Cost-effective interventions for mother and child health

Health interventions	Percent of Global Disease Burden Averted	Cost per DALY averted (global)	Estimated annual cost per capita (global)	Included in project
Integrated management of childhood illness	14.0	40.00	1.60	Yes
Expanded Program for Immunization	6.0	14.5	0.50	Yes
Prenatal and delivery care	4.0	40.00	3.80	Yes
Family planning	3.0	25.00	0.90	Yes

Source: Adapted from Cleason et al, 2000

91. **The choice of the project components, notably through a result-based approach, also relies on a strong economic rationale.** The PBF approach has already demonstrated its effectiveness and efficiency in addressing health system bottlenecks in the context of the DRC. The PBF approach operates through decentralizing health financing to front-line providers. The mechanism responds to the concern that a large source of system inefficiency originated from the extremely limited share of executed financial flows to provinces (less than a 1 percent) (PER, World Bank, 2014). Closing the gap between financial resources and effective service delivery is an obvious direct benefit for users. The PBF approach also relies on the assumption that an extrinsic motivation, without crowding out the intrinsic values, will encourage health personnel to adopt an entrepreneurial approach aimed at increasing the use and quality of services

[21] Disease Control Priorities, Second Edition, 2006

provided. Past experiences have proven to be strongly cost-effective for increasing use of services. With less than US$3 spent per capita, past experiences implemented in the DRC with the support of the World Bank and other partners, led to significant increases in assisted deliveries, antenatal care and immunization rates in targeted health zones.

Cost-Benefit analysis of the project

92. **A Cost-Benefit Analysis (CBA) was conducted to measure the project's economic performance and to ultimately assess its net returns against alternatives (e.g. status quo).** The analysis focused on the PBF output-related component consisting of 71 percent of the total budget. The method consisted of: (i) identifying the PBF project's inputs and outputs, (ii) monetizing the benefits of project, (iii) discounting the benefits and costs, and (iv) computing the net returns. Costs and benefits have been discounted with a real social discount rate over 4 years[22] estimated at 5 percent in real terms in this setting. It defines the rate at which future values in the economic analysis are discounted to the present and therefore reflects the social view on how net future project benefits should be valued against present ones. Computing of economic performance consisted of assessing the economic net present value (NPV) (i.e. the difference between the discounted total benefits and costs) and the economic rate of return (RR) (i.e. the rate that produced a zero value for the NPV). Projects with a rate of return (RR) lower than the social discount rate (5 percent) or a negative NPV are generally not considered economically sound.

93. **The CBA analysis shows a net value of US$ 30.7 million, with a rate of return of approximately 21.25 percent.** Those results demonstrate the positive economic performance of the PBF approach proposed in this project and its capacity to generate large returns for the country economy and society.

94. **Sensitivity analysis allows the determination of the 'critical' variables or parameters of the model**. Such variables are those whose variations, positive or negative, have the greatest impact on a project's financial and/or economic performance. The analysis is typically carried out by varying one element at a time and determining the effect of that change on RR or NPV. In the setting of the DRC's operation, results show that it is unlikely that the net return of the project will be sensibly modified, given prices of services purchased will unlikely be modified over the course of the project. A diminishing social discount rate is also expected not to affect results.

95. **Appropriateness of Public Sector Provision or Financing.** One of the outcomes of decades of conflict and instability in DRC is the privatization of education, health, and social protection services. The poor status of human development in the country is a result of pervasive market failures. Investing in health system and other public sector management systems will enable the Government to play a critical role in resource distribution to contribute to correcting salient market failures.

[22] Project duration is 4 years. The cost-benefit analysis was conducted over 5 years, given the first year will consist of finalizing project design and implementation arrangements. Services are expected to be purchased full speed starting Year 2.

96. **World Bank Value Added.** International organizations are essential in conceiving development norms and establishing regulatory frameworks for policy implementation. The World Bank is well placed to provide the necessary financial and technical assistance and to support Government ownership of these reforms. The comparative advantages of the World Bank in advancing the health reform agenda include: its impartiality, capacity to engage diverse groups in open dialogue, normative functions, and extensive networks of expertise. Finally, given the PBF portfolio of the WB, this positions the Bank among the leading organizations to support design and implementation of PBF projects in DRC.

B. Technical

97. **The project supports a package of basic and complementary health services, predominantly maternal and child health interventions aimed principally at improving health related MDGs in the 140 health zones in the 4 provinces**. The design of this project builds on several years of World Bank investment in the human development sectors especially health. The project will build on the current health sector project PARSS which is scheduled to close in December 2014. The approach of investing in maternal and child health interventions is endorsed by the Ministry of Public Health which is very concerned with the high levels of infant, child and maternal mortality rates and the slight increase in the total fertility rate. This project will reinforce the Government's priorities and aim to strengthen the health system and focus on maternal and child health interventions through PBF.

98. **The design of PBF arrangements in the DRC is based on the best practices observed and experiential knowledge gained in other successful PBF projects**. For instance, external entities (such as community-based organizations, the provincial purchasing agencies, and a third-party counter-verification agent, close collaboration with non-state actors such as UNICEF, Cordaid and SANRU) will be strongly involved in promoting and monitoring PBF results. Similarly, the mechanism to determine PBF credits is a "fee-for-service conditional on quality" system, which has been applied with successful results in other PBF projects such as in Rwanda, Burundi, ROC, Cameroon, Zambia, Zimbabwe, Nigeria, Benin and Chad. Such a system ensures that (i) the PBF mechanism is clear and can easily be understood by health workers and communities and (ii) the increase in the quantity of care is not detrimental to quality.

C. Financial Management

99. **In accordance with the Financial Management Manual issued in November 2005 as revised on March 2010, the financial management systems of CAGF/MOPH (Cellule d'Appui et de Gestion Financière du Minitère de la Santé Publique / Ministry of Public Health-MOPH) has been assessed to determine whether it is acceptable to the Bank with consideration for the country's post conflict situation.** To this end, the CAGF/MOPH must meet the following requirements: (i) assuring correctly and completely the recording of all transactions related to the project; (ii) facilitating the preparation of regular, timely, and reliable financial statements; (iii) safeguarding the project's assets; and (iv) facilitating the implementation of external auditing diligences as required by the Bank. The arrangement also aims to facilitate the disbursements of the project's resources and to ensure their effective use while, to the extent possible, using the country's own financial management systems.

100. **The FM assessment of CAGF/MOPH revealed some weaknesses.** The major weaknesses identified include (a) lack of familiarity with IDA procedures for reporting, disbursement arrangements, and auditing; (b) lack of sufficiently qualified staff; (c) weaknesses in the its financial reporting system, and (d) default of updating of its management tools: accounting software, and manuals of accounting procedures and financial management. As such, the overall FM risk when the project was prepared is considered **High**. The proposed financial management arrangements including the mitigation measures for this project are considered adequate to meet the Bank's minimum fiduciary requirements under OP/BP 10.00 (see Annex 3 for further details).

D. Procurement

101. **The procurement of activities under this project is the full responsibility of the MOPH through the DEP which will implement the project**. The procurement activities will be carried out at two levels: (i) the DEP of the MOPH at the central level; and (ii) the EUP-PBFs at the decentralized level. At the central level procurement activities will be carried out by the Procurement Management Unit (Cellule de Gestion des Projets et Marchés Publics – CGPMP) of the MOPH. The CGPMP reports to the General Secretary of the MOPH. At the decentralized level procurement activities will be carried out by the EUP-PBFs in the four provinces targeted by the project.

102. **The procurement risk is rated high** given: (i) the country context and associated risk; (ii) the low fiduciary capacity of the MOPH through "the Cellule d'Appui et de Gestion des Financements du secteur de la santé" which has been replaced by the newly created "Cellule d'Appui et de Gestion Financière du Ministère de la Santé Publique" pursuant to decree Nr. 1250/CAB/MIN/SP/013/CJ/2014 of June 10, 2014; (iii) the unproven experience of the CGPMP due to the fact it has never been functional since it was set up and has been recently staffed; and (iv) the unproven experience of the newly created EUP-PBFs. Procurement arrangements are included under Annex 3.

E. Social (including Safeguards)

103. **The project is expected to have a positive social impact by improving access to health care services for the poorest households.** Component 1 (through the payment for performance) will provide incentives for health facilities to reduce staff absenteeism and to improve staff responsiveness with patients. As a result, health facilities with PBF contracts will provide more and better quality care for marginalized populations. The project will also build on synergies with other HD projects being implemented in DRC. The project does not foresee construction.

104. **The project will be implemented in the area where indigenous peoples (IPs) are located.** While the project will not as such negatively affect IPs, OP/BP 4.10 policy is triggered to ensure that IPs will benefit from the project. The expected impacts are positive as the IPs do not have access to quality care and hence the project will ensure that free quality care is provided to them to ensure better health outcomes. Given that DRC is a fragile state, OP 10.00 allows the task team more time to finalize most safeguard instruments during implementation. (See Annex 11 for the Environmental and Social Screening Assessment Framework).

105. **The project will have a positive impact on gender in DRC.** Given that the project's main objectives are to improve maternal and child health in target areas, improving women's health is an essential component of the intervention. Particular attention will also be given to ensuring active participation of women in the health center committees (COSAs), and as community client satisfaction surveyors during the ex-post evaluations. The project is expected to have a positive impact not only on pregnant women but on all women, as PBF will improve the quality of care for the identified package of health services for the general population.

106. **This project builds on continuous consultation and communication with the Government.** The Government and Bank have been actively engaged in dialogue over the current PARSS project in DRC. This project has allowed the Bank team to conduct an ongoing dialogue with the Government, at both the national and local levels; development partners are also active in this dialogue. The components of the project build on lessons learned from the ongoing investment.

F. Environment (including Safeguards)

107. **The project is rated as Environmental Assessment (EA) category B**. Indeed, activities related to the proposed project may lead to an increase in Health Care Waste (HCW). So, only these wastes could be considered as environmental and social adverse impacts that will have to be generated by the project.

108. **Only two safeguard policies are triggered by the project.** There is **OP/BP 4.01 Environmental Assessment** because of the potential negative environmental and social impacts related to the handling and the disposal of medical and health waste (such as placentas, syringes, and material used for delivery of pregnant women) in health facilities covered by the project area. However, Health Care Waste to be generated by the project is expected to be site specific, small scale and easily manageable.

109. **The second safeguard policy is OP/PB 4.10 on Indigenous People.** The Indigenous Peoples Plan (IPP) that will be prepared and disclosed in country and at the Infoshop aims to ensure that indigenous peoples will benefit from social outputs of the project as it will cover indigenous people areas.

110. **To manage properly health care waste in accordance with OP/PB 4.01, the existing Health Care Waste Management Plan (HCWMP)** previously used under PARSS project, will be updated, reviewed, consulted upon and disclosed publicly both within the DRC and at Bank's Infoshop by effectiveness of the project.

111. **The World Bank's supervision missions will also include environmental and social safeguards specialists in order to assist the project implementation unit** by (i) providing regular implementation support, (ii) carrying out field reviews of safeguards implementation, and (iii) monitoring safeguards implementation based on periodic progress reports.

Two safeguard policies were triggered, as follows:

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

* By supporting the proposed project, the Bank does not intend to prejudice the final determination of the parties' claims on the disputed areas.

108. OP/BP 4.01 Environmental Assessment: This policy is triggered; the project has minimal environmental impacts that shall be governed by national and local laws and procedures. An existing medical waste management plan prepared for the ongoing Bank financed project will be updated during implementation to continue to facilitate the mitigation of potential adverse impacts. In addition, the plan will be reviewed twice a year and a sample of facilities will be visited to supervise implementation of the HMWP.

109. OP/BP 4.10 Indigenous People: This policy is triggered to ensure that indigenous peoples will benefit from the social outputs of the project. This project does not expect to negatively impact the indigenous population. An Indigenous Peoples Plan will be prepared and will be disclosed in country and at the InfoShop by effectiveness of the project.

ANNEX 1:RESULTS FRAMEWORK AND MONITORING

DEMOCRATIC REPUBLIC OF CONGO

Health System Strengthening for Better Maternal and Child Health Results Project (PDSS) (P147555)

PDO	Project Outcome Indicators	Use of Project Outcome Information
PDO: Improve *utilization* and *quality* of maternal and child health services in targeted areas within the Recipient's territory.	**1. Percentage of pregnant women having at least 3 antenatal care visits before delivery[23]**	**Assessing whether <u>utilization</u> of maternal and child health care has increased in the targeted areas.**
	2. Percentage of children aged between 6-23 months receiving preventive nutritional services at least four times per year.	
	3. New curative consultations per capita per year	
	4. Percentage of children fully immunized[24].	
	5. Average score of the quality checklist at the health center level[25].	**Assessing whether <u>quality</u> of health care has improved in the targeted areas.**
Intermediate Outcomes	**Intermediate Outcomes Indicators**	**Use of Intermediate Outcome Monitoring**
Components 1 and 2: Improve utilization	**6- Number of new and existing acceptors of modern contraceptive methods[26]**	**Tracking progress in terms of improving the**

[23] It is difficult to provide 4 ANC visits since most women do not come to the health center in the 1st trimester due to many reasons including cultural norms, stigma and lack of awareness of their pregnancy. This figure will be provided as the sum of all ANC visits in one year, divided by three, divided by the target population of pregnant women.

[24] The project will also measure fully immunized children under 1 which is a more sensitive and complete measure of correct and timely application of all obligatory immunizations done prior to 11 months of age. This measure is also a proxy of the quality of the EPI program (follow-up on defaulters; quality and effectiveness of outreach and community based programs).

[25] Criterion-based clinical measures and vignettes will also be included in the quality checklist. The quality checklist will be applied at two levels: at the health center and at the first level referral hospital level. This PDO indicator refers to the checklist at the health center level. The Impact Evaluation of this PBF project will specifically study the impact of PBF on quality of care. An example of a quality checklist from neighboring Congo-Brazzaville is available in annex 10

[26] Condom use and the use of traditional methods will not be used here as they are very difficult to verify. This indicator also has a considerable demand-side element (23% unmet need).

and quality of health services at health facilities through Performance-Based Financing and Improve Governance, Purchasing and Coaching and Strengthen Health Administration Directorates and Services through Performance Based Financing	**7- Number of newly diagnosed HAT patients[27].**	**supply-side factors that affect utilization and quality of maternal and child healthcare.**
	8- Percentage of Pregnant women counseled and tested for HIV.	
Component 3: Strengthen health system performance financing, health policy, and surveillance capacities.	**9. Average quality of nutritional services[28].**	**Assessing the project has strengthened the capacity of health authorities (at central and regional levels) for implementing and monitoring the national health policy.**
	10. Number of poor people benefiting from fee exemption mechanisms.	
	11. Number of health professional trained (WB Core indicator).	
Components 1-3	**12. Number of Direct project beneficiaries, (female).**	

[27] Human African Trypanosomiasis (HAT) is a significant public health problem in certain targeted areas. For instance, in the 14 Mai-Ndombe District health zones (Mai Ndombe will be a new Province), 50% of all newly diagnosed HAT cases in DRC are in Bandundu Province, and of which 50% are in Mai-Ndombe (North Bandundu). The project will purchase (a) newly diagnosed HAT cases and (b) treated and cured HAT cases.

[28] The quality of nutritional services (growth monitoring; BCC/IEC; vaccination for child hood diseases; Vit A; Zinc and Fe supplements; Mebendazole treatment) is checked through a sub-component of the quality checklist. Whereas the quantity of growth monitoring visits is purchased, the quality is measured and rewarded through a separate quantified quality checklist). The nutritional services quality sub-component consists of a mix of structural and process measures.

ANNEX 1: RESULTS FRAMEWORK AND MONITORING

DEMOCRATIC REPUBLIC OF CONGO:

Health System Strengthening for Better Maternal and Child Health Results Project (PDSS) (P147555)

Project Development Objectives: is to improve utilization and quality of maternal and child health services in targeted areas within the Recipient's territory.

These results are at	Project Level

Project Development Objective Indicators

				Cumulative Target Values							
Indicator Name	Core	Unit of Measure	Baseline[29]	YR1	YR2	YR3	YR4	End Target	Frequency	Data Source/ Methodology	Responsibility for Data Collection
1. Percentage of pregnant women having at least 3 antenatal care visits before delivery[30]	☐	Percentage	29.3	31	33	35	37	39	Quarterly	HMIS/PBF database	MOPH/HMIS
2. Percentage of children aged between 6-23 months	☐	Percentage	26.9	28	30	32	34	35	Quarterly	HMIS/PBF database	MOPH/HMIS

[29] Baseline indicators were taken from the HMIS 2013 and in some cases labeled "TBD" as they will be determined at the time of the baseline survey expected to be done by June 2015. The targets will also be adjusted once the baseline survey has been done. Other data are from the 2014 DHS, and drawn from the average for Bandundu and Equator provinces (82% of health zones and 83% of the target population)

[30] It is difficult to provide 4 ANC visits since most women do not come to the health center in the 1st trimester due to many reasons including cultural norms, stigma and lack of awareness of their pregnancy. This figure will be provided as the sum of all ANC visits in one year, divided by three, divided by the target population of pregnant women.

receiving preventive nutritional services at least four times per year.											
3. New curative consultations per capita per year.	☐	Rate	0.3	0.35	0.4	0.5	0.6	0.6	Quarterly	HMIS and PBF Database	MOPH/HMIS
4. Percentage of children fully immunized[31].	☐	Percentage	37.4	40	44	48	55	55	Quarterly	HMIS/PBF database	MOPH/HMIS
5. Average score of the quality checklist at health center level[32].	☐	Percentage	47.5	50	53	55	60	65	Quarterly	PBF database	MOPH/CT-FBR

Intermediate Results Indicators

				Cumulative Target Values							
Indicator	Core	Unit of	Baseline	YR1	YR2	YR3	YR4	End	Frequency	Data Source/ Methodology	Responsibility for Data

[31] The project will also measure fully immunized children under 1 which is a more sensitive and complete measure of correct and timely application of all obligatory immunizations done prior to 11 months of age. This measure is also a proxy of the quality of the EPI program (follow-up on defaulters; quality and effectiveness of outreach and community based programs).

[32] Criterion-based clinical measures and vignettes will also be included in the quality checklist. The quality checklist will be applied at two levels: at the health center and at the first level referral hospital level. This PDO indicator refers to the checklist at the health center level. The Impact Evaluation of this PBF project will specifically study the impact of PBF on quality of care.

Name		Measure						Target			Collection
6. Number of new and existing acceptors of modern contraceptive use[33]	☐	Number[34]	TBD						Quarterly	HMIS/PBF Database	MOPH/HMIS
7. The number of newly diagnosed HAT patients[35]	☐	Number	1,046	1,020	960	850	750	>500	Quarterly	HMIS/PBF Database	MOPH/HMIS
8. Percentage of pregnant women counseled and tested for HIV	☐	Percentage	17.5	20	22	25	28	30	Quarterly	HMIS/PBF Database	MOPH/HMIS
9. Average quality of nutritional services[36]	☐	Percentage	35	40	45	50	55	60	Quarterly	PBF database	MOPH/HMIS
10. Number of poor people	☐	Number	5,248	5,300	5,500	6,000	6,250	6,500	Quarterly	PBF Database	CT-FBR

[33] Condom use and the use of traditional methods will not be used here as they are very difficult to verify.
[34] DHS 2014: 1.5% of women aged 15-49 years on average in Equator and Bandundu provinces (gross of project). Use of sterilization; IUD; pills; injectable and implants
[35] Human African Trypanosomiasis (HAT) is a significant public health problem in certain targeted areas. For instance, in the 14 Mai-Ndombe District health zones (Mai Ndombe will be a new Province), 50% of all newly diagnosed HAT cases in DRC are in Bandundu Province, and of which 50% are in Mai-Ndombe (North Bandundu). The project will purchase (a) newly diagnosed HAT cases and (b) treated and cured HAT cases.
[36] The quality of nutritional services (growth monitoring; BCC/IEC; vaccination for child hood diseases; Vit A; Zinc and Fe supplements; Mebendazole treatment) is checked through a sub-component of the quality checklist. Whereas the quantity of growth monitoring visits is purchased, the quality is measured and rewarded through a separate quantified quality checklist). The nutritional services quality sub-component consists of a mix of structural and process measures.

benefiting from fee exemption mechanisms											
11. Health personnel receiving training (number)	☒	Number	0	1,000	1,200	1,500	1,800	2,000	Quarterly	Project records	CT-FBR
12. Number of Direct Beneficiaries, of which female[37]	☒	Number	TBD						Quarterly	HMIS	MOPH/HMIS

[37] Drawn from PBF database from services that are specifically used by women and for interventions of component 2 inclusive of women

ANNEX 1: RESULTS FRAMEWORK AND MONITORING
DEMOCRATIC REPUBLIC OF CONGO

Indicator	Numerator	Denominator	Comments
PDO: The project development objective (PDO) is to improve utilization and quality of maternal and child health services in targeted areas within the Recipient's territory.			
UTILIZATION			
1. Percentage of pregnant women having at least 3 antenatal care visits before delivery.	Total number of all new and standard ANC visits in one year divided by 3.	Number of pregnant women in the population (4%).	It is difficult to provide 4 ANC visits since most women do not come to the health center in the 1st trimester due to many reasons including cultural norms, stigma and lack of awareness of their pregnancy.
2. Percentage of children aged between 6-23 months receiving preventive nutritional services.at least 4 times per year	Number of children between 6-23 months receiving nutritional services at least 4 times per year.	Number of children between 6 and 23 months (6.5 %)[38].	Nutritional services will be preventive (growth monitoring) as well as curative (care for malnutrition), both services will be subsidized through PBF. The target is 6 times per year for children aged 6 months to 23 months, and 4 times per year for children aged 24 to 59 months. The nutritional services for these two age-groups will be purchased separately to be able to track the age-group 6-23 months (which is the most important one related to development outcomes)
3. New curative consultations per capita per year.	Number of new curative consultations per year.	Total population in the targeted areas.	60-70% of curative services are for women and children. This indicator would also reflect the improvement in the quality of services as well as the overcoming of financial barriers to health and the impact of policy work on human resources for health (rationalization).
4. Percentage of Children fully Immunized.	Number of fully immunized children under one year of age.	Number of children less than one year old (3.85%).	A child is considered fully immunized when she/he has received immunization for BCG, polio, DTC3, and measles. In the last few years the DTP vaccine has been replaced by Penta, which includes apart from DTP, Hemophilus Influenza and Hepatitis B.

[38] Total under 5 is 18.9%; total under 1 is 3.85%; from 6 to 59 months is 16.9%; from 6 to 23 months is 6.5%.

QUALITY			
5. Average score of the quality checklist at the health center level.	Sum of the quarterly quality score (%) of all PBF health centers.	Number of health centers contracted through PBF.	The quality check list is a comprehensive quality assessment of the quality in a health facility, that consist of over 150 data elements related to the following aspects: hygiene, drug availability, clinical care, equipment availability, drug management, financial management, laboratory, etc. Clinical audits (content of care measures) are also part of the quality assessment and the use of vignettes for assessing knowledge of providers will be introduced. Content of care weighting will be approximately 40%.
Intermediate Outcomes Indicators			
Component 1: Improve Utilization and Quality of Health Services at Health Facilities through Performance-Based Financing Component 2: Improve Governance, Purchasing and Coaching and Strengthen Health Administration Directorates and Services through Performance Based Financing			
6. Number of new and existing acceptors of modern contraceptive methods[39].	Number of new and existing acceptors of modern contraceptive methods.	N/A	Modern methods such as injections, pills, implants and IUDs, excluding condoms, would be taken into account. These methods are purchased at health center/community and first level referral hospital levels. 21% of the population is women of child bearing age (women between 15 and 49 years old), of which 23% have an unmet need.
7. Number of newly diagnosed HAT patients.	Number of newly diagnosed HAT patients.	N/A	Human African Trypanosomiasis (HAT) is a serious and deadly neglected tropical disease. 75% of all HAT cases in Africa are in DRC, of which over 50% are in two target areas of the project. During the first year of the project, new rapid test technology and new treatment options will start in combination with the purchase through PBF of newly diagnosed and newly treated patients.
8. Percentage of Pregnant women counseled and tested for HIV.	Number of Pregnant women counseled and tested for HIV.	Number of pregnant women	This indicator would provide some information about improvement in quality of care (comprehensiveness of ANC visit by provider).

9. Average quality of nutritional services	Sum of the nutritional section of the quarterly quality score (%) of all PBF health centers.	Number of health centers contracted through PBF	The nutritional section of the quantified quality checklist will be elaborate, with a significant weighting as related to the other sections. Furthermore, content of care for these services involving evidence for protocols application for Vit A, Fe/FA, Zinc and Mebendazole will be measured and rewarded.
Component 3: Strengthen Health System Performance Financing, Health Policy, and Surveillance Capacities			
10. Number of poor people benefiting from fee exemption mechanisms.	Number of poor people benefiting from fee exemption mechanisms.	N/A	The project would support mechanisms to exempt poorer people of fee payments, or to lower their level of fee payment at the health facility. These data are directly accessible through the PBF system. At the health center level up to 5% of all consultations can be exempted, and at the hospital level, up to 10% of referred patients can be exempted, and up to 10% of admissions can be exempted. The exemptions are reimbursed through the PBF mechanism.
11. Number of health personnel trained (WB Core indicator).	Number of health professional trained.	N/A	
Components 1, 2 and 3			
12. Number of Direct project beneficiaries, (of which female).	Number of people benefiting from at least one health service.	N/A	The number of beneficiaries would be extracted from the PBF information system. The percentage of female beneficiaries will be approximated through a triangulation with the HMIS data, and by counting services which are exclusive for women (FP; ANC; deliveries etc.).
	Number of women benefiting from at least one health service.	Number of direct project beneficiaries.	

ANNEX 2: DETAILED PROJECT DESCRIPTION
DEMOCRATIC REPUBLIC OF CONGO

Health System Strengthening for Better Maternal and Child Health Results Project (PDSS) (P147555)

1. **The project will modify and expand the current PBF project from 84 to 140 health zones** across Equateur, Bandundu, Maniema and Katanga provinces, covering an estimated 17 million inhabitants. The project will comprise of the following components.

Component 1: Improve Utilization and Quality of Health Services at Health Facilities through Performance-Based Financing. Total costs including contingencies US$120 million equivalent of which US$115 million from IDA and US$5 million from HRITF**.**

2. **This component would be supported by IDA and the HRITF as well as development partner parallel funding from UNICEF, Global Fund and GAVI**. PBF will be financed through separate fund holding arrangements,[40] 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 in the new health operation in DRC will build on and extend the current EUP model, which has already been designed and implemented for PBF operations in Nord Kivu, Sud Kivu, and the Kasai provinces since 2009. The model has shown to be an effective and efficient model for successful PBF operations in these contexts, leading to not only successful implementation of PBF at lower costs (transaction costs of around 15 percent for EUP versus 30 percent or higher for international NGOs), but also strengthening national capacity for service delivery in even the most challenging contexts. The use of the EUPs will continue to contribute to strengthening national capacity for service delivery. Creating local purchasing arrangements is a novel strategy that is being applied to PBF in Burkina Faso and Congo-Brazzaville.

3. **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.**[41] The Haut Katanga PBF pilot's impact evaluation has yielded key lessons for designing and implementing PBF in DRC; these have been used to fine tune 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 15-25 targeted services at each level, (2) verification needs to be done systematically and continuously in order to ensure accountability; (3) community engagement and counter-verification are key as are applying rigorous sanctions in the case of fraud; (4) the importance of measuring and paying for quality; (5) a sufficiently high output budget of around US$3 per capita per year is required; (6) results monitoring with regular feedback through a well-functioning data management solution is essential, and (7) high quality technical assistance is not a luxury but essential. These lessons as well as lessons (both positive and negative) from PBF projects funded by the European Union in Kasai and by Cordaid in

[40] The exact fund holding arrangements are still under discussion.
[41] Global Burden of Disease study 2010.

South-Kivu[42] in addition to the growing experiential knowledge on PBF design from other PBF projects globally[43] will help shape the thinking of the potential benefit of scaling up PBF in DRC for this new operation.

4. **During the final year of the PARSS project, the predominantly input-based financing focus has shifted to a complete output-and performance based financing focus.** The current PARSS project covers 84 health zones across Equateur, Bandundu, Kinshasa, Maniema and Katanga provinces. The project currently covers 813 health centers (613 public; 40 private for profit and 130 confessional centers; 78 first level referral hospitals (57 public; 3 private for profit and 18 confessional; 79 health zone health teams; 5 provincial health teams and 10 district health teams. In the proposed PDSS project, the number of target health zones will be increased from 84 to 120, the number of health centers will be between 1,200 and 1,500, while the number of first level referral hospitals will be approximately 120.

5. **This component will provide grants for a package of health services including MCH services at health center/community and first level referral hospital levels**. Public, quasi-public and private health facilities, including health centers and first level referral hospitals, will be selected in rural and urban areas. It is not expected that tertiary hospitals will be part of this project.

6. **This component would directly pay PBF grants to health service providers**. DRC will contract with EUPs to provide contract management and verification services and other support such as monitoring/supervision and providing investment funds in addition to capacity building services in the selected health zones in the 4 target provinces. In the selected health zones, the EUP will sign performance-based contracts with health facilities for the provision of a defined package of health services. PBF grants (based on the selected services to be purchased) will be paid to the health facilities that have 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 by the health district teams and certified by the EUPs, and ratified through special governing boards at the province level. After the quantity and quality of services provided are certified, payment will be released to contracted health facilities via fund-holding arrangements.

7. **PBF grants financed under this component (based on the selected services to be purchased) will be paid to these health facilities 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 these services are certified, payment will be released to contracted health facilities via the fund-holding entities.

[42] Soeters, R., P.-B. Peerenboom, et al. (2011). "Performance Based Health Financing Experiment Improves Care in a Failed State." Health Affairs **30**(8): 1518-1527.
[43] Fritsche, G., R. Soeters, et al. (2014). Performance-Based Financing Toolkit. Washington DC, © World Bank. https://openknowledge.worldbank.org/handle/10986/17194 License: CC BY 3.0 IGO.

8. **Two benefit packages of health services have been designed in DRC for use in the PBF approach**. They are the Minimum Package of Activities (MPA), which contains 21-22 preventive and curative primary health services to be provided in public and private health centers, and the Complementary Package of Activities (CPA), with 24 services to be delivered at first level referral at public and private hospitals. These benefit packages were designed during a technical meeting in August 2013 for use in the PARSS pilot and are based on international best practice. The services can be adjusted depending on the Burden of Disease of the targeted provinces as necessary. The services selected provide a great potential for accelerating DRC's achievements for the health related MDGs 1, 4, 5 and 6 and are based on the burden of disease for DRC[44]. The service packages are currently being reviewed.

9. **MPA- Minimum package of activities at the health center and community level consists of 22 services. These services are currently being revised to include a focus on neglected tropical diseases.**

1. New curative consultation
2. New curative consultation – indigent (fee exemption up to 5% of volume)
3. Minor surgery
4. Referral for a severe condition arrived at the hospital
5. Fully vaccinated child
6. Antenatal care: second to the fifth tetanus toxoid vaccination
7. Antenatal consultation: new
8. Antenatal consultation: standard visit 2-4
9. Institutional delivery
10. Postnatal consultation (under discussion)
11. Family planning: new and recurrent user of modern family planning method (pills and injection)
12. Family planning: IUD and implant
13. Growth monitoring: child aged 6-23 months for growth monitoring (under discussion)
14. Growth monitoring: child aged 24-59 months for growth monitoring
15. Home visit : (domestic waste disposal ; latrine ; insecticide treated bed net available; access to clean water ; family planning use – incl. condom, vaccination status ; nutritional status children)
16. Voluntary counseling and testing for HIV
17. Prevention of mother to child transmission of HIV : HIV+ pregnant woman put under ARV treatment protocol
18. Prevention of mother to child transmission of HIV: child born from HIV+ mother put under ARV treatment protocol
19. Acid fast bacilli positive pulmonary tuberculosis patient diagnosed
20. Acid fast bacilli positive pulmonary tuberculosis patient treated and cured
21. HAT: newly diagnosed patient
22. HAT: patient treated and cured.

[44] According to the 2010 Global Burden of Disease studies, for the first ten conditions that cause the highest burden of disease; Democratic of Congo ranks the worst (15th ranking) for eight conditions among its comparator countries. These conditions are HIV/AIDS, Malaria, Diarrheal diseases, Lower respiratory tract infections, Protein energy malnutrition, Road injuries, Congenital anomalies and Meningitis.

10. **CPA- Complementary Package of Activities at the first level referral hospital consist of 24 services and include (minor revisions might be done):**

1. Outpatient consultation of a referred patient seen by a medical doctor
2. Admission day
3. Admission day – indigent (fee exemption up to 10% of volume)
4. Major Surgery (defined list)
5. Major Surgery (defined list: fee exemption up to 10% of volume)
6. Minor Surgery
7. Minor Surgery (fee exemption up to 10% of volume)
8. Blood transfusion (voluntary)
9. Institutional delivery - normal
10. Caesarean section
11. Institutional delivery – complicated
12. Antenatal consultation: new and standard visit
13. Voluntary counseling and testing for HIV
14. Prevention of mother to child transmission of HIV :HIV+ pregnant client put under anti-retroviral protocol
15. Prevention of mother to child transmission of HIV : newborn from an HIV+ mother put under anti-retroviral protocol
16. Treatment: new HIV+ clients put under ARV treatment
17. Client under anti-retroviral treatment seen six-monthly
18. Acid fast bacilli positive pulmonary tuberculosis patient diagnosed
19. Acid fast bacilli positive pulmonary tuberculosis patient treated and cured
20. Family planning: new and recurrent user of modern family planning method (pills and injection)
21. Family planning: new user of an intrauterine device or implant
22. Family planning: bilateral tuba ligation and vasectomy
23. HAT: newly diagnosed patient
24. HAT: patient treated and cured.

11. **A quantified quality checklist will be designed for each level of the service package incorporating lessons learned from PARSS and taking into account international best practice**. For each level, for health centers and hospitals, a quantified quality checklist will be designed. The checklists used in the current project will provide the foundation for these checklists. They will also incorporate experience from other contexts on process oriented quality of care measures with increased weights given to process measures. They will also introduce measures related to rational prescribing of generic drugs, essential medicines management and tracer medicines. Vignettes to test knowledge of providers on common conditions will also be introduced in the quality checklists. An example of this checklist for use at the health center level is available in annex 9.

12. **Intense results monitoring is the hallmark of the PBF approach; the results monitoring consists of a mix of ex-ante and ex-post verifications**. Quarterly performance payments will be based on: (i) ex-ante verification of quantity (EUP-PBF) and quality of health services (ECZS) at health centers; (ii) ex-ante verification of quantity (EUP-PBF) and quality of health services (DPS with select medical specialists) at hospitals; (iii) ex-ante verification by a

third party (ACVE) for DEP; CT-FBR; HMIS and EUP-PBF's; (iv) ex-ante verification by the DPS for the ECZS; and (v) ex-ante verification by the ACVE for the certified drug distributors. Ex-post verification, that is, verification after payment has been made, will be carried out by the independent third party (ACVE) – through a protocol using random sampling- on the quality of services at health centers and hospitals; and the performance frameworks of the ECZS.

13. **PBF output budget, costing and PBF approach.** A preliminary costing of the variable costs (excluding HR) of the basic and complementary package of health services has been done. A Human resource study was conducted during project preparation which will inform the project on the actual take home income, expense patterns of health workers and identify health workers' behaviors to address poor motivation/remuneration. These costing and HR study will help to inform the fee setting and the overall PBF budget. Based on an examination of similar contexts, taking into account the salary structure, fiscal space constraints and sustainability, and financing fee-exemptions for the poorest of the poor, it is estimated that an output budget of at the least US$3 per capita per year would be necessary.

a. The PBF approach is a fee-for-service provider payment method with additional 25 percent maximum earnings based on the quality measure.
b. Geographic equity adjustments are also planned during project implementation, these allow for the possibility to ring-fence provincial output budgets, as well as health center and hospital output budgets (2/3 for health centers versus 1/3 for hospitals) and to set differential fees based on rural hardship criteria.

14. **Further work on the detailed design and initial implementation was done during project preparation,** which 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: Improve Governance, Purchasing and Coaching and Strengthen Health Administration Directorates and Services through Performance Based Financing. Total costs including contingencies US$65.2 million equivalent of which US$63.7 million from IDA and US$1.5 million from HRITF.

15. **Component 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 (DPS) accountable for services through incentive mechanisms; (iii) internal performance framework contracts with the CT-FBR vis-à-vis their roles in the health system and implementation of PBF; and (iv) performance frameworks with the DEP/MOPH, who will coordinate key aspects of the project in close collaboration with the various technical units with the MOPH.

16. **This component will also finance activities related to verification and counter-verification of the DPS, EUPs, ECZSs, HMIS, regional drug stores and quality results of health facilities**. An external evaluation agency (Agence de Contre-Vérification Externe - ACVE) will assess the performance of the EUP, DPS, SNIS department/MOPH and the regional drug stores.

17. **Contract management and verification: an innovative purchasing arrangement will be created covering each of the four provinces.** An innovative strategy will be followed to build local capacity in PBF contract management and verification functions as described above through the EUPs. These local organizations will be created bottom-up drawing from existing local human resources and experts that have developed over the past 14 years of implementation of PBF projects in DRC. 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.

18. **Performance frameworks will also be introduced at all levels of the health system** and will hold provincial health directorates (DPS – *division provincial de santé)*, health zone teams (ECZS- *équipe cadre de zone de santé*) and regional drug distribution outlets (CDR – *central de distribution regional*) accountable for their tasks through strong incentive mechanisms. Internal performance frameworks 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. The DPS contracts are the accumulation of intense inter-partner collaboration and are a harmonized approach to engaging the provincial health administration through a results-based financing approach.[45]

19. **The DEP/MOPH will coordinate key aspects of the project in close collaboration with the various technical units within the MOPH most notably with the RBF technical support cell (CT-FBR)**. The DEP and the CT-FBR will be strengthened with 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 (SNIS) will have the responsibility to maintain the PBF web-enabled application database. The DEP, CT-FBR and the health management information system department (SNIS) will be under performance contracts.

20. **Verification of the DEP, CT-FBR, HMIS, DPSs, EUPs, and CDR performance will occur each quarter by the ACVE** in collaboration with the internal monitoring unit of the MOPH. The verified data will be benchmarked on a publicly available website. The ACVE will also counter-verify, using a defined protocol, the quality performance of hospitals and health centers.

[45] The contracts are called 'contract unique', and they will be written between the Secretary General of the MOPH and each of the 26 new provincial health teams. Partners are aligning and coordinating with the MOPH who has a high degree of ownership towards this DPS contract as it allows them to do three things: (i) provide structural financing to DPSs of about US$0.4 per capita per year; (ii) implement the health administrative reforms that will create 15 new DPSs in addition to the existing 11 DPSs and (iii) will decrease significantly the vertical and horizontal fragmentation while strengthening the stewardship functions. The PBF portal http://www.fbrsanterdc.cd/ will benchmark publicly the DPS performance which will contribute to enhancing governance.

Component 3: Strengthen Health Sector Performance – Financing, Health Policy, and Surveillance Capacities. Total costs including contingencies US$41.3 million equivalent.

21. **Component 3 is supporting components 1 and 2; it will focus on institutional capacity building and technical support in various dimensions of health system strengthening that will directly reinforce the investments of component 1**. Component 1 will support Performance Based Financing approaches, the setup of explicit benefit packages, provincial institutional arrangements including a purchaser - provider split, data driven health system management, enhanced transparency and governance that will be positive examples for the policy dialogue at provincial and national level. Component 3 investments will reinforce the reform process with a special 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 thus allowing 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 in an attempt to address inequities in the system. The project aims at having a catalytic role on health system reform through the complementarities of the components.

22. **This component would be supported by IDA resources**. The aim of the component is the development of a medium term strategic vision that would lead to better policy making, harmonized efforts and better allocation of resources in the health sector. This strategic vision would include a clear direction on decentralization, the Universal Health Coverage (UHC) agenda, health financing reform and human resource management reform.

23. **Accordingly, the component 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 Directorate, the Health Management Information System (HMIS) Unit, the Performance Based Financing Technical Unit (CT-FBR), the Human Resources Direction, the future directorates 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 support to the DPSs.

Sub-component 3.1: Support to Improve Health Financing Reform and System Decentralization - Total costs including contingencies US$4.4 million.

24. **This component will support the Government in its reform process to strengthen the health system with a focus on:** (i) a better planning and budgeting processes at national and decentralized levels through the use of Mid Term Expenditure Frameworks (MTEFs), (ii) the policy dialogue and design of the national health financing and the Universal Health Coverage (UHC) strategies, (iii) the strengthening of the MOPH leadership on health sector investments both financed by national, provincial or external sources, and (iv) the institutional support to key entities of the MOHP.

25. **In 2013, the Government initiated the design of both a new health financing strategy and a Universal Health Coverage Law (UHC)**. The project will support the national dialogue on health financing strategy and 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, health financing reform and the UHC roadmap, (iii) high level consultations with Government and parliament members, as well as, external partners, and (iv) commissioning studies to support the policy dialogue.

26. **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 DPSs from 11 to 26. The managers of the 26 DPSs have been recruited through a competitive and transparent process. The reforms include alignment by all partners to fund these DPSs through a common contract. The DPS contracts will provide funding to the DPSs by the different partners. This is innovative in that this would be the first time all partners would provide funding through a common contract to the DPSs in an attempt to avoid fragmentation of funding of the current system. [46]

27. **This sub-component will fully cover the provinces of Equateur and Bandundu. This is a result of a close partnership with the Global Fund and UNICEF.** This alignment is necessary in order to increase efficiencies and to achieve better results from the resources development partners are devoting to the health sector in the DRC. A consensus among the partners has been achieved to support the concept of a '*contrat unique*' (single contract). This will lead to a single contract with the provincial health directorate and lead to one single performance framework (with some room for provincial adjustments) and one single monitoring and evaluation mechanism. The Government and development partners are currently discussing the amount of financing required, approximately US$0.15 per capita per year, this is a significant improvement from the current system. A recent survey conducted by the DEP and the WB highlighted the level of fragmentation at the provincial level; an average of 8 different contracts are signed, resulting in a highly inefficient and ineffective system. This '*contrat unique*' will be the start of a harmonized contracting system at the decentralized provincial level and will be fully integrated with the PBF system at the national, health zone and health facility levels.

28. **There is a lack of clarity as to how and when the Government is willing to initiate decentralization of health workforce management and payment**. When decentralization reform is initiated, the project will support the policy dialogue on human resource management reform at the national and provincial levels. This sub-component will also reinforce the quality of health service delivery by improving the quality of care provided by health workers.

[46] The contracts are called 'contract unique', and they will be written between the Secretary General of the MOPH and each of the 26 new provincial health teams. Partners are aligning and coordinating with the MOPH who has a high degree of ownership towards this DPS contract as it allows them to do three things: (i) provide structural financing to DPSs of about US$0.4 per capita per year; (ii) implement the health administrative reforms that will create 15 new DPSs in addition to the existing 11 DPSs and (iii) will decrease significantly the vertical and horizontal fragmentation while strengthening the stewardship functions. The PBF portal http://www.fbrsanterdc.cd/ will benchmark publicly the DPS performance which will contribute to enhancing governance.

29. **Potential quality of care activities (QoC) to be supported under this sub-component could include:** (i) development of a National QoC Improvement Strategy and operational plan; (ii) dissemination of clinical practice guidelines and protocols; (iii) development and scaling up of quality assurance/continuous quality improvement modalities; and (iv) establishment and strengthening of professional associations (doctors, nurses, lab technicians) to self-regulate and improve QoC among its members etc. These QoC activities will complement the pay-for-quality approach of the PBF grants under Component 1 and 2. These activities will be prepared in collaboration with the other key partners.

30. **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 counterpart endorsement and partnership, 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) the strengthening of the existing capacity for research, and analytical work, as well as the strengthening of national institutions such as the statistic bureau, the planning department and other Government entities that will be developed and executed during the project period.

Sub-component 3.2: Health Sector Monitoring and Evaluation (M&E) Strengthening and Project Management. Total cost including contingencies US$16.9 million.

31. **The limited capacity of the DRC's health information system results in inadequate monitoring and evaluation (M&E) of health sector performance and consequently an inability to use data for decision making**. Since 2013, the Government with support of external partners has 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.

32. **The project will support the HMIS Unit and CT-FBR in the rollout of the DHIS2 and PBF IT system**. It will support the interoperability of web based IT systems and strengthen the HMIS unit for the development of an integrated e-health architecture. This sub-component is fully aligned with the HD Systems Strengthening Project (P145965) and will complement its work in this area.

33. The combination of DHIS2, PBF IT systems and an open data initiative is part of the effort 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 provide a powerful tool to employ results monitoring and encourage better governance. Introducing an ICT sub-component to the project to build the capacity of the MOPH

and 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, including tasks related to epidemic disease surveillance such as Ebola and other highly infectious diseases.

Sub-component 3.3: Ebola Preparedness Plan US$20 million

112. **Based on the approaches developed in the emergency responses in Liberia, Sierra Leone and Guinea, this sub-component will provide essential equipment, supplies, drugs and vehicles that are critical in ensuring that the country is prepared for an EVD outbreak in DRC.** Additional community level activities and a nationwide protocol will be carried out as described in Annex 11. It is expected that the equipment and supplies procured under the project will contribute to the overall level of emergency response preparedness in DRC, and be useful for communicable disease outbreaks other than EVD. Close collaboration with other UN agencies such as WHO, UNICEF and some international NGOs such as MSF will take place. A Memorandum of Understanding with these organizations to procure some of the goods and services will be considered.

33. **An Impact Evaluation (IE) financed by a separate (Bank executed TF) HRITF will be embedded in the phased scaling-up of PBF:** The HRITF will fund an Impact Evaluation (US$2.5 million), which will naturally fit into the phased scaling-up of PBF. The Impact Evaluation (see Annex 8) has a specific focus on the role of PBF, in combination with various demand-side interventions such as household visits for improved health-seeking behavior and targeting of the poor for improved financial access to a package of essential health services. The Impact Evaluation design was finalized and validated during the project appraisal mission in October 2014.

ANNEX 3: IMPLEMENTATION ARRANGEMENTS
DEMOCRATIC REPUBLIC OF CONGO

Health System Strengthening Project for Better Maternal and Child Health Results Project (PDSS) (P147555)

1. **The health system in the Democratic Republic of Congo comprises a health pyramid with 3 levels**: (i) a national central level, consisting of the General Secretariat with central departments and specialized programs, (ii) an intermediate provincial level consisting of the Provincial Health Directorate (DPS) and (iii) an operational level consisting of the health area, which includes the structures that provide health care health (hospitals for the Complementary Health Packages and health centers for the Basic Health Package) and the community organized in a community Health Committee (COGE) and in the health area Development Committee (CODESA).

2. **As part of the health system reform initiated in 2006 through the health system strengthening strategy (SRSS, 2006 and 2010)**, significant actions have been initiated since 2010 by the Government, and these include the revision of the organizational structure of the Ministry of Public Health which led to a reduction in the number of central offices from 13 to 7, and the separation between inspection functions and duties of health administration. Furthermore, DRC was divided into 26 provinces (from the previous 11) each with a Provincial Health Directorate (DPS – *Division Provincial de Santé).* Unlike the previous configuration, the intermediate level (provincial level) will be a single level with the disappearance of the health districts. For parts of the country, some satellite offices will be kept to ensure close supervision of the health zones. The DPS will become decentralized structures of provincial power with a head of division supported by six offices.

3. **At its heart, the central level will set up some specialized cells that have been and are attached to the Secretary General of Health**. These are the Management Support Unit (CAG / Ministry of Public Health-MOPH), which are the anchor for several projects (EU- FED, GF, GAVI etc.), the Technical Unit for Performance-Based Financing (CT-FBR) that receives technical and financial support from MSH/USAID and Cordaid, the Monitoring and Evaluation Cell (CS&E) which deals with the monitoring of programs and projects under the MOPH. In addition to these units at the central level, there are specialized directorates such as PNTS the PNLTHA, EPI, PNLS, the PNLP, etc.

4. The PDSS will be embedded in the Ministry of Public Health and will be coordinated and managed by the DEP. In this project, normative responsibility and control reside with the Secretary General (SG) for Health. The project will be anchored within the MOPH; this is different from the institutional arrangement in the current PARSS which was set-up with a project implementation unit (PIU). The project will introduce internal performance contracts for central MOPH departments. For instance the DEP, the CT-FBR and the HMIS Division will all be under performance contracts. These contracts will be set up based on the results which will be defined in conjunction with the national health development plan (PNDS). This approach guarantees the application of the project standards and procedures with its strategies. It provides

support and advice, compliance monitoring and monitoring of contractual commitments by the contracted departments.

5. **The Planning and Evaluation directorate of the MOPH (DEP-Health) will coordinate and implement the project and will also function as the fund holder**. In PARSS, the DEP is currently working on several issues related to study and planning for the health system as part of its mission and is leading the reform of the DPS. The DEP will coordinate and manage the project from the central level. It will be supported by experts with a strong knowledge of management, including health systems management, health financing as well as expertise in Bank fiduciary procedures. The DEP will sign a performance contract with the Secretary General based on its mission and certain objectively verifiable processes and outputs. The DEP will carry out the coordination and monitoring of project contracts and manage the Public Utilities (EUPs) that will be set-up in the provinces and which will function as the PBF contract management and verification agents.

6. **The Health Management Information System (HMIS-SNIS) Directorate will be strengthened in its role as health information manager**. In the last several months, the HMIS Directorate has received technical and financial support from various partners for the implementation of the DHIS-2 – system which is replacing the GESIS. In addition, the DRC has developed a PBF web-enabled application based on OpenRBF (http://www.fbrsanterdc.cd/) to improve governance in this area. Under the PDSS, the HMIS Directorate will be strengthened to enable effective management of communication tools. The HMIS Directorate will sign a performance contract with the Secretary General of Health to manage the web portal and the DHIS-2.

7. **The Results-Based Financing Technical Support Cell (CT-FBR/ MOPH) will continue to play a supporting role in the technical implementation of performance-based financing**. The CT-FBR was established in 2011 and is attached to the office of the Secretary General of Health. This unit's mission is to support the implementation of Results Based Financing in DRC. Under this project, the CT-FBR will be supported by PBF experts to strengthen their technical and monitoring capacity. The technical unit will be under a performance contract with the Secretary General of Health.

8. **The Monitoring and Evaluation Cell of the MOPH will be responsible for assessing the performance of the directorates and units/directions that are under the SG**. This cell is placed under the responsibility of the SG and will work jointly with a third party agency to monitor and evaluate structures under performance contracts by this project. This unit will report directly on the results produced by each contracted structure.

9. **The extended team will be a specialized technical group comprised of PBF-experts from different agencies which will constitute a horizontal coordination mechanism and will provide advisory support for the implementation of the project**. These experts come from different institutions of the Ministry and local and international organizations that have experience with PBF.

10. **The Provincial Health Directorate (DPS) is the main lever of the health pyramid for technical support areas in the provision and regulation of health services**. As part of the implementation of the PBF, the DPS will sign a single integrated performance contract ("*contrat unique*") with the provincial Ministry of Health or the Secretary General MOPH (to be determined) that will be evaluated quarterly by the monitoring and evaluation cell of the MOPH in collaboration with an external verification agency. The DPS will have among other functions: (i) regular supervisory visits to their health zones, (ii) organize and participate - in collaboration with clinicians specialized in quality of care- quarterly quality assessments in the first level referral hospitals (HGR); and (iii) provide the secretariat of the provincial PBF steering committee.

11. **The provincial PBF steering committee is a sub-committee of the existing financing and contracting committee (CPP-SS) to strengthen governance and institutional fit.** A fundamental institutional element of the PBF approach in DRC is the provincial PBF steering committee which ensures good governance of the approach by the province. The quarterly meeting of the provincial PBF steering is a meeting in which the consolidated quarterly PBF Health Zone invoices are approved (or changed if necessary). This committee will also discuss issues related to decentralized management of PBF. This committee will have a contract with the head of the provincial health department.

12. **Public Utilities (EUPs) will be created by the project following the model of the EUPs in the Kivus.** In South Kivu, the agency (*Agence d'Achat des Performances*) is a not-for-profit association which has a mandate to improve the quantity and quality of health services, ensure broad based access, and promote community participation. The institution has managed performance funding since 2006, serving as the fiduciary agency for different partners (e.g. Cordaid, European Union, UNICEF, UNDP, Dutch Cooperation and GAVI). In North Kivu, the purchasing agency (*Fonds d'Achat des Services de Santé*) is also an autonomous public service institution established with the mission of "managing funds of different partners and the Government for interventions to improve access to quality health services." The agency currently has a devolution convention from MoF to manage European Union funds and implement the performance based approach.

13. **The EUPs are expected to be much more cost- efficient than international NGOs.** This model of EUPs will be created in the provinces targeted by the project. They will be coached by the DEP/MOPH and will take care of the following activities: (i) contracting: identifying health facilities to contract on the basis of the provincial health map and existing health facility population norms; (ii) negotiating management plans and performance contracts with health facilities for PMA and PCA services; (iii) provide training on PBF for health service providers collaboration with the health zone management teams; (iv) verify the quantity of services provided by health facilities; (v) provide coaching to health facilities in collaboration with the health zone health teams; (vi) participate in the evaluation of the performance of health zone management teams in collaboration with the provincial health departments; (vii) select and coach local grassroots organizations for carrying out community client satisfaction surveys; (viii) enter information about the quantity and the quality of services in the web-enabled application; (ix) monitor the performance of EUP- antennas that are placed under the supervision of EUP; and (x) disseminate the results from community surveys.

14. **Given the limited geographical access in some of the provinces such as Equateur and Bandundu, EUP satellites will be created to ensure efficient and effective coverage for the verification function**. To make possible efficient and effective implementation of quantity verification and the organization of community client satisfaction surveys, the EUPs will establish antennas in inaccessible or difficult to access areas. These antennas will rely on the management and supervision of the main EUP, which will be placed in the capitals of the current provinces to participate in sectoral dialogue and dissemination of PBF results.

15. **The health zone management teams (ECZS –*Equipe Cadre de Zone de Santé)* will have an important role in the regulation of the quality of health facilities**. As part of the implementation of the PBF, the health zone team signs a performance contract with the EUP. The health zone health team will be responsible for: (i) conducting each quarter a quality of care assessment in each contracted health center using a quantified quality checklist; (ii) providing technical support (supervision, coaching, compliance etc.) to health facilities; (iii) strengthening the analysis and consolidation of the HMIS data and providing feedback on the quantity and quality of services of health facilities as well as support providers in the organization of services and the implementation of their management plans; and (iv) organizing monthly review meetings to discuss the quantity and quality indicator trends.

16. **Health facilities (general reference hospitals and health centers) are structures which provide care and defined services**. They represent the key institutions of the primary health set-up. Health facilities which are select public, private or faith-based institutions have as main tasks: (i) Provide a minimum package of activities (health centers) or a complementary package of activities (promotional, preventive, curative, rehabilitative and administrative) – (hospitals) as appropriate and following the standards dictated by the regulator; (ii) Strengthen the management of human, financial and material resources through a vision of autonomy and implement the recommendations that have been made during supervisory missions; (iii) Sign a performance contract with the EUP on basic list of selected services, (iv) Develop the management plan each quarter which reflects and discusses access of the population to quality health services; and (v) Develop internal procedures for allocating performance bonuses to staff using the indices tool and the individual performance evaluation tool.

17. **An external counter-verification agent (ACVE), contracted by the DEP/MOPH will carry out ex-ante verifications on central MOPH departments**, on DPS performance and on CDR performance, and will have a counter-verification function (ex-post, that is: after payment) for the performance of the health zone health teams, and the quality performance of health centers and hospitals.

18. **Community institutions will be involved in social mobilization and community verification to strengthen the voice of the population**. The community is involved in the following activities: (i) Participation in meetings of the Health Committee (COGE) and development committees of health areas (CODESA); (ii) Co-management and use of funds providing assistance to the health facility guided by the objectives and targets set out in the management plan; (ii) participate in discussions and negotiations with the manager of the health facility on the fee structures; (iii) through local grassroots organizations (GROs; ASLOs) that are contracted by the EUPs, contribute to the community client satisfaction surveys; (iv) use the

results of these community surveys to strengthen the voice of the people and improve user satisfaction.

FIGURE 1: INSTITUTIONAL ARRANGEMENTS

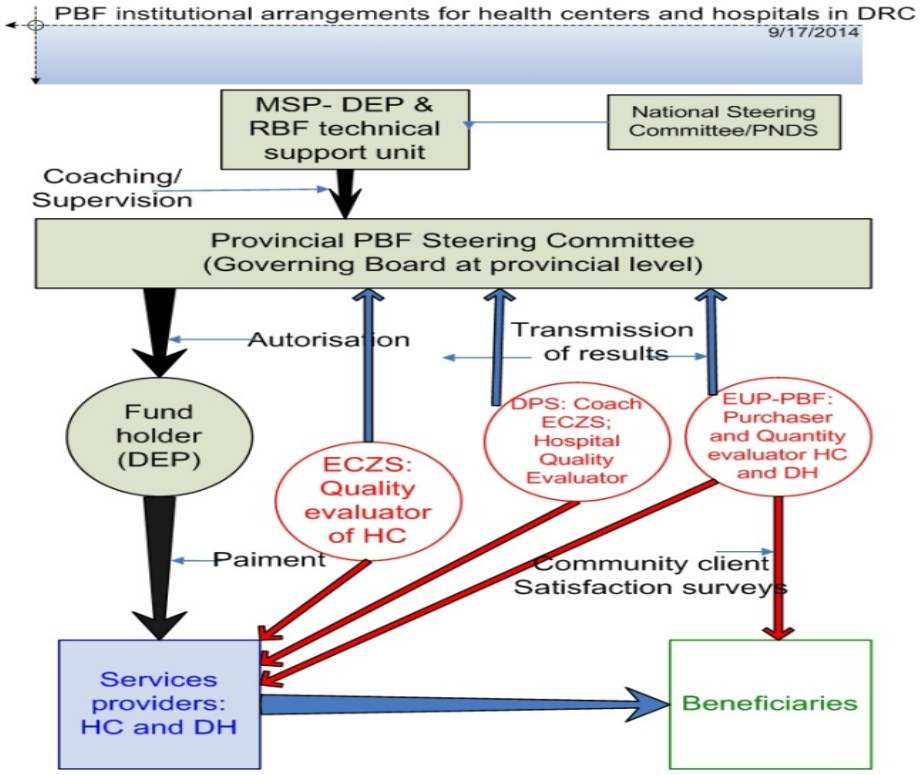


FIGURE 2: QUARTERLY CYCLE AT HEALTH FACILITIES

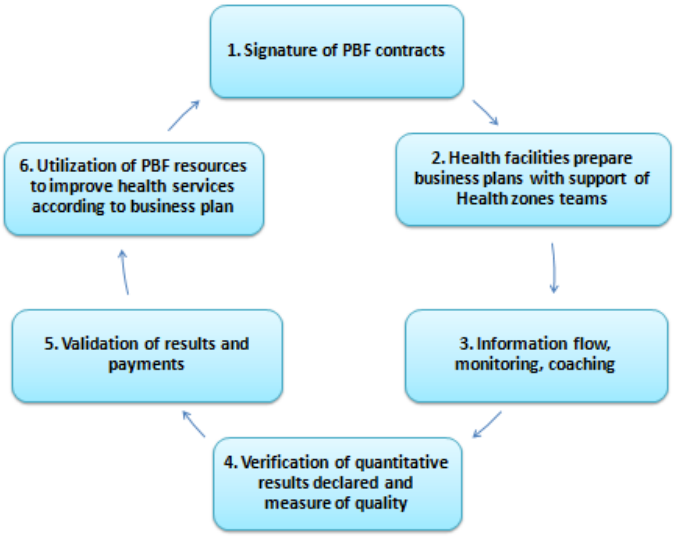
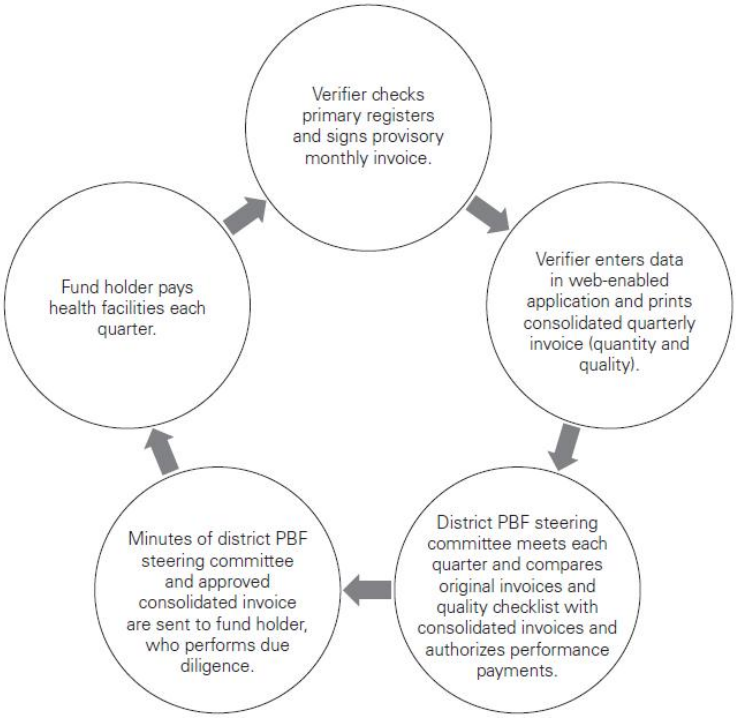


FIGURE 3: VERIFICATION CYCLE



19. **This project will also be implemented in close collaboration with UNICEF, Global Fund, and GAVI in the targeted areas**. UNICEF will not only contribute to the purchase of quality health outputs, but will also introduce Family Kits (both at the household and health facility level) as well as introduce and strengthen their community based interventions in the project targeted areas. The budgetary allocation at the community level through the purchase of a 'household visit as per protocol' through the PBF approach will be dovetailing with the family health kit intervention and it will strengthen the delivery and the monitoring of this intervention too. Collaboration with UNICEF will benefit from their large contingent of project staff (UNICEF has 510 staff in DRC – the largest UNICEF office in the world) to strengthen coaching at health facility levels. GAVI and the Global Fund will continue to pay for medicines (antimalarial; anti-TB; and HIV medicines, as well as vaccines), health results and health administration performance. In addition, GAVI is investing about US$53 million in support of the distribution of the drugs nationwide. Alignment is an important distinguishing/underlying feature of this project and is explained in detail in Annex 9.

Financial Management, Disbursements and Procurement

20. **In accordance with the Financial Management Manual issued in November 2005 as revised on March 2010, the financial management systems of CAGF/MOPH (Cellule d'Appui et de Gestion Financière du Ministère de la Santé Publique / Ministry of Public Health-MOPH) has been assessed to determine whether it is acceptable to the Bank with consideration for the country's post conflict situation.** To this end, the CAGF/MOPH must meet the following requirements: (i) assuring correctly and completely the recording of all transactions related to the project; (ii) facilitating the preparation of regular, timely, and reliable

financial statements; (iii) safeguarding the project's assets; and (iv) facilitating the implementation of external auditing diligences as required by the Bank. The arrangement also aims to facilitate the disbursements of the project's resources and to ensure their effective use while, to the extent possible, using the country's own financial management systems.

21. **The FM assessment of CAGF/MOPH revealed some weaknesses.** These include (a) lack of familiarity with IDA procedures for reporting, disbursement arrangements, and auditing; (b) lack of sufficiently qualified staff; (c) weaknesses in its financial reporting system, and (d) default of updating its management tools: accounting software, and manuals of accounting procedures and financial management. Furthermore, the external audit of CAGF/MOPH carried out in June 2013 revealed several weaknesses and deficiencies which justify the restructuring measures taken by Governmental authorities.

22. **In line with the FM assessment and the restructuring measures taken by Governmental authorities and in order to mitigate the fiduciary risks and enable CAGF/MOPH to carry out financial management activities, the following actions are required:** (i) The design of an appropriate internal control systems; (ii) the strengthening of the FM staffing arrangements currently in place through the recruitment of experienced staff ; (iii) the updating of the manual of financial and accounting procedures; (iv) the purchasing of an appropriate accounting software; (v) the establishment of a credible and effective Internal Audit function; (vi) the recruitment of an independent external auditor in compliance with acceptable Terms of Reference to IDA, (vii) the rolling out of a training plan which includes, inter-alia, training on IDA disbursement procedures, and training on IDA financial reporting arrangements.

23. **Based on this overall residual FM risk, the project will be supervised 3-4 times a year**. This will be done to ensure that project FM arrangements still operate well and funds are used for the intended purposes and in an efficient way. In addition, the project accounts will be audited bi-annually and reports submitted to IDA no later than 3 months after the end of each semester. Furthermore, Bank's supervision will devote specific attention to the financial management arrangements in place to support the project's implementation activities. Particularly, under the component 3, Bank's team will provide specific support to the Health Management Information System (HMIS) Unit for strengthening the health management information system. The same support will be provided to the Human Resources Direction, for the management of the process to its migration to direction of resource management (Direction des affaires financières - DAF).

Country PFM situation and Use of Country System

24. **The Country Financial Accountability Assessment (CFAA), the Public Expenditures Review (PER), and the Public Expenditure and Financial Accountability (PEFA) 2008 and 2012 have shown an unsatisfactory economic and financial control environment including weak budgeting preparation and control, financial reporting, external audit and human resources**. In-depth structural reforms are consequently required in the areas of economic governance, public expenditure management, financial sector and public enterprises to strengthen capacity in the public administration. To this end, with the support of the donor community, the Government of DRC has undertaken a series of Public Financial Management (PFM) reforms in budget preparation and execution, adhesion to Treasury forecasts, preparation

of regular budget execution reports, and simplification of the national budget classification system.

25. **The first critical step of these series of PFM reforms is the adoption in July 2011 of a new PFM Organic Law preceded by the adoption of a new Procurement code in December 2008. Additional decrees are being finalized to further clarify the Organic Law**. Yet, there is reason for cautious optimism; since it will take time for these reforms to yield substantial improvements in the management of public funds. As a result, the overall country fiduciary risk is still considered high. The repeated PEFA, concluded at the end of 2012, took stock of the areas of progress and revised the existing PFM strategy plan accordingly. The new project "Strengthening PFM and Accountability" (P145747), effective since May 2014, will strengthen the PFM system both at the central and some provinces levels. The outcomes of the Use of the Country national PFM Systems (UCS) assessment report which had been undertaken in April 2013 will be gradually implemented for the Bank-financed projects. Concerning internal and external audits, discussions will be held with the Government to organize the working environment of the Inspection Générale des Finances (IGF) and the Cour des comptes.

26. In that vein, the proposed project will be entrusted to the CAGF/MOPH in close collaboration with other technical units of the MOPH particularly the DEP/MOPH (Département d'Etude et de Planification/Ministry of Public Health), the PBF technical cell Cellule-Technique - Performance Based Financing (CT-PBF).

Risk Assessment and Mitigation Measures

27. **The Bank's principal concern is to ensure that project funds are used economically and efficiently for the intended purpose**. Assessment of the risks that the project funds will not be so used is an important part of the financial management assessment work. The risk features are determined over two elements: (i) the risk associated to the project as a whole (inherent risk), and (ii) the risk linked to a weak control environment of the project implementation (control risk). The content of these risks is described below.

Risk	Risk rating	Risk Mitigating Measures Incorporated into Project Design	Risk after mitigation measures	Conditions for effectiveness (Y/N)
INHERENT RISK	**H**		**H**	
Country level Poor governance and slow pace of implementation of PFM reforms that might hamper the overall PFM environment.	H	Some PFM reform programs are currently ongoing through IDA-financed projects Enhancing Governance Capacity (P104041), and Establishing Capacity for Core Public Management (P117382), in addition to the project "Strengthening	H	N

		PFM and Accountability" (P145747) effective since May 2014. These reforms will address the key new challenges the country is facing.		
Entity level Lack of coordination of involved stakeholders, limited capacity of the CAGF/MOPH in implementing World Bank-financed projects and political interference of the Ministry etc.	H	CAGF/MOPH will ensure the Project's financial management Follow-up the recruitment process of the financial management team at the CAGF/MOPH level in order to ensure that the recruited consultants have adequately high experience in financial management. Establish a manual of procedures, as part of the PIM which clarifies the roles and responsibilities of the various stakeholders. The PIM will provide define implementation procedures in line with adequate fiduciary requirements. Provide Technical Assistance to the CAGF/MOPH by rolling out the fiduciary training plan which aims at strengthening the capacity of this entity's fiduciary staff and establishment of a credible internal audit unit reporting to the project steering committee.	H	N
Project level Weak capacity, lack of	S	The PIM will improve involved stakeholders'	S	N

availability of different stakeholders involved in other tasks within their usual duties and risk of fraud and corruption.		capacity.		
CONTROL RISK	**S**		**S**	
Budgeting Weak budgetary execution and control inducing budgetary overspending or the inefficient use of funds.	S	The PIM will pave the way for the Project activities planning and the related budgets preparation, as well as the collection of information from involved stakeholders.	S	N
Accounting Lack of reliable accounting system and low knowledge of the financial management procedures of the World Bank.	S	Purchase appropriate accounting software, customized to generate the financial reports of the project. Implement appropriate training sessions based on agreed accounting procedures.	S	N
Internal Controls and Internal Audit Weak compliance with FM procedures manual and of circumventing internal control systems	S	(i) Regular internal audit missions (technical and financial audit) will be conducted during the project implementation with a focus on fraud and corruption risk; (ii) Recruitment of an internal audit consultant who will contribute to project's internal control environment strengthening; and (iii) establish a channel of collaboration between IGF and the project's internal audit unit to agree on project's risk mapping and work program.	S	N

Funds Flow Risk of misuse of funds and use of funds to pay non eligible purposes Risk of misused and inefficient use of funds. Weak capacity in the disbursement procedures of the World Bank which could affect the disbursement rate.	H	Organize frequent controls of each actor in order to help prevent and mitigate the risk of diversion of funds. Payment requests will be approved by the Coordinator and the Financial Manager prior to disbursement of funds. Require the future FM to ensure monthly submission of the withdrawal application.	S	N
Financial Reporting Delay and difficulties in the submission of acceptable IFRs to the World Bank due to weak capacity of the FM team and to the number of stakeholders involved in the project.	S	The Project's accounting software will facilitate the IFRs preparation Agreement on the format and content of the Interim Financial Report which will include the project specifics.	S	N
External Auditing External audit arrangements are not defined and lack of capacity of public institutions of control to assure the external audit of the project	S	Recruit an independent auditor based on TORs acceptable to IDA. DRC's Supreme Audit Institution (Cour des Comptes) should be involved in the selection process.	S	N
Overall FM risk	**H**		**H**	

The overall risk rating at preparation was High.

Strengths and Weaknesses

28. **The main strengths are: the existence of a Project Preparation Advance request which will finance** (i) the recruitment of experienced FM staff (ii) the setup of relevant accounting software, (iii) and the updating of the project implementation manual.

Financial Management Action Plan to reinforce the control environment

Issue	Remedial action recommended	Responsible entity	Completion	Effectiveness conditions
Staffing	Recruitment of the Financial Management team comprising (i) a qualified and experienced Financial Manager; and (ii) an experienced Accountant.	CAGF/MOPH	By Effectiveness	N
Information system accounting software	Installation of accounting software acceptable to the World Bank and establishment of an accounting system acceptable to World Bank.	CAGF/MOPH	Three months after effectiveness	N
Financial reporting: IFR	Format, content, and frequency of the IFR were discussed during project negotiation	CAGF/MOPH	By Effectiveness	N
Administrative, Accounting and Financial Manual of procedures	Update a manual of procedures administrative, financial and accounting (as part of the PIM) that also includes detailed procedures describing the system to pay recurrent expenditure with specific sections on anti-corruption aspects.	CAGF/MOPH	By Effectiveness	N
Internal auditing	Recruitment of an internal audit consultant who will contribute to the project internal control environment strengthening.	CAGF/MOPH	By Effectiveness	N
External financial auditing	Recruitment of the external auditor acceptable to IDA	CAGF/MOPH	Six months after effectiveness	N

29. **Governance and anticorruption considerations**. The country political situation has weakened the governance and corruption environment. In the context of the project, the following governance and anti-corruption measures will contribute to enhance transparency and accountability during the project implementation: (i) an effective implementation of the fiduciary mitigation measures should contribute to strengthen the control environment, (ii) ensure an appropriate representation and oversight of the Steering Committee involving key actors, (iii) guarantee transparency in the implementation of Project's activities and ensure the involvement of the stakeholders and public during the project implementation, (iv) the TOR of both the

internal audit unit and external auditor will include a specific chapter on corruption auditing, (v) the FM manual of procedures will include anti-corruption measures with a specific safety mechanism that will enable individual persons and NGOs to denounce abuses or irregularities, and (vi) finally, an Anti-corruption action plan will be prepared in addition to the robust FM arrangements designed to mitigate the fiduciary risks.

30. **Staffing and Training**: The CAGF/MOPH will retain staffing resources that are adequate for the level of project operations and activities and are sufficient to maintain accounting records relating to project financed transactions, and to prepare the project's financial reports. The FM function will be carried out by a team composed of (i) a qualified and experienced FM expert in charge of the supervision of all FM activities of the project; (ii) an experienced Accountant. This staff will be recruited through a competitive process in compliance with Bank's rules and the ministerial decree No 1250/CAB/MIN/SP/015/CJ/2014 on June 10, 2014 related to the "establishment of the Committee for selection of the staffs of CAG/MSP, CGPMP/MSP and Internal audit function of Ministry of Public Health". The team will have the overall FM responsibility over budgeting, accounting, reporting, disbursement, internal control, and auditing. The CAGF/MOPH accounting staff will have its capacity reinforced over the project implementation vis-à-vis the rolling out of the training plan that includes training on IDA disbursement procedures, and training on IDA financial reporting arrangements, among others.

31. **Budgeting**: The CAGF/MOPH in close collaboration with other technical units of the MOPH will prepare annual work plan and budget for implementing project activities taking into account the project's objectives. The work plan and budgets will identify the activities to be undertaken and the role of respective parties in implementation. Annual work plans and the budgets will be consolidated into a single document by the CAGF/MOPH with the support of the FM team, which will be submitted to the World Bank for no objection no later than November 30 of each year proceeding the year the work plan should be implemented. The consolidation will be done after the CAGF/MOPH ensures, through other technical units of the MOPH that the plan and budget meet the project objectives.

32. **Accounting Policies and Procedures**: The PIM will detail and document the project accounting, policies and procedures as well as the responsibilities of all stakeholders involved. A "multi-projects" and "multi-sites" accounting software will be purchased and customized to facilitate processing of financial information and to prepare interim quarterly financial statements as well as annual financial statements. FM staff will also be trained to ensure optimal use of the software application. Detailed FM documentation will be maintained in the Project files for the implementing entities.

33. **Internal Control and Internal Auditing:** CAGF/MOPH and DEP will ensure that staffing arrangements in place are sufficient to ensure adequate internal controls, preparation, approval and recording of transactions as well as segregation of duties. Internal control procedures will be detailed in the PIM. An internal auditor will be recruited to maintain a sound control environment that will be described in the PIM. In line with the DRC Use of Country System (UCS) Report to fully rely on Inspection Générale des Finances (IGF) for project's internal audit, the project's internal control system could be strengthened by establishing a

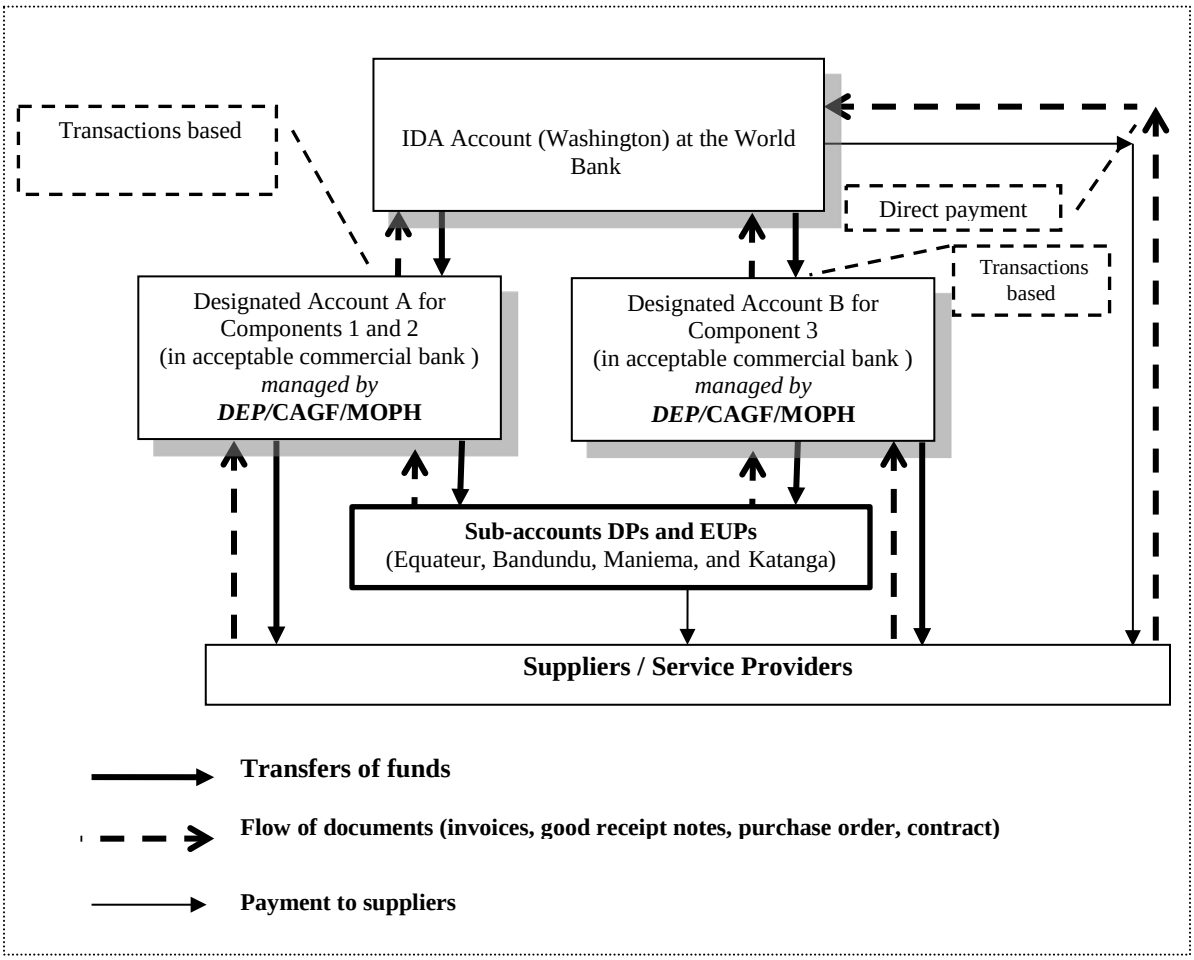
channel of collaboration between IGF and the project's internal audit unit to agree on project's risk mapping and work program.

34. **Funds Flow and Disbursement Arrangements**: Two Designated Accounts (DA) will be opened in a commercial bank on terms and conditions acceptable to IDA under the fiduciary responsibility of the CAGF/MOPH and overall oversight by the DEP. A first pooled Designated Account (DA.A) will be used to comingle proceeds of the IDA Financing with the proceeds of the HRITF and to jointly finance eligible expenditures in components 1 and 2 (PBF scheme) of the Project in the pro-rata share of their contribution to cost of this component. A second segregated Designated Account (DA.B) will be used to finance eligible expenditures in component 3 of the Project. These DAs will be managed according to the disbursement procedures described in the PIM and the Disbursement Letter (DL) for the Project. The ceiling of the account will be specified in the DL estimated to be the equivalent of four months of project cash needs and will take into account the Project's disbursement capacity. This Designated Account will be used to finance all eligible project expenditures under the different components. Payments will be made in accordance with the provisions of the manual of procedures (i.e. two authorized signatures will be required for any payment). CAGF/MOPH will open sub accounts at the provincial level. These sub-accounts will be used at decentralized level to pay suppliers and consultants selected through acceptable Bank procurement procedures. Replenishment of this account will be done at least once a month by the project upon submission of acceptable supporting documents. Payments from the sub-accounts will be subject to acceptable arrangements for the Bank. The Designated Account will be replenished against withdrawal applications supported by Statements of Expenditures (SOE) and other documents evidencing eligible expenditures as specified in the Disbursement Letter. All supporting documents should be retained at the project and readily accessible for review by periodic IDA implementation support missions and external auditors.

Disbursement arrangements:

35. **Disbursement method:** Upon Credit/Grant effectiveness, transaction-based disbursements will be used during the first year of the project implementation. Thereafter, the option to disburse against submission of quarterly unaudited Interim Financial Report (also known as the Report-based disbursements) could be considered subject to the quality and timeliness of the IFRs submitted to the Bank and the overall financial management performance as assessed in due course. In the case of the use of the report-based disbursement, the DA ceiling will be equal to the cash forecast for two quarters as provided in the quarterly unaudited Interim Financial Report. The option of disbursing the funds through direct payments to suppliers/contractors for eligible expenditures will also be available for payments equivalent to twenty percent (20%) or more of the DA ceiling. Another acceptable method of withdrawing proceeds from the IDA grant is the special commitment method whereby IDA may pay amounts to a third party for eligible expenditures to be paid by the Recipient under an irrevocable Letter of Credit (LC).

Diagram of the Flow of Funds



36. **Disbursement of Funds to other Service Providers and Suppliers**: The DEP/CAGF/MOPH will make disbursements to service providers and suppliers of goods and services in accordance with the payment modalities, as specified in the respective contracts/conventions as well as the procedures described in the project's Administrative, Accounting, and Financial Manual. In addition to these supporting documents, the Project will consider the findings of the internal audit unit while approving the payments. The DEP/CAGF/MOPH, with the support of its internal audit unit, will reserve the right to verify the expenditures ex-post, and refunds might be requested for non-respect of contractual clauses. Misappropriated activities could result in the suspension of financing for a given entity.

37. Disbursements by category: The table below sets out the expenditure categories to be financed out of the IDA Credit and Grant. This table takes into account the prevailing Country Financing parameter in setting out the financing levels. In accordance with Bank standard procurement requirements, contracts will continue to be approved "all taxes included" for local expenditures.

Category	Amount of the Credit Allocated (expressed in SDR)	Percentage of Expenditures to be Financed by the Credit (inclusive of Taxes)	Amount of the Grant Allocated (expressed in SDR)]	Percentage of Expenditures to be Financed by the Grant (inclusive of Taxes)
(1) PBF Grants for Parts 1 and 2 of the Project	75,600,000	59%	45,700,000	36%
(2) Goods non-consulting services, consultants' services, Operational Costs, Training and Workshops for the Project (except for Part 3(a)(iv) of the Project)	9,900,000	100%	0	0%
(3) Goods non-consulting services, consultants' services, Operational Costs, Training and Workshops for the Recipient's Ebola preparedness plan under Part 3(a)(iv) of the Project	0	0%	13,500,000	100%
(4) Refund of Preparation Advance	2,500,000	Amount payable pursuant to Section 2.07 of the General Conditions	1,700,000	Amount payable pursuant to Section 2.07 of the General Conditions
TOTAL AMOUNT	88,000,000		60,900,000	

38. **Financial Reporting and Monitoring**: CAGF/MOPH in close collaboration with other technical units of the MOPH will have to prepare quarterly IFR and annual Financial Statement composed of the following: (i) Financial reports (sources and uses of funds by funding source and uses of funds by activities of the project), (ii) Projected expenditures and cash forecast for the next quarter (four months), and (iii) Bank reconciliation statement for the Designated

Accounts and the Transactions Accounts showing the cash balance available at end of the semester under review. IFR will be submitted no later than 45 after the end of the semester.

39. **External Auditing**: The project's financial statements and internal control system will be subject to external bi-annual audit by an independent external auditor which will be recruited on ToRs acceptable to IDA. The external auditor will give an opinion on the bi-annual financial statements in accordance with auditing standards of IFAC. In addition to audit reports, the external auditor will also produce a management letter on internal control to improve the accounting controls and compliance with financial covenants under the financing agreement. The project will be required to submit, no later than 3 months after the end of each semester, the bi-annual audited financial statements of the previous semester. In compliance with the DRC UCS Report, the DRC's Supreme Audit Institution (Cour des Comptes) could start being involved in the process of the external auditors' selection and their reports reviewing. In line with the new access to information policy, the project will comply with the disclosure policy of the Bank of audit reports (for instance making available to the public without delay after receipt of all reports final financial audit, including audit reports qualified) and place the information on its official website within one month after acceptance of final report by IDA.

40. **Implementation support plan**: The bank's FM implementation support mission will be consistent with a risk-based approach, and will involve a collaborative approach with the entire Task Team. Based on the current overall residual FM risk, the project will be supervised 3-4 times a year to ensure that project FM arrangements still operate well and funds are used for the intended purposes and in an efficient way. A first implementation support mission will be performed three months after the project effectiveness. Afterwards, the missions will be scheduled by using the risk based approach model and will include the following diligences: (i) monitoring of the financial management arrangements during the supervision process at intervals determined by the risk rating assigned to the overall FM Assessment at entry and subsequently during Implementation (ISR); (ii) integrated fiduciary review on key contracts, (iii) review the IFRs; (iv) review the audit reports and management letters from the external auditors and follow-up on material accountability issues by engaging with the task team leader, Client, and/or Auditors; the quality of the audit (internal and external) also is to be monitored closely to ensure that it covers all relevant aspects and provide enough confidence on the appropriate use of funds by recipients; (v) physical supervision on the ground specially; (vi) assistance to build or maintain appropriate financial management capacity; and (vii) The supervision mission will include transactions reviews of expenditures occurred.

41. **Conclusions of the FM Assessment**: The overall residual FM risk at preparation was considered High. The proposed financial management arrangements for this project are considered adequate to meet the Bank's minimum fiduciary requirements under OP/BP10.00.

Procurement

General: Procurement rules to be applied

42. **Applicable guidelines**: Procurement for the proposed project would be carried out in accordance with the World Bank's "Guidelines including: (i) Procurement of Goods, Works and Non-Consulting Services under IBRD Loans and IDA Credits and Grants by World Bank

Borrowers" dated January 2011 and updated in July 2014; (ii) Selection and Employment of Consultants under IBRD Loans and IDA Credits and Grants by World Bank Borrowers" dated January 2011and updated in July 2014; (iii) Guidelines on Preventing and Combating Fraud and Corruption in Projects Financed by IBRD Loans and IDA Credits and Grants dated October 15, 2006 and revised in January 2011; and (iv) the provisions stipulated in the Financing Agreement. The various items under different expenditure categories are described below. For each contract to be financed by the Grant (TF) and Credit, the different procurement methods or consultant selection methods, the need for pre-qualification, estimated costs, prior review requirements and time frame are agreed between the Borrower and the Bank in the Procurement Plan. The procurement plan would be updated at least annually or as required to reflect the actual project implementation needs and improvements in institutional capacity.

Reference to the National Procurement Regulatory Framework

43. **For all contracts awarded through NCB method**, the Bank may authorize the use of the national institutions and regulations that comprise the law including its texts of application, the institutions set up for the control and regulation and the institutions responsible for procurement activities implementation. The national competitive bidding procedures currently in force in the DRC deviate slightly from the World Bank Procurement Guidelines NCB procedures for procurement of Works, Goods and services (other than consultants services); thus, they have been already reviewed and appropriate modifications have been proposed to assure economy, efficiency, transparency, and broad consistency with the provisions included in Section I and paragraphs 3.3 and 3.4 of the Bank Procurement Guidelines (refer to the paragraph below).

Requirements for National Competitive Bidding

44. **The procedures to be followed for National Competitive Bidding shall be those set forth in the Recipient's Procurement Code of April 27, 2010**, as revised from time to time in a manner deemed acceptable to the Association, subject, however, to the modifications described in the following paragraphs required for compliance with the Procurement Guidelines:

(a) Standard Bidding Documents: All standard bidding documents to be used for the Project under NCB shall be found acceptable to the World Bank before their use during the implementation of the Project;

(b) Eligibility: Eligibility of bidders and acceptability of their goods and services shall not be based on their nationality and/or their origin; and association with a national firm shall not be a condition for participation in a bidding process. Therefore, except for the ineligibility situations referred to in paragraphs 1.10(a) (i) and 1.10(a) (ii) of the Procurement Guidelines, the eligibility of bidders must be based solely on their qualification, experience and capacity to carry out the contract related to the specific bidding process;

(c) Advertising and Bid Preparation Time: Bidding opportunities shall be advertised at least in a national newspaper of wide circulation and on the website of the Recipient's Procurement Regulator (Autorité de Régulation des Marchés Publics) and bidders

should be given at least 30 days from the date of invitation to bid or the date of availability of the bidding documents, whichever is later;

(d) Criteria for Qualification of Bidders: Qualification criteria shall only concern the bidder's capability and resources to perform the contract taking into account objective and measurable factors. Such criteria for qualification of bidders shall be clearly specified in the bidding documents;

(e) Bid Evaluation and Contract Award: A contract shall be awarded to the substantially responsive and lowest evaluated bidder provided that such bidder meets the qualification criteria specified in the bidding documents. No scoring system shall be allowed for the evaluation of bids, and no "blanket" limitation to the number of lots which can be awarded to a bidder shall apply. The criteria for bid evaluation and the contract award conditions shall be clearly specified in the bidding documents;

(f) Preferences: No preference shall be given to domestic/regional bidders; to domestically/regionally manufactured goods; and to bidders forming a joint venture with a national firm or proposing national sub-contractors or carrying out economic activities in the territory of the Recipient;

(g) Publication of Contract Award: Information on all contract awards shall be published in at least a national newspaper of wide circulation or in the Recipient's Procurement Regulator (Autorité de Régulation des Marchés Publics) web-site;

(h) Fraud and Corruption: In accordance with the Procurement Guidelines, each bidding document and contract shall include provisions stating the World Bank's policy to sanction firms or individuals found to have engaged in fraud and corruption as set forth in the Procurement Guidelines;

(i) Inspection and Audit Rights: In accordance with the Procurement Guidelines, each bidding document and contract shall include provisions stating the World Bank's policy with respect to inspection and audit of accounts, records and other documents relating to the bid submission and contract performance;

(j) Requirement for administrative documents and/or tax clearance certificate: The bidding documents shall not require foreign bidders to produce any administrative or tax related certificates prior to confirmation of awarding a contract; and

(k) Modifications of a Signed Contract: Any change in the contract amount which, singly or combined with all previous changes, increases the original contract amount by fifteen (15) percent or more must be done through an amendment to the signed contract instead of signing a new contract.

Items to be procured and the methods to be used

45. **Advertisement: General Procurement Notice (GPN), Specific Procurement Notices (SPN), Requests for Expression of Interest, and results of the evaluation and contract award should be published in accordance with advertising provisions in the following guidelines**: "Guidelines: Procurement under IBRD Loans and IDA Credits and Grants and Grants by World Bank Borrowers" dated January 2011 and updated in July 2014; and "Guidelines: Selection and Employment of Consultants under IBRD Loans and IDA Credits and

Grants by World Bank Borrowers" dated January 2011. For this purpose, the MOPH through the DEP will prepare and submit to the Bank a General Procurement Notice (GPN). Specific Procurement Notice (SPN) for all goods, non-consulting services and works to be procured under International Competitive Bidding (ICB) and Requests for Expressions of Interests for all consulting services costing the equivalent of US$200,000 and above will be published in “Dg Market”, on the Bank’s external website, and in the national press, in addition to other media with wide circulation. All other specific procurement notices and other requests for expression of interest shall be published at a minimum in the national press with wide circulation.

46. **Procurement of goods and non-consultancy services**: goods procured under this project include mainly items that will contribute in bettering the work conditions of the implementing agency and institutions to be supported by the project and to strengthen the health system at central and decentralized level to manage, and coordinate the project. Non-consulting services under this project include payment to health facilities, maintenance of office equipment, training and workshops in the region and abroad. Depending on the size of the contracts goods and non-consultancy services procured under this project will be done either under ICB using Bank procurement rules that include the related SBD or under NCB using National Standard Bidding Documents agreed with or satisfactory to the Bank. Small value goods may be procured under shopping procedures. Direct contracting may be used where necessary if agreed in the procurement plan in accordance with the provisions of paragraph 3.7 to 3.8 of the Procurement Guidelines. The following additional methods may be used where appropriate: Performance Based Procurement through SSS of central MOPH departments (SG, DEP, CT-PBF, and HMIS) and decentralized MOPH departments in charge of management of PBF (DPS, Provincial PBF steering committee, ECZS), Procurement under Public Private Partnership Arrangements (PPP), and Community Participation in Procurement through SSS of local communities and/or nonGovernmental organizations (NGOs) to strengthen the voice of the population through social mobilization and community verification.

47. **Selection and employment of Consultants**: consultancy services required for the project would cover advisory services, consultancies and technical assistance and studies. The selection method for consultant services will be Quality and Cost Based Selection (QCBS) method whenever possible. Contracts for specialized assignments estimated to cost less than US$200,000 equivalent may be contracted through Consultant Qualification (CQ). The following additional methods may be used where appropriate: Quality Based Selection (QBS); Selection under a Fixed Budget (FB); and Least-Cost Selection (LCS).

48. **Short lists of consultants for services** estimated to cost less than the equivalent of US$100,000 per contract for ordinary services and US$200,000 for design and contract supervision may be composed entirely of national consultants in accordance with the provisions of paragraph 2.7 of the Consultant Guidelines. However, if foreign firms express interest, they will not be excluded from consideration. Single Source Selection (SSS) may be employed with prior approval of the Bank and will be in accordance with paragraphs 3.8 to 3.11 of the Consultant Guidelines. This category may cover (i) SSS of the EUPs as purchasing agencies to provide contract management and verification services and other technical support in addition to capacity building services in selected health zones in the 4 target provinces, and (ii) SSS of UN agencies such as UNICEF, UNFPA etc to provide technical assistance as well as services. All

services of Individual Consultants (IC) will be procured under contracts in accordance with the provisions of paragraphs 5.1 to 5.6 of the Guidelines.

49. **Operating Costs**: Operating costs shall consist of operations and maintenance costs for vehicles, office supplies, communication charges, equipment, utility charges, travel expenses, per diem and travels costs, training costs, workshops and seminar and associated costs, among others. Operating costs will not include salaries of civil servants.

50. **Training and Workshops**. Training and workshops will be based on capacity needs assessment. Detailed training plans and workshops activities will be developed during project implementation, and included in the project annual plan and budget for Bank's review and approval.

Implementation arrangements for procurement and capacity assessment

1) Implementation arrangements

51. **Guiding principles of the implementation of the procurement**: The Government and the World Bank agreed to mainstream the implementation of the project into the existing legal entities and structures and will be framed by the following principles: (i) MOPH to be made more responsible and accountable in project implementation with a focus on strengthening country systems; (ii) equity; and (iii) performance-based agreements which make providers accountable for delivering specific results. Procurement activities of the project will be carried out at two levels: (i) the DEP of the MOPH at the central level; and (ii) the EUP-PBFs at the decentralized level. At the central level procurement activities will be carried out by the Procurement Management Unit (Cellule de Gestion des Projets et Marchés Publics, CGPMP) of the MOPH. The CGPMP reports to the General Secretary of the MOPH. At the decentralized level procurement activities will be carried out by the EUP-PBFs in the four provinces targeted by the project. A specific Project Implementation Manual will be prepared for this project.

2) Assessments of the risks and the related mitigation measures

52. **The MOPH will be in charge of project implementation with the support and technical assistance of experts of specialized cells and directions some of them have long existed, and others have been created recently**. In terms of the sector and country context; the experience of other IDA and Internationally-funded projects (IFI); and the experience of the institutions in charge of procurement management, the procurement on the project is likely to involve the following risks:

a) The administrative system as it operates in practice creates opportunities for informal interference in the procurement process by senior officials – creating opportunities for waste, mismanagement, corruption, collusion and fraud;
b) Government officials likely to be involved in project procurement through tender committees and the national control system ensuring that the rules are respected and able to handle complaints from bidders may not be familiar with procurement procedures according to World Bank guidelines and rules;

c) Control and regulation mechanism according to the provisions of the Country procurement law and its application procedures could delay the procurement process if mandatory reviews are required;
d) MOPH's fiduciary capacity through "the Cellule d'Appui et de Gestion des Financements du secteur de la santé" (CAGF/MSP) has revealed several weaknesses and deficiencies which justify the restructuring measures taken by the Government to replace the CAGF/MOPH by the newly created "Cellule d'Appui et de Gestion Financière du Ministère de la Santé Publique" (CAG/MSP) pursuant to decree Nr. 1250/CAB/MIN/SP/013/CJ/2014 of June 10, 2014;
e) CGPMP has been newly staffed since its creation (refer to decree Nr. 1250/CAB/MIN/SP/015/CJ/2014 on June 10, 2014 to launch the recruitment process of the CGPMP's staff). As it has been functional only recently it has no experience implementing procurement activities for this project;
f) EUP-PBFs have been newly set up by the project. They have no experience implementing procurement activities for this project.

The overall unmitigated risk for procurement is **High**. Proposed corrective measures which have been agreed to mitigate the risk are summarized in the following table.

TABLE 1: ACTION PLAN CORRECTIVE MEASURES

Ref	Tasks	Responsibility	Due date
1	Prepare a specific Project Implementation Manual that will include procurement methods to be used in the project along with their step by step explanation as well as the standard and sample documents to be used for each method.	MOPH	By Effectiveness
2	Organize a launch workshop involving all stakeholders	MOPH	3 months after effectiveness
3	Identify the root cause of procurement delays at national level and propose appropriate solutions (global)	MOPH	By the end of 2015
4	Recruit a well-qualified procurement consultant with experience in World Bank procurement procedures who will support, train and coach the CGPMP at the central level	MOPH	Three months after effectiveness
5	Recruit 2 well-qualified procurement consultants with experience in World Bank procurement procedures who will periodically support, train and coach the EUP-PBFs at the decentralized level.	MOPH	Three months after effectiveness
6	Set up the project filing system in order to better keep procurement documents and reports and identify staffs responsible for this task. Train staff in data management.	MOPH	Three months after effectiveness

Frequency of Procurement Supervision

53. **In addition to the prior procurement review carried out by the Bank, the procurement specialist recommends at least one mission every three months for the first year** and one mission every six months for the next years to provide support to the implementation of procurement activities. This support will include not only the organization and functioning of the procurement team of CGPMP but also the implementation of procurement activities listed in the procurement plan. One post review of procurement activities will be carried out every year. As agreed with the Government, contracts will be published on the web. Annual compliance verification monitoring will also be carried out by an independent consultant and would aim to:

(a) verify that the procurement and contracting procedures and processes followed for the project were in accordance with the Financing Agreement;

(b) verify technical compliance, physical completion and price competitiveness of each contract in the selected representative sample;

(c) review and comment on contract administration and management issues as dealt with by the implementation entity;

(d) review capacity of the implementation entity in handling procurement efficiently; and

(e) identify improvements in the procurement process in the light of any identified deficiencies.

54. **Contract Management and Expenditure Reports**: As part of the Procurement Management Reports (PMR), the DEP will submit contract management and expenditure information in quarterly reports to the World Bank for the project. The procurement management report will consist of information on procurement of goods, works and consultants' services and compliance with agreed procurement methods. The report will compare procurement's performance against the plan agreed at negotiations and as appropriately updated at the end of each quarter. The report will also provide any information on complaints by bidders, unsatisfactory performance by contractors and any information on contractual disputes if any. These contract management reports will also provide details on payments under each contract, and will use these to ensure no contract over-payments are made or no payments are made to sanctioned entities.

Procurement planning

55. **The borrower has prepared a Procurement Plan for the first 18 months of the project implementation which provides the basis for the procurement methods**. This plan was discussed between the borrower and the Bank during negotiation. It will also be available in the project's database and in Bank's external website. The Procurement Plan will be updated in agreement with the Project Team annually or as required to reflect the actual project implementation needs and improvements in institutional capacity.

TABLE 2: THRESHOLDS FOR PROCUREMENT METHODS AND PRIOR REVIEW

Expenditure Category	Contract Value Threshold (US$)	Procurement Method	Contracts Subject to Prior Review by the Bank procurement (US$)
1. Works	≥10,000,000	ICB	All
	<10,000,000	NCB	All contracts ≥ 5.000.000
	<200,000	At least three quotations	None
	All amount	Direct contracting	100.000 or more
2. Goods	≥1,000,000	ICB	All
	<1,000,000	NCB	All contracts ≥500,000
	<500,000	Shopping from all major brands of vehicles dealers or distributors of petroleum products	Shortlist of: (i) vehicles dealers; and (ii) distributors of petroleum products. The technical specifications of vehicles.
	<100,000	Shopping	None
	All amount	Direct contracting	100.000 or more
2. Services			
	≥200,000		All
Firms	<200,000	CQ	None
	All amount	SSS	100.000 or more
Individual Cons.	≥100,000	IC	All
	<100,000	IC	None
	All amount	SSS	100.000 or more
All TORs regardless of the value of the contract are subject to prior review.			

Note: (ICB: international competitive bidding; NCB: national competitive bidding; CQ: Consultants qualification; SSS: Single source selection; IC: individual consultant.

Details of the Procurement Arrangements Involving International Competition

1) Goods, Works, and Non Consulting Services

List of main contract packages to be procured following ICB and direct contracting

1	2	3	4	5	6	7	8	9
Ref. No.	**Contract name**	**Estimated Cost US$**	**Procurement Method**	**Prequalification (Yes/No)**	**Nationale Preference (Yes/No)**	**Review (Priori / Post)**	**Expected Bid Opening Date**	**Com-ment**

2) Consulting Services

List of main consulting assignments with short-list of international firms

1	2	3	4	5	6	7
Ref. No.	**Contract name**	**Estimated Cost US$**	**Method**	**Review (Priori / Post)**	**Proposal submit date**	**Comment**

ANNEX 4

Operational Risk Assessment Framework (ORAF)

Health System Strengthening for Better Maternal and Child Health Results Project (PDSS) (P147555)

DEMOCRATIC REPUBLIC OF CONGO

<table>
<tr><td colspan="7">Project Stakeholder Risks</td></tr>
<tr><td>Stakeholder Risk</td><td>Rating</td><td colspan="5">Substantial</td></tr>
<tr><td rowspan="3">Risk Description:

Capacity needs to be strengthened within the MOHP at both the central and provincial levels to implement PBF and to strengthen the stewardship role of the Government. Additionally, this project will involve harmonization with development partners, some of whom have not implemented PBF, so this will need to be managed to ensure alignment of interests.</td><td colspan="6">Risk Management:

The project team will work with its respective stakeholders to prioritize the needs of both the Government and the development partners to guarantee accordance among all involved on the tools as well as devise a capacity building program to ensure that skills are being enhanced to implement the project.</td></tr>
<tr><td>Resp:</td><td>Status:</td><td>Stage:</td><td>Recurrent:</td><td>Due Date:</td><td>Frequency:</td></tr>
<tr><td>Both</td><td>In Progress</td><td>Both</td><td>X</td><td></td><td>Continuous</td></tr>
<tr><td colspan="7">Implementing Agency (IA) Risks (including Fiduciary Risks)</td></tr>
<tr><td>Capacity</td><td>Rating</td><td colspan="5">Substantial</td></tr>
<tr><td rowspan="3">Risk Description:

The capacity within the Ministry of Public Health is more on service delivery and health financing given the strong technical team it has in the planning unit. However, the MOPH does not have sufficient capacity for PBF project design and implement and hence these activities will be limited and might affect the timeliness and quality of implementation. For instance, there has been limited experience with the use of web enabled systems for monitoring and for reporting of results. Additionally, there has been limited experience with the use of the Purchasing Agencies - EUPs in the DRC. However, the MOPH does</td><td colspan="6">Risk Management:

The project has been specifically designed to help strengthen systems while building capacity in of the health ministry at all levels for both planning and implementation. The project will be heavily focused on enhancing capacity through a range of approaches from training, to direct coaching and technical assistance. One of the project components will enhance the Government's ability to implement PBF at the strategic central level as well as on the ground at the provincial and health zone levels. The Bank is also engaged with partners such as UNICEF (and likely others by the time the project become effective) who could support (with their own financing) the client during implementation.</td></tr>
<tr><td>Resp:</td><td>Status:</td><td>Stage:</td><td>Recurrent:</td><td>Due Date:</td><td>Frequency:</td></tr>
<tr><td>Both</td><td>In Progress</td><td>Both</td><td>X</td><td></td><td>Continuous</td></tr>
</table>

<table>
<tr><td>have a PBF Technical Unit which has been supported by Cordaid and MSH.</td><td>
Risk Management:
Technical support will be provided by hiring 3 to 4 TAs to be placed at the level of the planning unit and the PBF-technical unit to be able to carry out the project activities.
<table>
<tr><th>Resp:</th><th>Status:</th><th>Stage:</th><th>Recurrent:</th><th>Due Date:</th><th>Frequency:</th></tr>
<tr><td>Client</td><td>In Progress</td><td>Both</td><td>X</td><td></td><td>Continuous</td></tr>
</table>
Risk Management:
Training is being planned at all level of the system so the implementers and technical development partners are brought up to the same level of their understanding of a PBF system. Additional training will be conducted based on needs and knowledge acquired throughout the project implementation preparedness phase.
<table>
<tr><th>Resp:</th><th>Status:</th><th>Stage:</th><th>Recurrent:</th><th>Due Date:</th><th>Frequency:</th></tr>
<tr><td>Both</td><td>In Progress</td><td>Both</td><td>X</td><td></td><td>Continuous</td></tr>
</table>
</td></tr>
<tr><td>Governance</td><td>Rating High</td></tr>
<tr><td>Risk Description:

The current political will for reform of the social sectors might wane with Cabinet shuffles and/or elections. The President has announced the formation of a new Government of national unity which may affect the current climate of reform. Another related risk is that there may be weak demand from some provinces/Ministries for some of the areas of health systems strengthening proposed in the project. Autonomy of health centers to spend PBF revenues may lead to mismanagement of funds.</td><td>
Risk Management:
The institutional arrangements for the project consider governance as a core activity. To be transparent in this process, an operational manual will be created and shared with the main stakeholders; additionally, performance contracts will be written between EUPs and selected health facilities, these contracts will enable the process of delivering and paying for results to be very transparent. Civil society will play a pivotal role in ensuring community satisfaction and good governance. There will be a two pronged communications strategy which will ensure that the gains of the project are visible, thus providing senior Government official results which they can communicate and keep championing. The project also aims to communicate the new strategy of PBF to the population where the project is being implemented to ensure greater demand for services and enhanced transparency in the sector.
<table>
<tr><th>Resp:</th><th>Status:</th><th>Stage:</th><th>Recurrent:</th><th>Due Date:</th><th>Frequency:</th></tr>
<tr><td>Both</td><td>In Progress</td><td>Both</td><td>X</td><td></td><td>Continuous</td></tr>
</table>
Risk Management:
Financial management and procurement aspects of the project will be closely supervised
</td></tr>
</table>

	by the Bank. The Bank team will supervise procurement closely with a particular focus on larger contracts for implementation partners. Third party validation of results attained on the delivery of health interventions will be supported using similar mechanisms (e.g. community verification; and purchasing agency validation) as under IDA-supported health operations.					
	Resp:	**Status:**	**Stage:**	**Recurrent:**	**Due Date:**	**Frequency:**
	Bank	In Progress	Both	X		Trimestral
	Risk Management:					
	The Bank carried out its usual procurement and financial management assessments during preparation and identified key actions to limit procurement and financial management risk. In designing the systems, a strong focus will be given to the incentives that guide the behavior of officials and measures will be taken to recalibrate incentives as required.					
	Resp:	**Status:**	**Stage:**	**Recurrent:**	**Due Date:**	**Frequency:**
	Bank	In Progress	Both	X		Continuous
	Risk Management:					
	The project implementation manual will outline clear procurement and financial management processes. This is a follow-on project and as such the team has experience working in the DRC health sector where corruption can be pervasive and hinder the Project's ability to achieve desired results. Based on the lessons learned from the current project, the team will put in mitigating measures to ensure more transparency and less fraud and corruption.					
	Resp:	**Status:**	**Stage:**	**Recurrent:**	**Due Date:**	**Frequency:**
	Bank	In Progress	Both	X		Continuous

Project Risks

Design	**Rating**	**Substantial**
Risk Description: The complexity of the project will be mitigated with the new institutions that will need to be put in place and the	**Risk Management:** Health Facility Level: During project preparation, the team assessed the capacity of the Provincial Health Directorates and their experience with PBF; it was decided that funds	

<table>
<tr><td rowspan="4">rigorous verification and counter-verification associated with implementation and good governance.</td><td colspan="6">would be channeled through the single buyer/purchasing agencies to be set up in the targeted Provinces; and lessons from the Bank-funded PBF pilot in the Haut-Katanga province and experience with PBF schemes in other countries have been incorporated into the design as follows: clear and comprehensive packages of high impact interventions which can be easily measured and monitored; regular channeling of funds to facilities; relative prices which minimize risk of distortions; reliance on national health information systems to avoid creating parallel systems; a strong and independent system for data verification; and parallel reductions in user fees to enhance financial protection and overcome financial barriers to accessing health services. It was decided that the project will establish an equity fund as part of the PBF intervention to lower barriers to care for the most vulnerable people.</td></tr>
<tr><td>Resp:
Both</td><td>Status:
In Progress</td><td>Stage:
Both</td><td>Recurrent:
X</td><td>Due Date:</td><td>Frequency:
Continuous</td></tr>
<tr><td colspan="6">Risk Management:
During project preparation, clear quality standards for each service foreseen have been developed, as well as clear roles and responsibilities of quality control by the EUP. In addition, using umbrella implementation partners to ensure consistency of quality and approach of service providers will be explored as this has proven effective in other Bank projects. During implementation, the client and Bank team will monitor closely quality of services provided across implementation partners, including through using during the second half of the project quality assessment</td></tr>
<tr><td>Resp:
Both</td><td>Status:
In Progress</td><td>Stage:
Both</td><td>Recurrent:
X</td><td>Due Date:</td><td>Frequency:
Continuous</td></tr>
<tr><td>Social and Environmental</td><td>Rating</td><td colspan="5">Moderate</td></tr>
<tr><td>Risk Description:
The project is rated as an environmental category B as activities are not expected to have significant or irreversible environmental impacts, and would have limited to no localized adverse impacts, and no cumulative impact. Any negative social impact of the project is expected to be very low. Medical waste will be created which will require proper handling. Given the nature of</td><td colspan="6">Risk Management:
To ensure inclusion of Indigenous Peoples, an Indigenous Assessment will be prepared in the current project and will feed into the developing the national health strategy for the Indigenous people. Based on the results of the Assessment, an Indigenous Peoples Plan will be prepared during project implementation to ensure implementing partners can benefit from these plans. In addition, an Environmental Management Plan (EMP) and Medical Waste Management Plan (MWMP) will be developed. As per OP/BP10.00 for projects with special considerations, finalizing the EMPs, MWMPs and IPP will be</td></tr>
</table>

<table>
<tr><td rowspan="2">activities to be funded, it is likely that OP/BP 4.01 (Environmental Assessment) would be triggered. In addition, for DRC, OP/BP 4.10 (Indigenous People) will be triggered.</td><td colspan="6">deferred to the project implementation phase, while an action plan addressing applicable environmental and social policies was developed during project preparation.</td></tr>
<tr><td>Resp:
Client</td><td>Status:
In Progress</td><td>Stage:
Both</td><td>Recurrent:
☐</td><td>Due Date:
30-June-2015</td><td>Frequency:</td></tr>
<tr><td>Program and Donor</td><td>Rating</td><td colspan="5">Moderate</td></tr>
<tr><td rowspan="2">Risk Description:

There are many development partners in DRC (e.g. Belgian Cooperation, European Union, USAID, Canadian Foreign Affairs, Trade and Development) which are actively working in various parts of the country. The partners are organized under the GIBS chaired by the UNICEF. The partners are strongly motivated to harmonize and align their efforts around the national health strategy of the Ministry of Health and to that effect have signed a Charter mobilizing them to do so. The implication of so many partners might slow down implementation.</td><td colspan="6">Risk Management:

The health sector has a well-functioning donor coordination mechanism and the project shared the project plans with the group during project preparation and that regular updates are provided during implementation. The Bank will also call for TA matrices to be prepared for each sector to ensure there is no duplication and to seek synergies. UNICEF along GAVI, Global Fund and potential the Gates foundation has agreed to harmonize and align their interventions around the Bank project in the targeted areas. Dialogue is on-going with other partners to see how best all partners can work more strategically to support systems strengthening both from a policy perspective as well as supporting PBF more specifically.</td></tr>
<tr><td>Resp:
Bank</td><td>Status:
In Progress</td><td>Stage:
Both</td><td>Recurrent:
X</td><td>Due Date:</td><td>Frequency:
Continuous</td></tr>
<tr><td>Delivery Monitoring and Sustainability</td><td>Rating</td><td colspan="5">Moderate</td></tr>
<tr><td>Risk Description:

Monitoring and Evaluation are not being used effectively in the current PARSS project. Furthermore the National Health Management Information System (HMIS) is weak and doesn't produce reliable and timely data. The HMIS is still largely centralized at the national level, relies on paper-based processes, produce data too slowly to contribute to decision-making and provide none of the feedback to lower levels in the system that is critical to effective service delivery.</td><td colspan="6">Risk Management:

Monitoring and Evaluation (M&E) is a key component in the project because the project data must be analyzed regularly to inform the Government, the World Bank and other development partners about its results and impacts. More specifically the project will finance: (i) annual process evaluation; (ii) spot checks; (iii) one full impact evaluation, and (iv) annual independent audits of the system.

PBF is designed in a way that it provides 100% data availability from all PBF systems, through an open platform (see for instance the Nigerian one http://nphcda.thenewtechs.com). These data are publicly available. Also there are detailed monthly and quarterly health facility assessments, which feed into this public forum. In addition, there are quarterly community client satisfaction surveys which will inform the public and the Government on the level of satisfaction of the patients.</td></tr>
</table>

	Resp:	**Status:**	**Stage:**	**Recurrent:**	**Due Date:**	**Frequency:**
	Both	In Progress	Both	X		Continuous
	Resp:	**Status:**	**Stage:**	**Recurrent:**	**Due Date:**	**Frequency:**
				☐		

Overall Risk		
Overall Implementation Risk:	**Rating**	**Substantial**

Risk Description:

As the project is going to support the decentralization efforts and invest heavily in putting in place the Health Administration Directorates and work closely with local institutions that have been involved in PBF in the past, it is expected that these mitigating factors might help reduce the implementation risk to substantial from the current risk rating of High. Furthermore, with the anchoring of the project within the Ministry of Public Health rather than an external implementation unit, the implementation risk might be overcome as the directorate in charge of the project coordination and management will be supported by additional technical assistance in terms of project coordination, management, and PBF expertise.

ANNEX 5: IMPLEMENTATION SUPPORT PLAN
DEMOCRATIC REPUBLIC OF CONGO

Health System Strengthening for Better Maternal and Child Health Results Project (PDSS) (P147555)

1. The Implementation Support Plan (ISP) focuses on mitigating the risks identified in the ORAF, and aims at making implementation support to the client more flexible and efficient. It also seeks to provide the technical advice necessary to facilitate achievement of the PDO (linked to results/outcomes identified in the result framework), as well as identify the minimum requirements to meet the Bank's fiduciary obligations.

- **Technical:** Implementation support will include: (a) progress on objectives (b) fine tune strategies where required (c) drawing lessons from the implementation for wider applicability.
- **Financial management.** Implementation support will include: (a) reviewing submitted reports and providing timely feedback to the implementing agency; (b) supporting the development of the internal audit function within the MOPH; (c) providing training and support to the accountants within the DAF.
- **Procurement.** Implementation support will include: (a) providing additional staff and training as needed for the MOPH and PDSS team; (b) reviewing procurement documents and providing timely feedback to the MOPH and PDSS team; (c) providing detailed guidance on the Bank's procurement guidelines to the MOPH and PDSS team and (d) monitoring procurement progress against the detailed procurement plan.
- **Environmental and Social Safeguards.** The Bank team will supervise the implementation of the updated Health Care Medical Waste Management Plan and provide guidance to the MOPH and PDSS team. In addition the Bank will provide the needed supervision to ensure that needs of the Autochthone population are taken into account in the health services package as identified in the IPPF.
- **Other Issues.** Sector level risks will be addressed through policy dialogue with the Governments' Ministries.

Implementation Support Plan

2. Despite the Bank's experience in the country, the wide geographical scope and innovations in the project will require fairly intensive supervision, especially during the first two years of implementation. The Bank team members will be based either in Washington DC, or in country offices, and will be available to provide timely, efficient and effective implementation support to the clients. Formal supervision and field visits will be carried out at least 2 times annually. These will be complemented with monthly video conferences to discuss project progress. Detailed inputs from the Bank team are outlined below:

- **Technical, Policy and Legal/Regulatory inputs**. Technical, policy and legal/regulatory related inputs will be required to review bid documents to ensure fair competition, sound

technical specifications and standards, and confirmation that activities are in line with Government's health sector strategies.

- **Fiduciary requirements and inputs**. Training will be provided by the Bank's financial management and procurement specialists as needed. The Bank team will also help identify capacity building needs to strengthen financial management capacity and to improve procurement management efficiency. Financial management and the procurement specialists will be based in the country office to provide timely support. Formal supervision of financial management and procurement will be carried out semi-annually.
- **Safeguards**. Inputs from environment and social development specialists will be provided as needed.
- **Operation**. The task team will provide day-to-day supervision of all operational aspects, as well as coordination with the clients and among Bank team members. Relevant specialists will be identified as needed.

TABLE 1: IMPLEMENTATION SUPPORT PLAN

Time	***Focus***	***Skills Needed***	***Resource Estimate (US$)***
First twelve months	*Capacity building for the PBF*	*PBF Bank expert*	*200,000 (IDA +HRITF SPN)*
	Capacity building on FM, procurement and internal audit	*FM and procurement staff, and consultants*	
	Impact Evaluation baseline survey and capacity building on Impact Evaluation	*PI/AFTHW staff + Co-PI who is an expert in Impact Evaluation*	
12-48 months	*Implementation support*	*Same as above*	*150,000 each subsequent year*

Skills Needed	***Number of Staff Weeks***	***Number of Trips***	***Comments***
Task team leader	*10 SWs annually*	*Fields trips as required*	*Washington based*
Procurement	*5 SWs annually*	*Fields trips as required*	*Country office based*
FM Specialist	*5 SWs annually*	*Fields trips as required.*	*Country office based*
Nutrition Specialist	*1 SW annually*	*Fields trip as required*	*Country Office based*
Environment specialist	*1 SW annually*	*Field trip as required*	*DC based*
Health Specialist	*5 SWs annually*	*Fields trips as required*	*DC based*
M&E Specialist	*4 SW annually*	*Fields trips as*	*Country office based*

		required	
PBF Specialist	*8 SW annually*	*Fields trips as required*	*DC based*
Health financing specialist	*5 SW annually*	*Fields trips as required*	*DC based*
Economist	*4 SW annually*	*Fields trip as required*	*DC based*
Governance Specialist	*1 SW annually*	*Fields trips as required*	*Country office based*
Impact Evaluation Specialist	*8 SW annually*	*Fields trips as required*	*DC based*

ANNEX 6: WHAT IS PERFORMANCE BASED FINANCING DEMOCRATIC REPUBLIC OF CONGO

Health System Strengthening for Better Maternal and Child Health Results Project (PDSS) (P147555)

1. **Performance-Based Financing (PBF) is a supply-side Results-Based Financing (RBF) approach**.[47] 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.

2. **PBF is based on operational and tacit knowledge developed over the past 15 years in South-East Asia and Africa, and is in continuous development incorporating lessons learned**. The effectiveness of PBF was proven through a rigorous Impact Evaluation in Rwanda.[48] A PBF toolkit has been developed by the World Bank and an English version has been available since April 2014, while a French language version is available and a Spanish language version is being published.[49]

3. PBF is applicable in a wide variety of lower and middle income country contexts. The diversity and the applicability of PBF are evident when looking at the contexts where such programs are carried out: Burundi, DRC and Nigeria versus Indonesia, Kyrgyzstan and Vietnam. Currently, over 30 countries in Africa, and Central and South-East Asia are planning, designing, and implementing such programs. PBF has expanded rapidly in Sub-Saharan Africa; see image below.

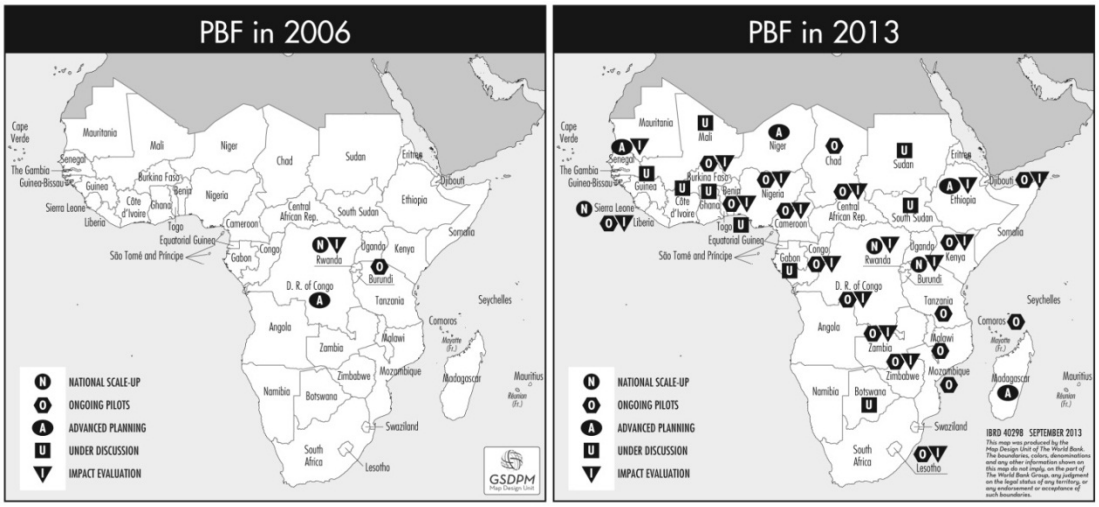
---

[47] Musgrove, P. (2011). Financial and Other Rewards For Good Performance or Results: A Guided Tour of Concepts and Terms and a Short Glossary. Washington DC.

48 (i) Basinga, P., P. Gertler, et al. (2011). Effect on maternal and child health services in Rwanda of payment to primary health-care providers for performance: an impact evaluation. The Lancet 377: 1421-1428; (ii) Gertler, P. and C. Vermeersch (2012). Using Performance Incentives to Improve Health Outcomes. *Policy Research Working Paper WPS6100*. Washington DC, The World Bank. Walque, D. d., P. J. Gertler, et al. (2013); (iii) Using Provider Performance Incentives to Increase HIV Testing and Counseling Services in Rwanda. *Policy Research Working Paper WPS6364*. Washington DC, The World Bank.

49 Fritsche, G., R. Soeters, et al. (2014). Performance-Based Financing Toolkit. Washington DC, © World Bank. https://openknowledge.worldbank.org/handle/10986/17194 License: CC BY 3.0 IGO.

Figure 1: Rapid expansion of PBF projects in Sub-Saharan Africa between 2006 and 2013



4. Certain aspects of PBF and how they relate to the Democratic Republic of Congo will be discussed in the following sections. These aspects are: (a) purchasing quality services; (b) separation of functions; (c) health facility autonomy; (d) verification and counter-verification; and (e) data management and invoicing.

Purchasing Quality Services

5. PBF purchases quality health services. Important notions are leveraging existing resources; changing incentive structures; purchasing balanced packages; purchasing conditional on quality; and PBF pricing versus the real cost of services.

6. PBF purchases quality health services through leveraging existing means of production. The purchase is through a fee-for-service provider payment mechanism, conditional on the quality of services. Key to understanding PBF is the notion of leveraging. Existing building, equipment, medical consumables, cash income from other sources and staffing are leveraged through PBF.

7. PBF changes incentive structures at various levels in the health system. The incentives need to be strong enough to influence health worker coping strategies while they provide additional income to enable health facilities to procure missing equipment, to maintain and repair equipment and premises and to stock essential life -saving medicines.

8. PBF purchases a balanced package of services at the community & health center level and at the first referral hospital level. A lack of coverage for essential health services guides purchasing at the community & health center level. At the hospital level additional services complementing the primary levels are purchased; for instance complicated deliveries or more sophisticated reproductive health services. In general, there are 15-25 services in each package. Ideally, incentives are targeted at preventive services used by everybody whilst facilitating access to curative services for the poorest. PBF budget allocation is about 2/3 at the community and health center level, and 1/3 for the first referral hospital level.

9. Quality is measured and rewarded through the use of a quantified quality checklist. This checklist is custom-made to reflect the particularities of each context. It is measured once per quarter, typically by an incentivized district health administration (for the health centers) or by a peer-evaluation mechanism (for the hospitals). The impact of the quality measure depends on the type of PBF system. It can be a quality bonus with a maximum of 25 percent of earnings (in the 'carrot' system) or a deduction of 100 percent of earnings if the quality is 0 (in the 'stick' system). In the case of DRC a quality bonus is applied. An example of such a quantified quality checklist is available in Annex 9.

10. PBF fees have little to do with the actual cost of services. First, the actual cost of a service (which includes apportioned annuity of building and equipment; staff cost; medicines and medical consumables) is much higher than a PBF fee for that service. Second, PBF is a pricing system; the fee is proportional to the relative public health importance and the level of coverage of that service. Third, a PBF fee includes a rural hardship element, and therefore the fee is higher in harder to reach areas. Finally, certain services can be targeted to the poorest of the poor and attract a higher fee than the same service for the better off. Also, PBF fees can be changed depending on budget availability; upward if more money becomes available, and downward if the disbursement is higher than expected. PBF is a strategic purchasing mechanism.

11. A simplified example of PBF is provided in Table 1. The bulleted list with bracketed numbers that follows this paragraph shows how the performance of the health facility is financed and how the health facility chooses to use the financing. In this example, individual health facilities are provided funds based on the quantity and quality of services they produce as independently verified. Each bracketed number refers to a field in table 1. For example, [1] refers to the number of children the health facility has fully immunized in the past quarter.

[1] If a health facility fully immunizes 60 children in a quarter;

[2] The health facility could earn US$120 (60 × US$2 per child fully immunized);

[3] The health facility could earn US$1,080 for 60 deliveries because each delivery earns US$18. A typical minimum package of PBF services at a health center would contain 15–25 services;

[4] This health facility would earn US$2,196 as unadjusted subtotal for the services it produced over the past quarter;

[5] The total amount would be adjusted for the remoteness or difficulty of the facility (equity bonus), because urban or peri-urban facilities could earn a disproportionate amount. In the example in table 1, this particular facility would earn 20 percent more because of the difficulties it faces;

[6] The total would also be adjusted by a quality score based on a checklist administered at the facility every quarter. This facility would earn 60 percent of what it would be entitled to because of the quality correction. The quality correction is a maximum of 25 percent of earnings from the past quarter [6]. This facility thus earns 60 percent of the 25 percent for its quality;

[7] The funds earned (US$3,030 in this example) are transferred to the bank account of the facility;

[8] In this example, the health facility also has some other sources of cash revenue (US$970), and these are added to the PBF earnings; and

[9] The health facility had US$4,000 in income over the past quarter, and the expenses section illustrates how this could have been used. The income can be used for

(a) Health facility operational costs, such as medicines and consumables, outreach expenses, and health facility maintenance and repair;

(b) Performance bonuses for health workers (up to 50 percent) according to defined criteria; this facility decided to spend 26 percent of its total income on performance bonuses (34 percent of its PBF earnings; however, because of other sources of cash income, such funds are managed integrally); and

(c) Savings; this health facility is saving not only to buy a motorcycle to facilitate community outreach but also to have a cash buffer.

Table 1: Simplified Example of How Performance-Based Financing Works in a Health Facility

Health facility revenues over the previous period	**Number provided**	**Unit price (US$)**	**Total earned (US$)**
Child fully vaccinated	60 [1]	2	120 [2]
Skilled birth attendance	60	18	1,080 [3]
Curative care	1,480	0.5	740
Curative care for the vulnerable patient (up to a maximum of 20% of curative consultations)	320	0.80	256
[A typical minimum package for a health center would contain 15 to 25 services.]	-	-	-
Subtotal			2,196 [4]
Remoteness (equity) bonus	+20%		439 [5]
Quality bonus	60% of 25%		395 [6]
Total PBF subsidies			3,030 [7]
Other revenues (direct—insurance, and so on)			970 [8]
Total revenues			4,000
Health facility expenses			

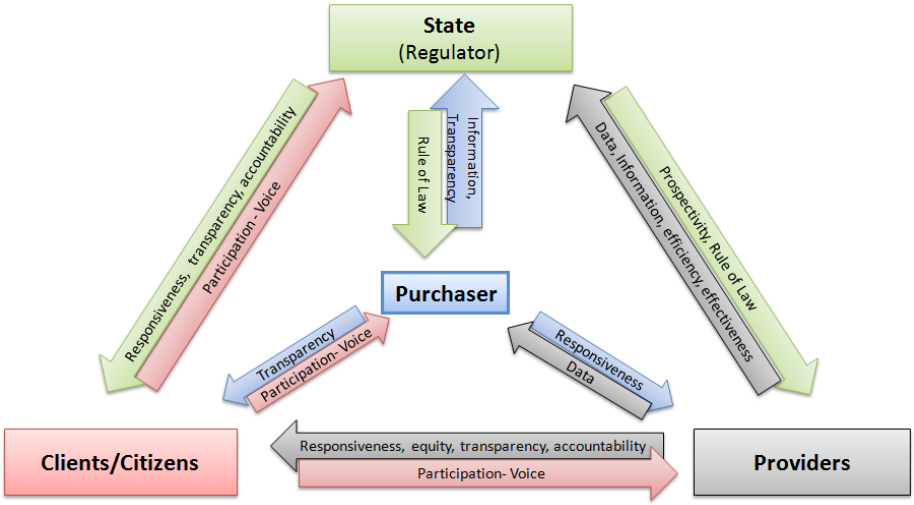
Health facility revenues over the previous period	Number provided	Unit price (US$)	Total earned (US$)
Fixed salaries staff			800
Operational costs			350
medicines and consumables			1,000
Outreach expenditures			250
Repairs to the health facility			300
Savings into health facility bank account			250
Subtotal			2,950
Bonuses to staff in the facility = total expenses minus subtotal			1,050
Total expenses			4,000 [9]

Separation of Functions

12. A precondition for obtaining credible performance results is a separation of functions. It is best practice to strive for a full separation of functions between the chief players in the health care arena: the fund-holder, the purchaser, the provider, the community, community health committees, local PBF steering committees and the national PBF coordination mechanisms.

13. In a separation of functions different functions are allocated to different health system stakeholders. In PBF, the following functions are distinguished: Provision; Regulation; Purchasing; Fund holding and Community voice. In Figure 2 below, the separation of functions is illustrated:

Figure 2: The Separation of Functions and its Governance Issues[50]



Health Facility Autonomy

14. Health facility autonomy is an important pre-requisite for PBF. Health facility autonomy is important in (i) holistic management of cash resources; (ii) managing a bank account; (iii) procurement of goods; (iv) repairs to facility and equipment; and (v) managing human resources.

15. Community oversight is important when decentralizing public funding. To enhance governance, community oversight mechanisms are strengthened when available, or introduced when absent.

Verification and Counter-Verification

16. Credible verification is at the heart of PBF systems and two types can be discerned.

a. The first type is the so-called 'ex-ante verification'; the verification before payment for performance is made. The *ex-ante quantity verification* is typically carried out by a third party contracted to do the purchasing on behalf of the fund holder(s) and regulator. The *ex-ante quality verification* is frequently carried out by the district health administration through a performance contract.
b. The second type is the 'ex-post verification'; the verification which is done after payment for performance has been carried out. Whereas the ex-ante verification is routinely (monthly and quarterly) carried out for all contracted health facilities, the ex-post verification is done on a random sample of health facilities and health administrations. Different systems exist, but the *ex-post quantity verification* is typically carried out by the purchasing agent, through grassroots organizations. Such

[50] Remme, M., P.-B. Peerenboom, et al. (2012). *Le Financement base sur la Performance et al Bonne Gouvernance*: *Leçons apprises in Republique Centrafricaine.* PBF Community Of Practice Working Paper Series WP8 ed.

mechanisms are also called 'community client satisfaction surveys'. On the one hand, such systems discourage the 'phantom patient phenomenon' (a service claimed that did not take place), and on the other they collect valuable feedback from the community on their perception of the quality of these services. Ex-post verification is also done on performance frameworks that are predominantly assessed through internal mechanisms, and on the quality checklists.

Data management and invoicing

17. PBF needs good data-management and invoicing systems to pay regularly for performance. Such PBF data-management and invoicing systems are characterized by (i) limited data-sets; (ii) good data accuracy; (iii) a high degree of data completeness; (iv) good data accessibility, and (v) transparency. In an increasing number of PBF projects, a web-enabled application is used. A public frontend makes accessible information on performance and payments to the general public. Accessibility to these web-enabled applications down to the district level is reasonable in lower and middle-income countries, and this accessibility is improving with growing connectivity. See for instance the Nigeria PBF portal https://nphcda.thenewtechs.com/ and the Cameroon PBF portal http://www.fbrcameroun.org/.

18. PBF data management and invoicing systems are purposefully linked to decentralized governance mechanisms. In well-designed PBF systems, a district level steering committee acts as a district-level governing board for PBF. Such decentralized decision making is important as knowledge on how health facilities function is best at the district level. Purposefully linking civil society and Government systems in this steering committee enhances governance significantly. Timely access to good quality data and invoices through the web-enabled application effectively enable such governance**.**

19. PBF approaches are dynamic, and in constant adaptation based on lessons learned and experiential knowledge gained. PBF approaches have evolved considerably since they were first applied in Cambodia in the late nineteen-nineties.[51,52] These experiences have moved for instance from contracting individuals to contracting institutions, from purchasing a restricted package to purchasing more comprehensive packages, from purchasing only quantity, to purchasing both quantity and quality, from not engaging the district health administration, to fully engaging the health administration not only at the district level, but also at higher levels such as the provincial and national levels. The PBF approaches have expanded to experimenting with the pharmaceutical supply chain, with the education sector, with road maintenance and even engaging the security forces.[53] Verification mechanisms and purchasing arrangements are also in a flux, while the increasing use of modern ICT solutions such as the use of mobile devices and the internet leads to better data availability, contribute to governance and learning.

20. **The purchase of a 'household visit as per protocol' is an example of ongoing experimentation and innovation in strategic purchasing through PBF approaches.** A novel

[51] Bhushan, I., S. Keller, et al. (2002). Achieving the Twin Objectives of Efficiency and Equity: Contracting Health Services in Cambodia. ERD Policy Brief No. 6. Philippines.
[52] Soeters, R. and F. Griffiths (2003). "Improving Government health services through contract management: a case from Cambodia." Health Policy and Planning 18(1): 74-83.
[53] Soeters, R., P.-B. Peerenboom, et al. (2011). "Performance Based Health Financing Experiment Improves Care in a Failed State." Health Affairs 30(8): 1518-1527.

area of experimentation is the purchase of the ‘household visit as per protocol’, which is piloted in Cameroun, Burkina Faso, Nigeria, Republic of Congo and the Democratic Republic of Congo. This activity evolved from early experimentation with how to engage the community and community health workers better, and which was initially focused on the purchase of bed net distribution and the construction of latrines. This ‘household visit as per protocol’ consists of a package of promotive and preventive health activities, based on a household needs-assessment and gap analysis and a business plan drawn up between the visiting health workers and the household. In DRC, this community based activity will blend in with the ‘family health kit’ delivery managed and coordinated by UNICEF, and thus is expected to contribute to an important disease preventive and curative activity too. Both in the Republic of Congo and in the Democratic Republic of Congo the impact evaluations will try to determine the effect of this community based activity on health service utilization. In both countries, advance social marketing techniques will be tested as part of the evolution of the household visits.

ANNEX 7: ECONOMIC AND FINANCIAL ANALYSIS
DEMOCRATIC REPUBLIC OF CONGO

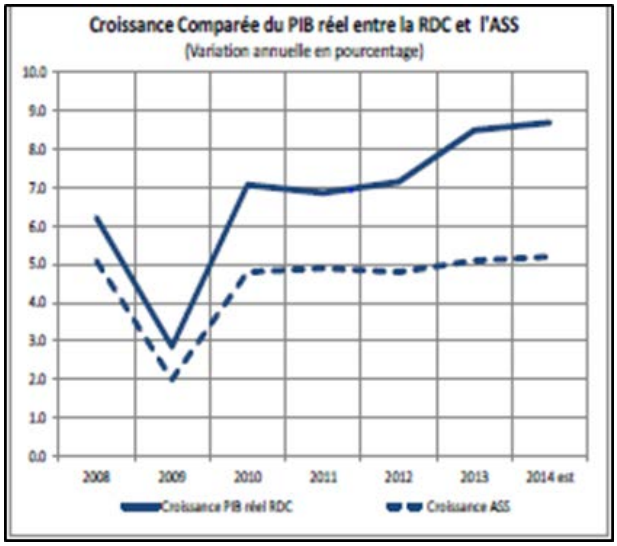
Health System Strengthening Project for Better Maternal and Child Health Results Project (PDSS) (P147555)

1. **Economic analysis plays a crucial role in informing the choice of project alternatives, especially in resource-constrained environments, and is often used to make decisions on how a project could enable efficient and equitable use of resources**. It also helps estimate the economic returns of sector-specific investments. The economic analysis of the proposed Health Systems Strengthening Project for the DRC will (i) provide an overview of the macro-fiscal and health financing context of the country, (ii) analyze the economic rationale for investing in the health sector in the DRC; (iii) investigate the costs and benefits of the proposed project's components and activities, through a Cost-Benefit Analysis (CBA). The analysis is informed by existing primary and secondary data sources, including a Public Expenditure Review (World Bank, 2014), National Health Accounts (Government, 2011), Economic Updates (World Bank, 2014), and Demographic Health Surveys and Multiple Indicator Cluster Surveys (2010, 2014).

Health financing in the DRC: Rapid income growth but limited resource mobilization for health

2. **Since 2010, despite a security context which remains fragile, the macroeconomic results of the DRC are largely superior to the rest of the sub-Saharan African region**. The DRC displays strong growth rates thanks in particular to the dynamism of the mining activities. This growth has reached 7.4 percent on average in 2010-2013 with a peak of 8.5 percent in 2013 (Fig.1). However, the growth in the mining sector and natural resources is not reflected by an increased mobilization of revenues for the Government (13 percent of GDP in 2013). In effect, the DRC is in the paradoxical situation whereby, mining production is increasing rapidly but mining revenues do not seem to translate into revenues for the Government (World Bank, Economic Update, 2014). The shortfall of revenues does not allow the DRC to have the necessary means to increase its investments in human development, social sectors and particularly in health. It is estimated that the DRC has the potential for increasing its revenues (to 29 percent of GDP), if the macro-economic stability (including a 0 controlled inflation is maintained, and for increasing its fiscal space for health (up to 3.5 percent of GDP) and (is there a number for the SS, otherwise SS should be taken out) social sectors.

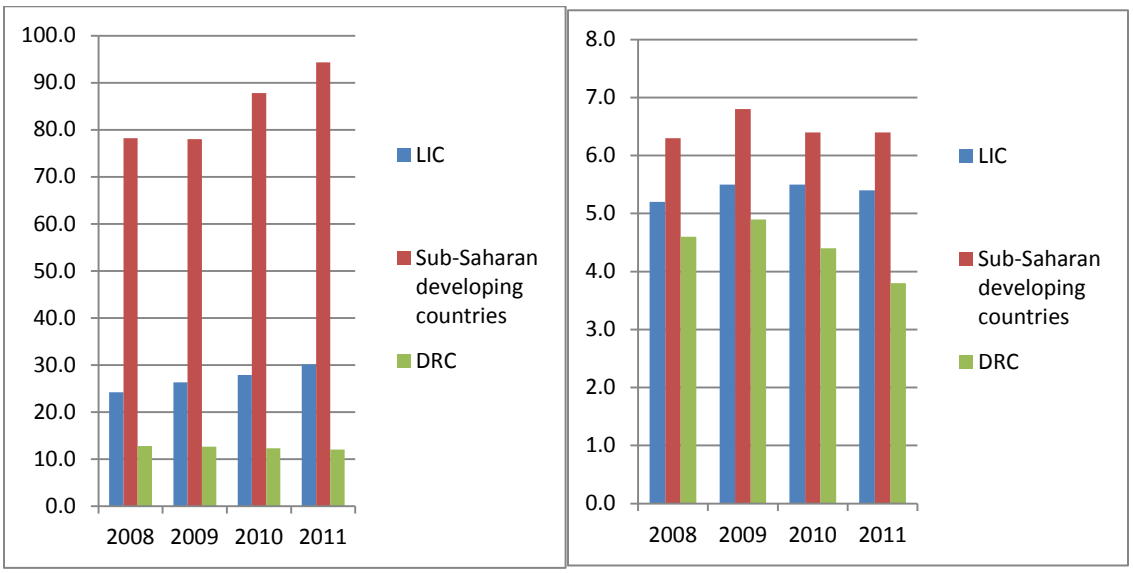
Figure 1: Trends in income growth, Sub-Saharan African Region and DRC, 2008-2014



Source: Economic Update, World Bank, 2014

3. **While the income growth was rapid and relatively stable, the DRC spent less and less for health as a share of GDP between 2008 and 2011.** The DRC spent US$12 per capita for health in 2011. In current value, the total health expenditure has changed little during 2008-2011, as well as per capita. The latter has even slightly decreased from US$12.8 in 2008 to US$12 in 2011 (National Health Accounts 2011). Thus, following the strong increase of GDP over the period, the share of health has decreased from 8 percent in 2008 to 6 percent of GDP in 2011. Accordingly, the DRC spends less than similar countries on healthcare. While sub-Saharan Africa and the low-income countries have seen their total health spending increase, the gap with the DRC is amplified between 2008 and 2011 (Fig.2&3).

Figures 2 & 3: Total health spending per capita and a share of GDP, 2008-2011



Source: National Health Accounts (DRC) and World Development Indicators (others)

4. **The sources of finance for health mainly rely on external development assistance (40.4 percent on average 2008-2011) and household funds (39.6 percent).** Second, external assistance has become the primary funder of health between 2008 (34 percent) and 2011 (47 percent). In 2011 households financed 37 percent of the total health spending, while in 2008 it was 42 percent. Government, including central and provincial sources of finance, accounted for only 15 percent in 2008, and that share has declined to 12 percent in 2011. The private sector contributed 3-4 percent of the total expenditure in 2011 through the direct payment of health care costs for employees (World Bank, PER, 2014).

5. **Government health expenditures (from domestic resources) represented only US$1 (constant value 2007) per capita in 2013**. Their share in the GDP, in the total public expenditure and per capita has declined between 2007 and 2013. Health's share (3.95 percent on average 2007-2013) of total Government spending has declined between 2007 (6.8 percent) and 2013 (5.3 percent). In relation to GDP, they represented in 2013 0.7 percent, a level equivalent to that of 2007, but the trend had been declining up to 2009 (0.3 percent) with a recovery thereafter. Government health expenditures per capita have followed the same patterns, after declining rather sharply between 2007 and 2010, they have recovered and even exceeded their 2007 level in 2013. However, the depreciation of the national currency (Francs Congolais) led to a volume per capita (US$1) in 2013, still significantly below the level of 2007 (US$1.5).

6. **The execution of Government health expenditures is unpredictable, ranging from 66 percent (2009) to 128 percent (2007).** MOPH expenditures greatly exceeded the voted budget in 2007, 2008 and 2013, whereas they were significantly lower in 2009 and 2012 (between 67 and 70 percent of execution). This caused an erratic pattern in constant value, with a reduction in the amounts up to 2010 and then annual increases of 7 percent to more than 50 percent. Meanwhile, the provincial transfers allocations have rarely taken place; in 2011, no payment had been made under these budget codes. In 2012, it was 1 percent of the expenditures that have been executed while for 2013, the expenditures were almost zero, with 0.1 percent of the allocated amounts having been executed. These allocations remain therefore, to date, still "virtual" (World Bank, PER, 2014).

7. **Government current expenditure is largely driven by the wage bill.** The current expenditure represents nearly 87 percent of Government health expenditures over the period (with 68 percent and 73 percent respectively in 2007 and 2013, but more than 90 percent or even 97 percent for the other years), and therefore less than 15 percent is devoted to investments. Staff costs consume more than 85 percent of current expenditure over the period (42 percent in 2006). Compared with the situation at the beginning of the period (2007-2008), there is a marked deterioration of the financing of operational expenditure and investment. However, it should be noted that up to 2007/2008, health personnel was only nominally supported by the Government budget, and the introduction of a more effective remuneration system can be considered a step forward for the sector. Since 2013, there has been an increase in the funds made available to front-line facilities (PESS program) (World Bank, PER, 2014).

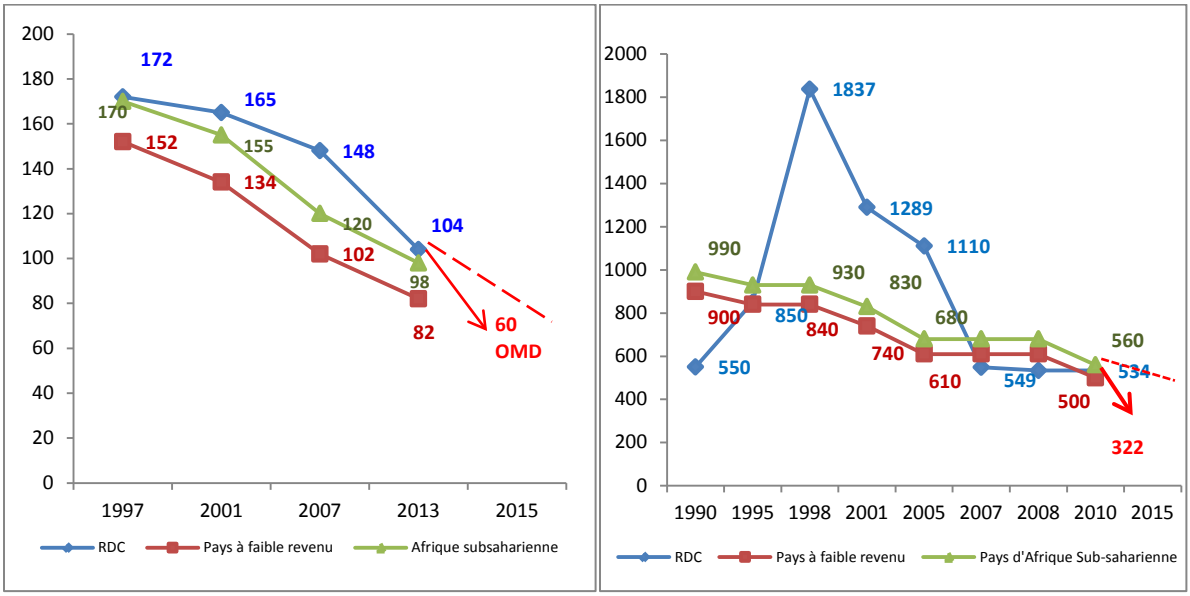
Economic rationale for investing in the health sector in the DRC

8. **Investment in health pays off.** Improving health outcomes and access to health services is critical to building all citizens' capabilities and enabling them to compete for jobs and

opportunities generated through inclusive and sustainable development. Providing health services equitably to all citizens to prevent the ill-effects of diseases and injuries, and to do so without exposing them to burdensome and often catastrophic medical expenses, has been demonstrated to yield significant socioeconomic as well as health benefits at the individual and population levels. Returns on health investment have been increasingly documented over the past two decades recognizing economic benefits through increases in personal and national incomes, and the value of better health in and of itself national incomes, and the value of better health in and of itself (Sachs 2001; Deaton 2003; Bloom and Canning 2008, Savedoff et al 2012, The Lancet Commission on Investing in Health 2013). Several studies have measured the effects of good health on income and growth, showing that healthier people are more able to work and have productive lives in the long term. Bloom and Canning (2000, 2008) defined the health-income relation using four main categories: ”mediators” productivity, investments in physical capital and education, and demographic dividend. Health improvements have accounted for about 11% of economic growth in low-income and middle-income countries between 2000 and 2011 (The Lancet Commission on Investing in Health 2013).

9. **In 2013, the DRC was tied with Niger for the last position on the Human Development Index (HDI, 2013) classification.** The health indicators are alarming in spite of recent progress. MDG 4 (60 for 1,000) and 5 (332 to 100,000) will not be met in 2015, nor in 2020 (national target) (Fig. 4&5). Following a period of strong increase at the end of the 1990s, maternal mortality has experienced a steady decline since the beginning of the 2000s, but has stagnated since 2007 at around 540 deaths per 100,000 live births (549 in 2007 and 534 in 2010).

Figures 4 and 5: Under five mortality rates (1990-2013) and maternal mortality ratios (1990-2010) in DRC and peer countries

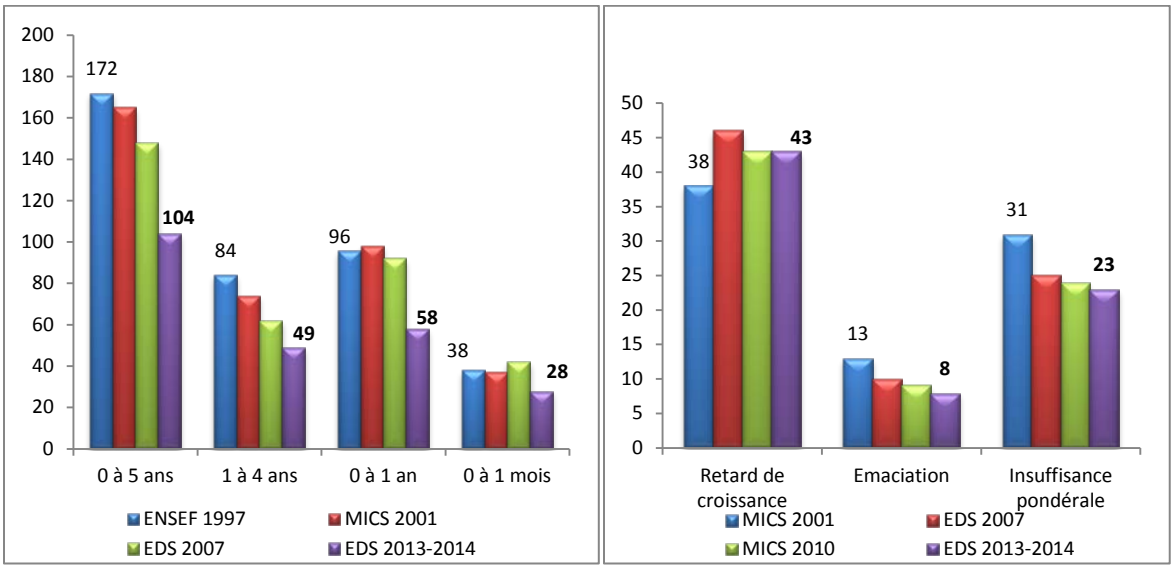


Source : ENSEF (1997), MICS (2001 et 2010), EDS (2007 et 2013-2014) for DRC and World Development Indicators for other countries

10. **Infant mortality (0-1 year), estimated at more than 90 per thousand between 1997 and 2007, has been reduced by almost half in 2013-2014 (58 per thousand)**. Rapid progress

has also been recorded for the 0-5 year mortality; over the past few years it has decreased from 172 per thousand in 1997 to 148 per thousand in 2007 and then 104 per thousand in 2013-2014 (Fig.6). However, malnutrition continues to affect 43percent of children, of which almost half severely, in 2013-2014. The prevalence of malnutrition has not been altered significantly since 2010 and there are even significant increases in the eastern regions of the country (>40 percent).There has been an increase in delays of growth which affect 43 percent of children in 2014 against 38 percent in 2001). Stunting (8 percent) and underweight (23 percent) have not recorded significant progress between 2007 and 2013-2014.

Figure 6 & 7: Child mortality and malnutrition (2001-2014), DRC



Source : ENSEF (1997), MICS (2001 et 2010), EDS (2007 et 2013-2014)

10. **The availability of quality services remains limited in the DRC and impedes the achievement of better health outcomes.** The supply of care, in quantity and quality, remains limited in the country, with only half of the first level facilities able to provide the minimum package of activities (PMA). The delivery model includes theoretically 516 health zones with 417 reference hospitals (HGR) and 8717 health areas (AS), of which only 8363 actually have a health center (CS). Health facilities face numerous challenges related to infrastructure and equipment; 22 percent of hospitals have electricity and 29% have running water (potable or not). The majority of hospitals (59 percent) were built before the country's independence in the 1960s. In practice, only 28 percent of reference hospitals are able to provide clients with a complementary package of activities (PCA), as opposed to 55 percent of health centers which can offer the minimum package (MSP 2009). Due to the ineffectiveness of the public sector, it is estimated that half of the care seeking is made to the private sector, mainly in faith-based facilities.

11. **Access to healthcare is also challenging, with nearly 60 percent of children under the age of five without effective access to basic treatment (DHS 2013-2014).** Access to qualified personnel is one of the major challenges. The difference between urban and rural areas, between Kinshasa and the provinces in terms of distribution of trained health personnel is glaring (ratio of

1 to 5 between Kinshasa and the provinces). In addition, access to quality medicines remains problematic. The main obstacles to accessing healthcare cited by users in various surveys remains high costs, despite the removal of user fees for malaria, HIV/AIDS and tuberculosis (35 percent), especially in the rural areas (35.7 percent) and among the poorest (40.5 percent). Self-medication is the second major cause which explains (30.9 percent) the non-use of health services. The financial barriers are felt particularly among the rural populations (46 percent of the causes of non-use to care in Katanga, 43 percent in the Eastern Kasai and 41 percent in the South Kivu), and by the poorest quintile (40 percent of the causes of non-recourse to care, against 25 percent among the richest people).

12. **The overall goal of the present project (PDO) is to improve utilization and quality of maternal and child health services in the targeted areas of DRC**. The project is designed to improve MCH delivery systems through the scaling-up of PBF. The project also intends to strengthen health system related components that thwart the effective delivery of quality services. The focus is on improving HRH performance, quality of services and financial access. The project will target 140 health zones in 4 provinces (Bandundu, Maniema, Equateur, and Katanga). The project will target approximately 18.1 million people. Based on performance, PBF grants will be used to finance health facilities at selected provinces and health zones to improve quantity and quality of health services. The supply-side component of the project will include geographical equity adjustments and financing of user fee-exemptions for the poor. To generate demand, a large budgetary allocation for household visits will be provided to enhance preventive and curative health seeking behavior.

13. **Investing in maternal and child health services is critical to improving access to quality services for direct beneficiaries.** The economic justification relies on the disproportionate burden of maternal and neonatal deaths in the DRC and the fact that affordable and cost-effective interventions to prevent these avoidable deaths are available. Evidence for low-income countries suggests that improved coverage with a package of interventions directed to mothers and children is extremely cost-effective (US$82-US$142 per DALY averted)[54]. The interventions proposed under this project are all considered global "best buys" in this respect.

Table 1: Cost-effective interventions for mother and child health

Health interventions	Percent of Global Disease Burden Averted	Cost per DALY averted (global)	Estimated annual cost per capita (global)	Included in project
Integrated management of childhood illness	14.0	40.00	1.60	Yes
Expanded Program for Immunization	6.0	14.5	0.50	Yes
Prenatal and delivery care	4.0	40.00	3.80	Yes
Family planning	3.0	25.00	0.90	Yes

Source: Adapted from Cleason et al, 2000

[54] Disease Control Priorities, Second Edition, 2006

14. **The choice of the project components, notably through a result-based approach, also relies on a strong economic rationale.** The PBF approach has already demonstrated its effectiveness and efficiency in addressing health system bottlenecks in the context of the DRC. The PBF approach operates through decentralizing health financing to front-line providers. The mechanism responds to the concern that a large source of system inefficiency originated from the extremely limited share of executed financial flows to provinces (less than a 1%) (PER, World Bank, 2014). Closing the gap between financial resources and effective service delivery is an obvious direct benefit for users. The PBF approach also relies on the assumption that an extrinsic motivation, without crowding out the intrinsic values, will encourage health personnel to adopt an entrepreneurial approach aimed at increasing the use and quality of services provided. Past experiences have proven to be strongly cost-effective for increasing use of services. With less than US$3 spent per capita, past experiences implemented in the DRC with the support of the World Bank and other partners, led to significant increase in assisted delivery, antenatal care and immunization rate in targeted health zones.

Cost-Benefit analysis of the project

15. **A Cost-Benefit Analysis (CBA) was conducted to measure project's economic performance** and to ultimately assess its net returns against alternatives (e.g statu quo). The analysis focused on the PBF output-related component consisting of 81% of the World Bank PBF budget. The method consisted of: (i) identifying the PBF project's inputs and outputs, (ii) monetizing benefits of project, (iii) discounting benefits and costs and (iv) computing the net returns. Costs and benefits have been discounted with a real social discount rate over 5 years[55] estimated at 5% in real terms in this setting. It defines the rate at which future values in the economic analysis are discounted to the present and therefore reflects the social view on how net future project benefits should be valued against present ones. Calculations of economic performance consisted of assessing the economic net present value (NPV) (i.e. the difference between the discounted total benefits and costs) and the economic rate of return (RR) (i.e. the rate that produced a zero value for the NPV). Projects with an RR lower than the social discount rate (5%) or a negative NPV are generally not considered economically sound.

16. Only direct costs and benefits of the PBF project were accounted for direct costs consisted of total PBF project costs for purchasing services, supporting health administration based on their performance, and strengthening quality of services. Indirect costs were not included in the analysis due to difficulties in assessing and monetizing (e.g opportunity costs supported by users). Direct benefits refer to total gains generated from the use of health services delivered to beneficiaries. The analysis did not account for quality upgrading. Indirect benefits were not accounted for (e.g. user's behavior change).

[55] Project duration is 4 years. The cost-benefit analysis was conducted over 5 years, given the first year will consist of finalizing project design and implementation arrangements. Services are expected to be purchased full speed starting Year 2.

Estimation of the NPV and RR:

$$ENPV = \sum_{t=0}^{n} a_t S_t = \frac{S_0}{(1+i)^0} + \frac{S_1}{(1+i)^1} + \ldots + \frac{S_n}{(1+i)^n}$$

$$0 = \sum \frac{St}{(1+ERR)^t}$$

17. **The CBA analysis shows a net value of US$22.8 million, with a rate of return of approximately 16.09%.** Those results demonstrate the positive economic performance of the PBF approach proposed in this project and its capacity to generate large returns for the country economy and society.

18. **Sensitivity analysis allows the determination of the 'critical' variables or parameters of the model**. Such variables are those whose variations, positive or negative, have the greatest impact on a project's financial and/or economic performance. The analysis is typically carried out by varying one element at a time and determining the effect of that change on RR or NPV. In the setting of the DRC's operation, results show that it is unlikely that the net return of the project will be sensibly modified, given prices of services purchased will unlikely be modified over the course of the project. A diminishing social discount rate is also not expected to affect results. The CBA relied on the following project parameters:

Table 2: CBA parameters

Parameter description	**Total**	**Source**
Total beneficiaries	18,157,321	Project estimation, using National Population Statistics projections
Total infant beneficiaries (0-1 year)	2,275,144	National health statistics
Total pregnant women beneficiaries	2,275,144	National health statistics
Total women in reproductive age	3,245,872	National health statistics
	Costs estimate in US$	
Total cost (all donors: World Bank, Global Fund, GAVI, and UNICEF)	285,390,887	Project estimation
Total World Bank Project budget (IDA and HRITF)	226,500,000	Project estimation
Total World Bank PBF component budget (excluding	91 percentof total project budget (or 201,700,000)	Project estimation

component 3)		
Total PBF-related output budget	81 percent (or 164,788,900) of PBF components:	Project estimation
	- 112,125,057 (or 55 percent of PBF components) services purchasing	
	- 21,852,355 (or 15 percent) output-based support for supervision	
	- 30,810,133 (or 11 percent) investments in quality	
Per capita output budget (per year)	3.93 (all donors) 3 (World Bank)	Project estimation
	-2.18 per capita for direct services purchasing	
	-0.60 per capita output payments for health administration	
Social discount rate	5 percent	Standard rate
Budget execution rate	80 percent	Project estimation based on PBF pilots

Table 3: Cost Benefit Analysis results

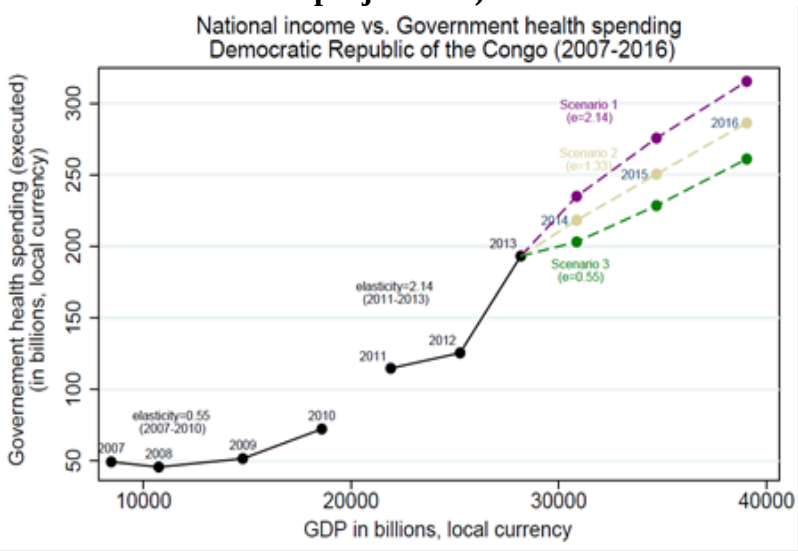
In US$		
Cumulative discounted costs		**141,866,424**
Cumulative discounted benefits		**164,695,906**
Cumulative Costs benefits balance, or Net Present Value (NPV)		**22,829,482**
Return Rate (RR)		**16.09 percent**

Sustainability issues

19. **The selection of the project components, especially the PBF and the health systems strengthening approach, creates the conditions for a sustainable investment in the sector.** By boosting the system's reliance on existing health facilities and delivery mechanisms, the

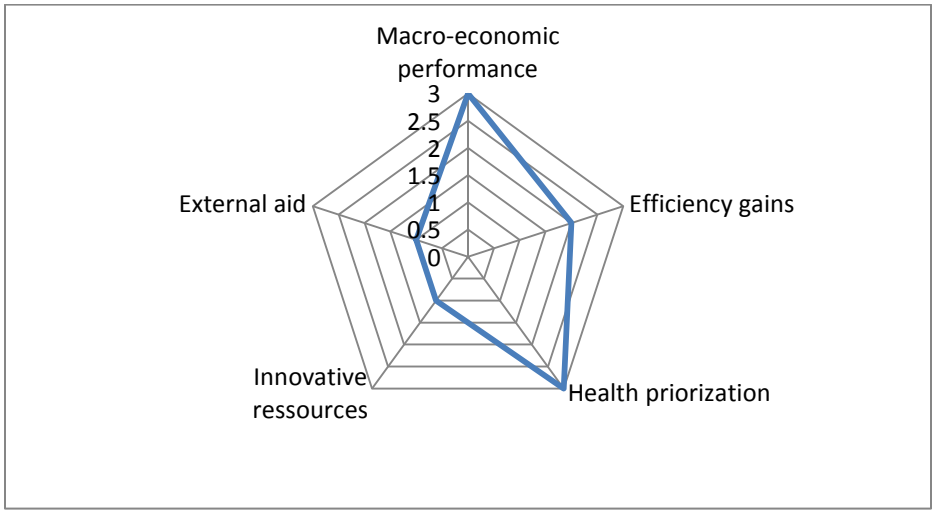
project will be directly contributing towards the sustainability of the sector. By spending US$3.6 per capita, per year (including overhead costs), the cost is likely to be affordable and sustainable in the long term for the country. Despite the fiscal fragility of the health sector in the DRC, there is a noticeable space to further connecting health investments with income growth. The analysis shows that Government health spending has been benefiting from the economic growth from 2011 onwards (e=2.14 from 2011 to 2013, against e=0.55 between 2007 and 2010). If this trend (e>2) will be sustained through 2016, Government health spending could further benefit from the robust macro-economic performance in the medium term and exceed 300 billion FC (against 193 billion FC in 2013, in current value) (Fig.8).

Figure 8: Elasticity of Government health spending to income growth, DRC (2007-2016 projections.)



20. **The situation provides realistic options for sustaining the present project expected results over time in the DRC, including through the mobilization of domestic resources.** In the medium run, there is sizeable room for increasing the fiscal space for health, mainly through (i) a more effective mobilization of Government revenues; (ii) a re-prioritization of Government budget toward health; and (iii) extra gains in technical and allocative efficiency of health spending than could free-up resources for the sector (PER, World Bank, 2014) (fig.9).

Figure 9: Analysis of the potential sources of fiscal space for health (medium term), DRC



Source: PER, World Bank, 2014

21. **Inputs for Ebola preparedness:** according to the MOPH, 68 cases of Ebola have been confirmed in Lokolia, Boende, and Watshikengo (Equateur province). 49 deaths have been reported, as of October 2014. This outbreak is not related to the ongoing Ebola outbreaks in Guinea, Liberia, and Sierra Leone. The outbreak has been traced to a single patient who became infected after preparing bush meat (CDC, 2014). Ebola is a recurring issue for the DRC, where the virus was first identified in the settlements along the banks of the river Ebola, from which it takes its name. This is the seventh local outbreak since the first in 1976.

22. **Beyond the terrible toll in human lives, the Ebola epidemic also has a significant economic impact in terms of forgone outputs, higher fiscal deficits, rising prices, lower real household incomes and greater poverty**. These economic impacts include the costs of healthcare and forgone productivity of those directly affected, but also, they arise from the aversion behavior of other response to the disease (World Bank, Economic Impact of the 2014 Ebola Epidemic). It is estimated that the short-term economic impact would range from 2.1 to 3.4 percentage points of GDP in Guinea, Liberia and Sierra Leone. This forgone output corresponds to about US$360M in 2013 prices. The economic impact for the DRC has not been measured, but it is expected to be lower than 0.5 percentage point, given the more limited scale of the epidemic.

23. **Preparedness and response plans, such as the one supported under this project, have helped mitigate the economic impact of the epidemic in other settings**. It may enable the DRC to also reduce the effects of the sickness and mortality, which consume healthcare resources and subtract people from the labor force. Through the preparedness plan, behavioral effects are also expected to be reduced, and thereby their economic impact mitigated (reduced fear of contagion, increased labor force participation, rebound in local trade and transportation). The behavioral aspect is less sensitive to the actual number of cases as it is driven by aversion behavior. Information, sensitization, mass campaign may positively impact, inspire confidence and help resume to normal economic activity.

ANNEX 8: PBF IMPACT EVALUATION
DEMOCRATIC REPUBLIC OF CONGO

Health System Strengthening for Better Maternal and Child Health Results Project (PDSS) (P147555)

1. **The Government of the Democratic Republic of Congo aims to use evidence-based information to decide if PBF is a worthy financing strategy to be scaled up countrywide**. Component 1 will therefore include an Impact Evaluation using health facility and population-based household surveys. This Impact Evaluation is funded by a Bank-executed Trust Fund (TF) that is separate from this IDA funding and in addition to the Health Results Innovation Trust Fund (HRITF) funding of US$6.5 million. It is a separate HRITF grant of US$2.5 million. Below is a description of the objective of the Impact Evaluation and how it will be used by the Government to determine the merits of PBF.

2. **The overall objective of the impact evaluation is to scientifically evaluate the impact of the PBF interventions** on maternal and child health outcomes, quality of care and health service utilization.

3. **The impact evaluation will be composed of three main building blocks**. The first will evaluate the total impact of the PBF model on the outcomes of interest. The second will focus on quality of care and assess the effects of the indicators that will be used to measure and pay for quality within the PBF scheme. The third will estimate the effects of the community engagement mechanisms that are introduced within the PBF framework to promote demand for health services and preventative health behaviors at the household level. The identification strategy will allow the impact evaluation to measure the causal effects and cost-effectiveness of the different elements of the PBF program.

4. **The study will rely on experimental design in the health zones supported by the project**. Randomized assignment will occur at three levels:

- **a.** A phased rollout of PBF across health zones where previous PBF pilots did not take place. A sample of health zones will be randomly assigned into PBF treatment group (50%) and control group (50%) at the launch of the project. Two years later, PBF will be introduced in the control areas.
- **b.** Three types of quality checklists used for measurement and payment for quality of care will be introduced in PBF health zones through randomized assignment at the health facility level (both health center and hospital) to test the effects of the content of the checklist on quality of care. One checklist will emphasize structural quality, another will emphasize process and content of care while the last will incorporate health providers ability to correctly answer clinical vignette questions.
- **c.** Two community engagement approaches - household visits and community behavior targeting - will be introduced in PBF health zones through randomized assignment at the health center level to test the effects of these interventions on nutrition, health services utilization and preventative health behaviors. The household visit will be introduced at selected catchment areas at the launch of the

PBF scheme while the community behavior targeting will be introduced in the PBF framework two years later.

5. **The effect identification will be based on a basic mean outcome comparison of treatment and control areas**. To evaluate the effect of the PBF package, the IE will explore the random variation in timing generated by the phased-in rollout of the program across districts. The two additional interventions will be randomly rolled out within health zones covered by the PBF, and can thus directly be compared to PBF only as well as to a pure control group.

6. **The Impact Evaluation will collect data on service coverage and health behaviors using household surveys**, while facility surveys will be implemented for the quality indicators. Both household and facility surveys will be conducted by a third-party research firm that is not involved in any aspect of PBF implementation.

7. **Separate HRITF funding will cover all primary activities related to the PBF impact evaluation**. These include data collection, data analysis and report writing, and information dissemination activities. A *baseline survey* will be conducted prior to the piloting of PBF. A *midline survey* will be conducted after year 2 as PBF is scaled up to all health zones supported by the project. An *endline survey* will be conducted three and a half years after the baseline survey and a year and a half after the community behavior targeting intervention will be introduced. Dissemination activities will include restitution of baseline, midline and endline surveys results to key stakeholders in the Democratic Republic of Congo, presentations in international conferences and peer-reviewed journal publications.

ANNEX 9: PARTNERSHIP ALIGNMENT AND HARMONIZATION DEMOCRATIC REPUBLIC OF CONGO

Health System Strengthening for Better Maternal and Child Health Results Project (PDSS) (P147555)

1. **In DRC a unique and innovative partnership will finance and support the scale up of the Results-based financing (RBF) program**. The Global Fund, UNICEF, World Bank and the RMNCH trust fund are coming together with the Government to design a program that aims to rapidly increase access to essential maternal and child health services. It is expected that by the end of 2015, all the health zones in two provinces (Equateur and Bandundu) will be covered by a comprehensive package of services implemented through Performance-Based Financing (PBF). The GFAMT and UNICEF have committed financial, technical and human resources to work with the WB to scale-up PBF in DRC (see table 1 below).

2. **The three agencies will work synergistically to complement each other and utilize their comparative advantage to maximize effectiveness, avoid duplication of efforts and improve efficient use of resources**. The GFAMT is expected to provide essential malaria test kits and drugs as well as HIV/TB commodities to health facilities participating in PBF. In addition, the GFATM will finance key services for Malaria, TB, and HIV in 96 out of 110 targeted health zones in the Bandundu and Equateur. It will also finance the entire PBF package of services and performance framework (rather than just the 3 disease services) in the remaining 14 health zones in Bandundu.

3. **UNICEF will support the health facilities by supplying the Kit Familiaux both at the health facility and community level**; additionally, they will finance community mobilization, decentralized monitoring and management for results, and technical assistance. UNICEF will also contribute funding towards the PBF package of services allocating its resources on IMCI indicators. The UNICEF DRC office has reassigned its human and financial resources and is mobilizing additional resources to support further expansion of this joint initiative beyond 2015. The objective of this partnership is to support the Government's acceleration program to Achieve MDGs 4 and 5. It is expected that more than 200 health zones will be covered by 2017/2018.

4. **The WB, in addition to contributing significant financing as part of its new Health System Strengthening Project**, will support the set up and management of the PBF program as well as the verification of results. Scaling up PBF costs an estimated $3.5 per capita per year which includes the output budget and the overhead costs of PBF, but excluding the drugs and donated kits and management costs of the various agencies.

5. **This collaborative approach will contribute towards the provision of an integrated package of services implemented through PBF, offered to a larger portion of the population**. It is expected that such alignment of development partners will contribute to not only strengthening the health system (efficient, efficacy and better governance) both from a service delivery and stewardship aspect but will also achieve the intended results in terms of improving utilization and quality of care as well as achieving the intended maternal and child health results. Finally this is aligned with the Ministry of Public Health's objective to reduce

partners' fragmentation and ensure harmonization. Discussions for further alignment with GAVI, USAID, UNFPA and Gates Foundation are ongoing.

Table 1: Harmonization Efforts between Partners in DRC

Alignment of partners	Specific tasks	Pay for Performance in the project areas (140 health zones)
Government through the project (WB financing)	Setting up purchasing arrangements for PBF mechanisms at national; provincial, health zone and health facility level\ Web-enabled application with modular payment function (management of separate fund holders) Training for PBF at all levels specific studies; technical assistance; conferences; policy dialogue	YES Estimated at about US$3.6 per capita per year Investment units through business plan approach at US$0.5 per capita per year Performance payments for central (US$0.18 per capita per year); provincial (US$0.21 per capita per year) and health zone administration (US$0.5 per capita per year)
World Bank	Impact Evaluation	n/a
Global Fund	Inputs for Malaria; TB and HIV (drugs; ITNs) Implementing partners SANRU, Caritas, and Cordaid will be participating in PBF evaluations at hospital level, in province level PBF steering committee meetings Alignment with PBF tools such as business plan and indice tool; quality checklists. Purchasing of malaria, TB and HIV related indicators	YES Levels of output pay are being discussed but can be in the range of US$1 per capita, financing of DPS at US$0.50 per capita per year; contribution to health zone teams performance frameworks
GAVI	Converted classical input program mostly to output based financing component	YES Levels of output financing for services are being discussed, financing of DPS at US$0.15 per capita per year; contribution to health zone teams performance frameworks to be discussed.
UNICEF	Health Kits and community level intervention Monitoring of community based activities	YES Levels of output financing for services in the range of US$0.64 per capita per year

Alignment of partners	Specific tasks	Pay for Performance in the project areas (140 health zones)
	Tapping onto the large network of UNICEF staff in the field (500 field staff in all in DRC) to provide supervision and coordination efforts in Equateur and Bandundu Contribution by health staff to PBF quality evaluations in hospitals, assessment of DPS and health zone team performance; participation in provincial PBF steering committee meetings TA at provincial level alignment with PBF tools in coaching (business plan; indice tool)	for two years for 40 health zones out of 110 health zones in Equateur and Bandundu

ANNEX 10: PRE-EPIDEMIC PREPAREDNESS

FOR EBOLA AND MARBURG VIRAL DISEASE

Health System Strengthening for Better Maternal and Child Health Results Project (PDSS) (P147555)

1. **In the context of the Bank's response on Ebola, this technical annex describes the programmatic elements of enhancing preparedness for Ebola and Marburg Virus Disease in DRC**. This technical annex is based on current World Health Organization Guidelines (WHO, August 2014),[56] the WHO Road Map (August 2014),[57] WHO Operational Plan (September 2014)[58], the WB briefing note for country teams on Ebola preparedness, and the DRC experience with seven previous Ebola Viral Disease epidemics.

2. **The 2014 Ebola Virus Disease outbreak in Western Africa is unprecedented, and warrants an unparalleled response**. Guinea, Sierra Leone and Liberia have Ebola Viral Disease outbreaks where the number of cases is still increasing. Senegal has reported one case that is contained, and Nigeria has two clusters which have been contained. DRC has an outbreak of an unrelated Ebola Viral Disease strain that seems contained. Under the leadership of World Bank Senior Management, a unified response is under way. An initial US$105M operation was approved by the World Bank Board Sept 16, 2014.[59] The project is financing the WHO roadmap (https://extranet.who.int/ebola/#) in Guinea, Sierra Leone and Liberia (WHO, August 2014), and was fully disbursed by end September 2014. A new emergency operation is currently underway bringing total Bank financing of the Ebola emergency response to US$400M.

3. **For countries that are not yet affected or countries that are affected such as DRC, it is critical that the pre-epidemic preparedness phase, in the WHO document on Ebola and Marburg virus disease epidemics (WHO, August 2014), is fully implemented.** The interventions in this technical annex are based on the 12 stages of the pre-epidemic phase as advised by the WHO.

4. **Based on the demand of the Minister of Finance of the DRC, US$20M from the current health operation that is being prepared will be put aside to finance the Ebola and Marburg Viral Disease pre-epidemic preparedness.** Although DRC has good experience with containing Ebola Virus Disease (EVD) outbreaks, it is necessary to be vigilant and to boost the pre-epidemic preparedness for EVD nationwide. Until now, EVD outbreaks in DRC, including the first ever documented outbreak in Equateur province from where the

---

[56] WHO Standard Operating Procedures (SOPs) - Ebola and Marburg virus disease epidemics: preparedness, alert, control and evaluation" Interim Version 1.2 (August 2014 version) that describes how to deal with Ebola Viral Disease (annex 1 draws from it) http://www.who.int/csr/resources/publications/ebola/manual_EVD/en/

[57] The WHO roadmap for containing Ebola (website and document that can be downloaded): https://extranet.who.int/ebola/#

[58] WHO Operational Plan to Support Preparedness for EVD Outbreaks (16 Sept, 2014)

59 An additional US$12M has been made available through restructuring existing health projects.

virus got its name from a nearby river (Yambuku 1976) have been in rural remote and isolated areas where containment has been relatively easy. Containing outbreaks in heavily urbanized areas in DRC, as was done in Nigeria recently, would require an enhanced preparedness and augmented response.

5. **Where possible, the Ebola and Marburg Viral Disease pre-epidemic preparedness will be included in the current health system strengthening project**. The '**contrat unique**', the performance contract for the new 26 provincial health directorates which is in its final stages of design will be adjusted to include enhanced surveillance responsibilities. In the 140 health zones that the project will cover in the proposed health project – and which include the overall majority of the 80 health zones covered by the current health project- disease surveillance and other epidemic preparedness activities will be included in the health administration's performance contracts at all levels. The table below indicates what activities will be part of the DRC pre-epidemic preparedness response to be done at the country level.

6. **Table showing the 12 stages of the pre-epidemic preparedness phase** according to the WHO, and its application in the proposed health project.[60]

Stage 1: Step up routine surveillance for all viral hemorrhagic fevers	
COMPONENTS	**ACTIONS**
Obtain provincial or national standard case definitions as set forth in the Technical Guidelines for Integrated Disease Surveillance and Response – (see annex 3A of the doc)	Will be done
Disseminate case definitions in health-care facilities.	Will be done
Use the standard case definition for routine surveillance	Will be developed
Systematically search for possible suspected viral hemorrhagic fever (VHF) cases during supervisory visits	Will be included in the contrat unique
Immediately report any case that fits the case definition	Will be done
Train/retrain staff in VHF surveillance	Will be done
Raise the awareness among health-care workers of surveillance capacity requirements as described in the International Health Regulations – (see annex 34 of the doc)	Will be done, through contrat unique nationwide, and additionally through health zone administration in PBF areas

60 Ebola and Marburg virus disease epidemics: preparedness, alert, control and evaluation" Interim Version 1.2, pp 26-29 WHO August 2014

Stage 2. Implement community-based surveillance	
COMPONENTS	**ACTIONS**
Explain and make known the early warning system in the community	Using the extensive community health worker network in DRC, in collaboration with UNICEF and civil society
Identify resource persons (community health-care workers, Red Cross volunteers, religious leaders, traditional midwives, traditional healers, village chiefs, etc.) and train them in community-based surveillance	Will be done
Organize regular health promotion activities in communities, especially those in risk areas and those engaged in risk activities (hunters, mineworkers, et. al)	Will be done
Disseminate simplified case definitions for community use	Will be done
Engage resource persons to report any suspicion or rumor to health-care facilities or health-care workers and apply basic hygiene practices	Will be done
Provide feedback to resource persons about the status of reported rumors	Will be done

Stage 3. Create a system for the collection, packaging, storage, and shipment of specimens	
COMPONENTS	**ACTIONS**
Make sure sample collection materials and personal protective equipment (PPE) are available in the at-risk districts	Will be done
Be aware of and apply the guidelines for the collection, packaging, storage, and shipment of specimens collected from suspected VHF cases. (WHO/CDC recommend contacting WHO/CDC for guidance on testing) – (annex 6 of doc)	Will be done
Make sure adequate boxes and receptacles are available for triple packaging of specimens collected from suspected VHF case – (see annex 7 of	Will be done

Stage 3. Create a system for the collection, packaging, storage, and shipment of specimens	
COMPONENTS	**ACTIONS**
doc)	
Make sure the exact address for the national reference laboratory/ies is available	Will be done
Be aware of the shipping routes for specimens to national reference laboratories	Will be done
Collaborate with the national reference laboratory/ies	Will be done

Stage 4. Establish/strengthen epidemic management committees and rapid response teams	
COMPONENTS	**ACTIONS**
Develop or revise the competencies of epidemic management committees and rapid response teams	Revision competencies of existing committees and rapid response teams and developed further if necessary
Appoint members of the epidemic management committees and rapid response teams	Done
Make sure epidemic management committees and rapid response teams are multisectoral in nature	Will be done
Ensure the epidemic management committees and rapid response teams are functioning	Will be done: functionality will be included in the 'contrat unique' provincial performance contracts of all 26 provincial health directorates
Hold regular meetings to review the epidemiological situation and take stock of medicines, equipment, and other supplies needed	Will be done: functionality will be included in the 'contrat unique' provincial performance contracts of all 26 provincial health directorates

Stage 5. Implement standard infection control precautions in health-care settings	
COMPONENTS	**ACTIONS**
Disseminate the aide memoire on standard precautions in health-care facilities	Will be done, translation is already available
Train health-care workers on standard	Will be done

Stage 5. Implement standard infection control precautions in health-care settings	
COMPONENTS	**ACTIONS**
infection control precautions in health care facilities	
Post copies of standard infection control precautions in health-care facilities	Will be done
Implement standard infection control precautions in health-care facilities	Will be done (a) in PBF health facilities across 140 health zones (24% of the population); special emphasis on hygiene and standard infection control precautions through the quantified quality checklists; (b) in health zones not covered by PBF, the 'contrat unique' will emphasize that the health administration places special attention on these standards.
Make sure that basic hospital-acquired infection control materials (gloves, masks, gowns) and hygiene supplies (soap, alcohol, etc.) are available in health-care facilities	Will be done
Implement the fact sheet on safe management of waste from health-care activities	Will be done

Stage 6. Stockpile personal protective equipment and other supplies needed for epidemiological investigation at the district provincial and national levels.	
COMPONENTS	**ACTIONS**
Build, manage and maintain, in proper storage conditions, a minimum supply of PPEs, disinfectants, and other materials needed to apply standard infection control precautions equivalent to three module A (annex 30 doc) and one module B (annex 31 doc) of the PPE kit in the WHO catalogue	Will be done, partially through the 'contrat unique'
Build, manage and maintain, in proper storage conditions, a minimum supply of sample collection and shipment material	Will be done, partially through the 'contrat unique'
Update the list of cold chain facilities, the waste management system, the	Will be done, partially through the 'contrat unique'

Stage 6. Stockpile personal protective equipment and other supplies needed for epidemiological investigation at the district provincial and national levels.	
COMPONENTS	**ACTIONS**
telecommunications network, and available vehicles in working order in the district health units. Consider repairing defective equipment	
Keep a backup supply of fuel	Will be done, partially through the 'contrat unique'

Stage 7. Improve health –related behaviors among at-risk and vulnerable groups	
COMPONENTS	**ACTIONS**
Promote and strengthen standard infection prevention and control practices within the community e.g. hand washing, food safety, etc.	Will be done, partially through the community health works network, UNICEF and civil society
Collaborate with surveillance teams to promote early detection and reporting among at-risk and vulnerable groups	Will be done, partially through the 'contrat unique'
Work with the national/provincial authorities to identify risk group and risk behaviors and encourage the adoption of risk reduction practices that prevent infection or reduce community transmission. Adapt them to the local practice	Will be done
Develop and disseminate health promotion material as part of a health promotion strategy that targets specific risk reduction actions	Will be done
Raise public awareness of Ebola and Marburg virus disease, especially among risk groups such as hunters, miners, traditional midwives and healers, religious communities, health-care workers, opinion makers, etc.	Will be done

Stage 8. Build or strengthen collaborative links between human health services and health services in mines (Marburg)	
COMPONENTS	**ACTIONS**

Establish a framework for collaboration	Will be done
Hold regular on-site meetings with mine surveillance officers	Will be done
Inform miners about Marburg disease, risk behaviors and individual infection control measures	Will be done
Conduct surveillance of illness in miners in risk areas to facilitate detection of the introduction of the Marburg virus	Will be done
If mine health services report an outbreak among miners or suspected CHF cases, the local health authorities must be on alert and assist them in their investigations	Will be done

Stage 9. Build or strengthen collaborative links between human health services and wildlife services (Ebola)	
COMPONENTS	**ACTIONS**
Establish a framework for collaboration between sectors	Will be done
Hold regular on-site meetings with wildlife surveillance officers	Will be done
Inform water and forest officers and hunters about Ebola disease, risk behavior and individual infection control measures	Will be done
Conduct surveillance to facilitate detection of the introduction of EVD and illness among hunters in risk areas	Will be done
Ask wildlife officers in national parks and reserves to strengthen surveillance for causes of wild animal mortality (especially in gorillas, chimpanzees and monkeys)	Will be done

Stage 10. Notify veterinary services and public health authorities	
COMPONENTS	**ACTIONS**
If the specimen taken from animals tests positive for Ebola or Marburg, both the veterinary services and the public health authorities must be notified immediately.	Will be done

Stage 11. Conduct a comprehensive awareness-raising, social mobilization campaign focusing on promoting specific risk reduction and healthy protection behaviors	
COMPONENTS	**ACTIONS**
As soon as the alert about confirmed animal cases is issued, the Ministry of Health should organize its response teams	Will be done
The response teams should prepare an awareness-raising and behaviorally - focused social mobilization campaign to prevent introduction of the virus into the human population and its spread	Will be done
The prevention campaign should: inform the public about the disease; risk behaviors, and individual and community infection control measures; launch a comprehensive social mobilization campaign to promote infection control practices; and strengthen basic infection control precautions in health care settings.	Will be done

Stage 12. Response team	
COMPONENTS	**PROCURABLE**
Response teams must: step up surveillance; strengthen diagnostic capacities for Ebola and Marburg and strengthen collaboration between human and animal health services.	Will be done

ANNEX 11: ENVIRONMENTAL AND SOCIAL SCREENING AND ASSESSMENT FRAMEWORK
DEMOCRATIC REPUBLIC OF CONGO

Health System Strengthening for Better
Maternal and Child Health Results Project (PDSS) (P147555)

I. Objectives

1. **OP 10.00, paragraph 12 allows for the deferral of certain safeguards instruments in cases where the Borrower/beneficiary or, as appropriate, the member country is deemed by the Bank to experience capacity constraints because of fragility or specific vulnerabilities (including for small states**). This condition is applicable to the Democratic Republic of Congo. This Environmental and Social Screening and Assessment Framework (ESSAF) has been prepared in order to ensure compliance with the World Bank's safeguard policies during the implementation of the project; it also provides general guidelines, codes of practice and procedures to be integrated into the implementation of the Health System Strengthening Project financed by the World Bank in the Democratic Republic of Congo. Its objective is to ensure that activities under the proposed recovery operations will address the following issues:

- avoid health and medical waste management as a result of either individual activity or their cumulative effects;
- not threaten human health;
- avoid any adverse impacts on Indigenous People and promote culturally appropriate benefit-sharing; and
- enhance positive environmental and social outcomes.

II. General Principles

2. **Recognizing the emergency nature of the proposed emergency operation and the related need for providing immediate assistance**, while at the same time ensuring due diligence in managing potential environmental and social risks, the ESSAF is based on the following principles:

- The proposed operation will improve utilization and quality of maternal and child health services in multiple targeted areas. To ensure effective application of the World Bank's safeguard policies, the ESSAF provides guidance on the approach to be taken during project implementation for the selection and design of subprojects and the planning of mitigation measures;
- The project will be implemented in areas that could be occupied by indigenous people. In this case, Indigenous People Plans (IPPs), for the specific subprojects will be prepared during project implementation, according to the requirements of OP 4.10;

- Consultation and disclosure requirements will be simplified to meet the special needs of this operation. The full ESSAF will be disclosed in the Ministry of Health and other public places in DRC and at the World Bank's InfoShop.

III. Environmental and Social Screening and Assessment Framework

3. **The current ESSAF has been developed specifically for this proposed operation to ensure due diligence, to avoid causing harm, and to ensure consistent treatment of environmental (health and medical waste) social and issues**. The purpose of this Framework is also to assist the project team in screening all the subprojects for their likely environmental and social impacts, identifying documentation and preparation requirements and prioritizing the investments.

4. **OP 4.01 Environmental Assessment.** The proposed project will improve utilization and quality of maternal and child health services in targeted areas. This means potential negative environmental impacts of the project are linked to the handling and disposal of medical and health waste (such as placentas, syringes, and material used for delivery of pregnant women) in health facilities covered by the project area. The work in these areas will be done under OP/PB 4.01.

5. **As potential environment adverse impacts are expected to be moderated, in small scale and manageable, the proposed project is classified as environmental Category B**. As an operation in a fragile state, the requirement to carry out a Health Care Waste Management Plan (HCWMP) will be undertaken during project implementation. This instrument will be consulted upon, finalized and disclosed by project effectiveness.

6. **OP 4.10 Indigenous Peoples.** The policy related to Indigenous People is triggered by the project because of the presence of this community in areas where the project is expected to be implemented. Once the exact areas of activities are identified during project implementation, an Indigenous Peoples Plan will be prepared, consulted upon and disclosed by project effectiveness.

7. **Except for OP4.01 and OP4.10, it is not anticipated that OP 4.04, OP 4.11, OP 4.36, OP 4.37, OP4.09, OP4.12, OP 7.50** and **OP 7.60** would be triggered as the project will not affect natural habitats, physical cultural resources or forests, utilize pesticides or pest management techniques, or involve the construction of new dams or use of existing dams. It also does not involve land acquisition leading to involuntary resettlement and/or restrictions of access to resources or livelihoods, nor will the project be implemented on any international waterways nor disputed area.

8. **OP 4.04 Natural Habitats.** There is no potential impact on Natural Habitats that would involve the triggering of this policy. The activities envisaged under the proposed project will not induce impacts on natural habitats, flora and fauna, or biodiversity.

9. **OP 4.09 Pest Management**. The project does not involve pest management. So, the policy is not triggered.

10. **OP 4.11 Physical Cultural Resources.** No civil works activities are expected to be undertaken under the proposed operation.

11. **OP 4.36 Forest**. The policy is not triggered as no activity that could induce forest impacts is foreseen.

12. **OP 4.37 Safety of Dams.** This policy is not triggered, as there will be no dam construction or rehabilitation or use of existing dams that will necessitate dam safety status report.

13. **OP 7.50 Projects on International Waterways.** The proposed project does not include any subprojects that would trigger this OP.

14. **OP 7.60 Projects in disputed areas.** This policy is not triggered because project intervention sites are not within disputed areas.

15. **OP 4.12 Involuntary Resettlement.** As indicated on OP 4.11, no civil works will be funded under the project. Consequently, there will be no land acquisition leading to involuntary resettlement or restrictions of access to resources or livelihoods.

IV. Safeguard Screening and Mitigation

16. In terms of safeguard screening and mitigation process, all health or medical waste must be collected and managed following medical guidance/guidelines as described below.

For waste collection, the project must use:

- Waterproof and "autoclavable'' bins with lids and which have rigid and waterproof plastic bags ;
- Boxes that secure tightly and are puncture resistant;
- Waterproof dustbins with "autoclavable'' covers that are equipped with an anti-reflux device;
- Sealed with lid bins, equipped with bags and rigid waterproof plastic;
- Rigid waterproof bins fitted lid and bags.

For waste elimination:

- Any destruction of waste must be in a technologically appropriate and effective disposal Methods that are ecologically sustainable;
- Disposal methods of waste must present minimal risk for health workers and the community.

For Indigenous Peoples:

- Once Indigenous Peoples are found in the project area, a social assessment will be prepared, according to the requirements of OP 4.10. This assessment will inform the

project of any adverse impacts on Indigenous Peoples, and propose measures to avoid such impacts and support culturally appropriate benefit-sharing, which will be included in the Indigenous Peoples Plan (IPP). The IPP will also include a Grievance Redress Mechanism and monitoring and evaluation of project outcomes for Indigenous Peoples.

- During preparation of the social assessment and IPP and during project implementation, there will be free, prior and informed consultations with Indigenous Peoples leading to broad community support for the project. Documentation will be made available in local languages and in a manner understandable to Indigenous Peoples.

V. Responsibilities for Safeguard Screening and Mitigation

17. The project coordination unit will be in charge of the implementation of the current ESSAF (screening, identification of measures) under the oversight of the national institution in charge of the environmental safeguard procedures and that called the *GEEC (Groupe d'Etudes Environnementales du Congo*). The will be responsible for following up all safeguards concerns and responsible for applying the safeguard screening and mitigation requirements to each subproject.

VI. Capacity Building and Monitoring of Safeguard Framework Implementation

18. **As part of the capacity building to be provided for implementation of the proposed operation, the PIU's environmental and social specialist will receive training in ESSAF's application from the Bank's safeguards specialists**. During supervision, the project team will assess the implementation of the ESSAF, and recommend additional strengthening, if required.

VII. Consultation and Disclosure

19. **This ESSAF will be shared with the ministries directly involved (Environment, Finance and Health**), participating local Governments, concerned nonGovernmental organizations and development partners of the Democratic Republic of Congo involved in the Health System Strengthening Project. It will be disclosed in-country and at the World Bank's InfoShop.

20. **The proposed operation will improve utilization and quality of maternal and child health services in targeted areas which could be occupied by Indigenous Peoples**. During the elaboration of studies related to Health Care Waste Management plan and the Indigenous Peoples Plan, World Bank safeguard policies relating to consultation and disclosure will apply. In particular, the implementing agency will consult project-affected groups, local non-Governmental organizations and Indigenous Peoples on the project's environmental and social aspects, and will take their views into account. The implementing agency will initiate these consultations as early as possible, and for meaningful consultations, will provide relevant material in a timely manner prior to consultation, in a form and language(s) that are understandable and accessible to the groups being consulted.

ANNEX 12: EXAMPLE OF A QUANTIFIED QUALITY CHECKLIST FOR HEALTH CENTERS FROM NIGERIA (2014)
DEMOCRATIC REPUBLIC OF CONGO

Health System Strengthening for Better Maternal and Child Health Results Project (PDSS) (P147555)

[……..…...] MOH/[…..……..] PHCDA

Quarterly Quality Review of Health Centers

version 14 December, 2013

Date:	Name Supervisor:	LGA:	Ward:
Medical Staff Total:		HF:	Population:
Non-Medical Staff Total:			

1	General Management [max 21 points]	YES	NO
1.1	**Presence of map of health facility catchment area**	**1**	**0**
1.1.1	Health map of the health area available and on the notice board of the health facility showing villages, main roads, natural barriers, special points and distance		
1.2	**HMIS reports - business plan - minutes of meetings and patient cards (OPD, ANC, Partographs, FP and Bed head tickets) well stored**	**4**	**0**
1.2.1	In cupboard and in box files and accessible by the duty manager		
1.3	**Staff duty roster available and well displayed up to date for current month and visible for staff and patients**	**1**	**0**
1.4	**Technical meetings with staff conducted monthly and minutes available**	**3**	**0; 1;2**
1.4.1	Each monthly minutes contains at least: (i) date of the meeting; (ii) signed list of participants; (iii) follow-up of decisions taken during the previous meeting; (iv) there is a list of developed recommendations or decisions taken; (v) each month the monthly financial balance is discussed; (vi) minutes of the meeting are signed by the chair. For every meeting report that contains the above = 2 p. (max 3 reports)		
1.5	**Standard Sheets for referral available**	**1**	**0**
1.5.1	At least 10 standard sheets are present during the evaluation		
1.6	**Availability of communication radio or dedicated mobile phone for communication between health facility and general hospital**	**1**	**0**

1.6.1	Radio or mobile phone functional with batteries and/or call credit and contact details on the phone (e. g: Medical Director CH, HF Staff, LGA PBF HFs OICs, PHC Dept. PBF Team and SPHCD PBF Team, etc.)		
1.7	**HMIS reports are filled, updated and transmitted to the LGA on schedule**	**5**	**0**
1.7.1	Transmission of HMIS report is **after verification of the SPHCDA** of the monthly MPA invoice (including those of subcontracted HFs if applicable) and a signed receipt of acknowledgement is available		
1.8	**HMIS data analysis report for the quarter being assessed concerning priority problems**	**2**	**0**
1.8.1	Five priority health problems are followed each quarter and data have been updated up to the month prior to the supervisor's visit (all or nothing)		
1.9	**Health Facility RBF Committee meetings conducted monthly and minutes available**	**3**	**(0; 1; 2)**
1.9.1	Each monthly minutes contain: (i) date of the meeting; (ii) signed list of participants; (iii) follow-up of decisions taken during the previous meeting; (iv) there is a list of developed recommendations or decisions taken; (v) each month the monthly financial balance is discussed; (vi) minutes of the meeting are signed by the chair. Each report according to norms = 1 p (maximum 3 points)		
	Total Points (21)	../21	

Remarks
Date:
Name of Supervisor: Signature of the supervisor:

2	**Business Plan [max 9 points]**	**YES**	**NO**
2.1	**Quarterly business plan for the current period made and accessible**	**2**	**0**
2.1.1	Valid and renegotiated for the current quarter		
	(Section 2: Business Plan)		
2.2	**Business plan prepared with key stakeholders**	**2**	**0**
2.2.1	Facility RBF Committee Members involved (Chairman (president) signed off on the plan)		
2.2.2	Representative (s) of subcontracted private clinics or health posts involved (if applicable)		
2.3	**Business plan contains convincing geographic coverage plan**	**1**	**0**
2.3.1	Strategies for sub-contracts (e.g. villages at more than one hour by foot) are elaborated		
2.3.2	Mobile strategies (EPI, FP; ANC, household visits per protocol) are used and planned		
2.4	**Business plan analyses presence of untrained informal practitioners in catchment area**	**1**	**0**
2.4.1	HF treats this subject in the BP, and suggests a strategy for dealing with informal practitioners		

2.5	**Business plan analyses presence of trained practitioners operating without any permission**	**1**	**0**
2.5.1	BP may suggest to include them or to discourage if quality conditions are not met		
2.6	**Business plan shows a plan to assure financial accessibility for the population**	**2**	**0**
2.6.1	Business plan shows negotiated rates between HF, committee and community		
2.6.2	Business plan shows planning for care for the indigents		
	Total Points (9)	../9	
3	**Finance [max 15 points]**	**YES**	**NO**
3.1	**Financial and accounting documents available and well kept**	**5**	**0**
3.1.1	Monthly financial report available and correctly filled		
3.1.2	Theoretical balance of cash-book corresponds to liquidity in cash		
3.2	**Document available (Indice Tool) to show that quarterly calculation of incomes, running costs, investments and variable performance subsidies are done**	**4**	**0**
3.2.1	This document guarantees running costs: = salaries, purchase of drugs and equipment, subcontracts, petty cash from small expenditures, social marketing, maintenance and rehabilitation		
3.2.2	This document calculates the performance bonus according to the formula: performance bonuses = income of the quarter - running costs		
3.3	**Contract salaries and benefits + performance bonuses do not exceed 50% of total HF income through PBF**	**2**	**0**
3.4	**Existence of monthly performance bonus system is known by staff**	**4**	**0**
3.4.1	Take a random staff member and ask what the performance bonus was last month, and what his or her individual performance % was. If both are explained then 4 points.		
	Total Points (15)	../15	

N_R	Revenue Categories	Revenues	N_E	Expense Categories	Expenses
1	Cost recovery (user-charges)		9	Salaries	
2	Cost recovery (pre-payment)		10	Performance bonuses	
3	Salaries from Gov. & other sources		11	Drugs and medical consum.	
4	PBF Subsidies from fund holders		12	Subsidies for sub-contracts	
5	Contributions from other sources		13	Cleaning and office costs	
6	Others		14	Transport costs	
7	Cash in hand (beginning of quarter)		15	Social marketing	
8	Bank balance at the beginning of the quarter		16	Infrastructure rehabilitation	
	Total Revenue		17	Equipment and furniture	
			18	Other	
				Total expenses	
			19	Put into reserve (cash at hand plus bank balance at the end of the quarter)	

4	**Care for the Indigents [max 4 points]**	**YES**	**NO**
4.1	**Planning for Care for the Indigents expenditures**	**1**	**0**

4.1.1	5% of curative consultations of the previous month: documented quantity in monthly management meetings		
4.2	**Indigent committee meets monthly**	**3**	**0; 1; 2**
4.2.1	The Indigent committee meets monthly to review the Care for the Indigent Category use. Each monthly minutes contain: (i) date of the meeting; (ii) signed list of participants; (iii) follow-up of decisions taken during the previous meeting; (iv) there is a list of developed recommendations or decisions taken; (v) each month the monthly financial balance is discussed; (vi) minutes of the meeting are signed by the chairman. Each report according to norms = 1 p		
	Total Points (4)	../4	
5	**Hygiene and Sterilization [max 31 points]**	**YES**	**NO**
5.1	**Fence health facility available and well-maintained**	**1**	**0**
5.1.1	Fence exists, can be closed at night and there are no holes		
5.2	**Availability of a garbage bin in the courtyard**	**1**	**0**
5.2.1	Bin with lid accessible to clients which is not full		
5.3	**Presence of sufficient latrines/toilets which are well-maintained**		
5.3.1	At least two functional latrines/toilets	**1**	**0**
5.3.2	Floor without fissures with single hole and lid	**0.5**	**0**
5.3.3	Recently cleaned without visible fecal matter	**0.5**	**0**
5.3.4	Door lockable from the inside, super structure with roofing, without flies and no smell	**0.5**	**0**
5.3.5	Smells of disinfectant	**0.5**	**0**
5.4	**Presence of sufficient showers which are well-maintained**		
5.4.1	At least one bathing facility (with floor without fissures, Door lockable from the inside, super structure with roofing)	**1**	**0**
5.4.2	Bathing facility with running water, or container with at the least 20 L of water	**0.5**	**0**
5.4.3	Evacuation of the waste water in a sanitation pit	**0.5**	**0**
5.5	**Waste pit for Health Care Waste is available and according to the norms**		
5.5.1	Waste disposal pit minimum 2 meters deep, lined with clay, concrete or brick or plastic, it is fenced and has a bright flag.	**12**	**0**
5.5.2	The waste pit is a minimum of 15 meters from the health facility, minimum of 50 meters from a household, and 100 meters from a water source		
5.5.3	Health Care Waste is not visible (covered by at the least 10 cm of soil or lime)		
5.5.4	The health facility maintains a register indicating the date of the creation of the pit(s), and the location (s)		
5.6	**Courtyard clean**	**1**	**0**
5.6.1	No waste or medical waste in the courtyard		
5.7	**Sterilization according to norms using a pressure sterilizer**	**3**	**0**
5.7.1	Sterilizer functional		
5.7.2	Sterilization protocol available and utilized (medical personnel present can explain the protocol or demonstrate the process)		
5.9	**Hygienic conditions assured during wound dressing and injections**	**2**	**0**

5.9.1	Yellow and Red Bins for medical waste with lid and foot pedal, lined with bag		
5.9.2	Security box for needles well positioned, and used (and not full)		
	(Section 5: Hygiene)		
5.9.3	Needle cutter available and used		
5.9.4	Container/bowl with lid containing disinfectant used for putting used instruments		
5.10	**Disposal of Health Care Waste according to National Norms**	**6**	**0**
5.10.1	Waste disposal of non-contaminated waste in Black Bin with lid and foot pedal, lined		
5.10.2	Waste disposal of contaminated HCW in Yellow Bins with lid and foot pedal, lined		
5.10.3	Waste disposal of organically HCW in Red Bins with lid and foot pedal, lined		
5.10.4	Protective gear for personnel managing HCW available; boots, plastic shorts, thick plastic/rubber gloves		
	Total Points (31)	../31	
6	**Curative Consultations [max 97 points]**	**YES**	**NO**
6.1	**Good conditions in waiting area**	**1**	**0**
6.1.1	Sufficient benches and or chairs protected against sun and rain and waiting area is not inside the consultation room		
6.2	**Unit fees of drugs displayed to the public**	**1**	**0**
6.2.1	Easily visible in the consultation room waiting area, updated, with (i) unit price per item; (ii) price for a standard treatment of the drug		
6.2.2	Drugs are all generics		
6.3	**Existence and use of waiting card system with numbers**	**1**	**0**
6.4	**Consultation room in good condition**	**5**	**0**
6.4.1	Walls with durable materials well painted, floor paved with cement without fissures, undamaged ceiling		
6.4.2	Consultation room and waiting space separated assuring confidentiality		
6.4.3	Windows with curtains		
6.4.4	Functional door with functional lock		
6.4.5	Running water (tap or water dispenser) with soap and clean towel available and used between patients		
6.5	**Consultation room (where emergencies are received) has 24/7 light**	**1**	**0**
6.5.1	Electricity or solar light **or** functioning high pressure kerosene light present		
6.6	**Consultations are done by skilled staff**	**2**	**0**
6.6.1	Identification of consulting staff in register (names, rank and signature)		
6.7	**Consulting staff is well-dressed**	**1**	**0**
6.7.1	Clean blouse and footwear		
6.8	**Correct numbering of registers**	**1**	**0**
6.8.1	Correct numbering and closed at the end of the month		
6.9	**Service availability 7/7**	**1**	**0**

6.9.1	Supervisor verifies entries in register for the last three Sundays		
6.10	**Malaria protocol put on wall and accessible for staff**	**1**	**0**
6.10.1	National protocol for diagnosis and treatment of simple and severe malaria		
6.11	**Simple malaria correctly treated**	**5**	**0**
6.11.1	Register see last five cases of simple malaria and review treatment acc protocol (one point for each correct treatment according to protocol: max 5 points)		
6.12	**WHO flow diagram for ARI put on wall and accessible for staff**	**1**	**0**
6.13	**ARI protocol applied**	**5**	**0**
6.13.1	See last five cases of ARI and review treatment acc protocol; register mentions Temp; RR; cough yes/no; diagnosis (one point for each correct treatment according to protocol: max 5 points)		
6.14	**WHO protocol for Diarrhea put on wall and accessible for staff**	**1**	**0**
6.15	**Diarrhea protocol applied**	**5**	**0**
6.15.1	See last five cases of Diarrhea and review treatment acc protocol (each correct treatment one point; max 5 points)		
6.16	**Proportion of consultations treated with antibiotics <30%**	**4**	**0**
6.16.1	See last 100 cases in register, check diagnosis and calculate the rate (< 30 cases)		
	(Section 6: OPD)		
6.17	**Treatment guidelines available in consultation room**	**1**	**0**
6.18	**Knowledge of tuberculosis danger signs and criteria for referral**	**5**	**0**
6.18.1	Select any available qualified medical staff, and ask the question on TB dangers signs		
6.18.2	Answer must contain at least 4 of the following signs: (i) weight loss; (ii) loss of appetite; (iii) fever; (iv) cough of more than 15 days duration; (v) night sweating		
6.19	**Stethoscope and BP machine available and functional**	**1**	**0**
6.19.1	Let nurse check BP and review measure		
6.20	**Thermometer available and functional**	**1**	**0**
6.21	**Otoscope available and functional**	**1**	**0**
6.22	**Examination bed available with mattress**	**1**	**0**
6.22.1	Non-torn, plastic cover, specific for the OPD consultations only		
6.23	**Weighing scale available and functional**	**1**	**0**
6.23.1	Inspect in comparison with known weight of supervisor: after weighing, the balance should return to zero		
6.24	**Integrated Management of Childhood Illnesses strategy is applied**	**2**	**0**
6.24.1	Protocol is available in the consultation room		
6.24.2	The last five IMCI cases are traced in the register and comply with the IMCI strategy (all five)		
6.25	**Determination of nutritional status**		

6.25.1	Determination of nutritional status of all children under 5 who come for consultation (check ten children under five through a random sampling method: take a random number between 1 and 3 and using this sampling interval check five consultations)	**2**	**0**
6.25.2	Determination of nutritional status of all women with a sick child under 6 months of age (as above)	**2**	**0**
6.25.3	Screening record of nutritional status available, up to date and properly filled out	**2**	**0**
6.26	**Direct observation of three consecutive children under five (each child maximum 14 points; max 42 points)**		
6.26.1	Ask about fever and IF FEVER ask about (i) since when; (ii) persistent or intermittent	**2**	**0**
6.26.2	Ask about cough and IF COUGH ask about since when	**2**	**0**
6.26.3	Ask for diarrhea IF DIARRHOEA then ask (i) since when; (ii) how often per day; (iii) consistency - water or mucus or bloody; (iv) vomiting	**2**	**0**
6.26.4	GENERAL IMPRESSION: awake or tired?	**2**	**0**
6.26.5	FIRST - COUNT RESPIRATION RATE (observe before touching child!!!)	**2**	**0**
6.26.6	Temperature (measure)	**2**	**0**
6.26.7	Skin pinch (in case of diarrhea) OR chest auscultation (in case of cough)	**2**	**0**
	Total Points (97)	../97	
7	**Family Planning [max 22 points]**	**YES**	**NO**
7.1	**At least one qualified staff trained in Family Planning**	**2**	**0**
7.2	**Confidentiality in consultancy room assured**	**2**	**0**
7.2.1	Room with closed doors, curtains at windows or non-transparent glass		
7.3	**Family planning methods available and visible in demonstration box for potential users**	**2**	**0**
7.3.1	Condoms; OAC; Injectable; Implant; IUD; are available in the demonstration box (**all five items**)		
7.3.2	Penis model available on the desk; box with condoms available with at the least 50 condoms		
7.4	**Staff correctly calculates number of clients expected monthly for oral and injectable contraceptives**	**1**	**0**
7.4.1	For example for 10.000 population (target is entire ward catchment pop) = 10.000 * 22.5% * 25%/12 * 4 * 90% (assuming 25% unmet need; 22.5% target population; 90% of oral/inject AC at HC level. Ask any medical personnel involved in care for clients to explain this target calculation.		
7.5	**Business plan contains strategy to achieve FP targets**	**3**	**0**
	(Section 7: FP)		
7.5.1	Collaboration with public sector, private sector and social marketing, mobile strategies, advocacy among local leaders etc (explicit mention in the BP)		
7.5.2	Involvement of HF staff in strategies (explicit mention of this in the BP)		
7.6	**Stock of oral and injectable contraceptives in adequate**	**2**	**0**
7.6.1	for example for 10.0000 pop 72 doses of oral (3 month cycles) and injectable methods combined		

7.7	**IUD available and staff trained to use it**	**3**	**0**
7.7.1	at least five IUDs and at the least one staff trained to use it		
7.8	**Implant method available and staff trained to use it**	**3**	**0**
7.8.1	at least five implants available and staff trained to use it		
7.9	**Strategies available for transfer of persons to hospital seeking permanent FP methods**	**2**	**0**
7.9.1	Referral system worked out - strategy to reduce prices; mobile strategy for surgery?		
7.10	**FP individual cards available and filled according to the format**	**2**	**0**
7.10.1	Check at least five cards for BP, hepatomegaly, varicose veins, weight (all cards; all elements checked)		
	Total Points (22)	../22	
8	**Laboratory [max 17 points]**	**YES**	**NO**
8.1	**Laboratory technician or technologist available**	**1**	**0**
8.2	**Laboratory is open every day of the week**	**1**	**0**
8.2.1	Supervisor verifies the last 4 Sundays in laboratory register		
8.3	**List of laboratory examinations visible for the public with fees**	**1**	**0**
8.4	**Results recorded correctly in laboratory register and match with results in inpatient sheets or OPD examination cards**	**3**	**0**
8.4.1	Supervisor verifies last five results		
8.5	**Availability of parasites demonstrations**	**1**	**0**
8.5.1	On plastic paper, in a color book, or put on wall		
8.5.2	Blood smear: Vivax, Ovale, Falciparum and Malariae		
8.5.3	Stools: Ascaris, entamoeba, ankylostoma and schistosome		
8.6	**Microscope available and functional**	**2**	**0**
8.6.1	functional objectives; immersion oil available, mirror or electricity		
8.6.2	blades, cover glass, GIEMSA available		
8.7	**Malaria rapid tests available**	**2**	**0**
8.7.1	At the least 20 tests available in the laboratory; non-expired		
8.8	**Centrifuge available and functional**	**1**	**0**
8.9	**Waste evacuation correctly carried out**	**2**	**0**
8.9.1	Organic waste in a bin with lid with disinfectant		
8.9.2	Security box for sharp objects available and destroyed according to waste disposal guidelines		
8.10	**Personnel adequately washes dirty pipettes in containers with disinfectant**	**1**	**0**
8.11	**Laboratory equipment for testing for PTB**	**2**	**0**

8.11.1	Reagents for AAFB testing; stock control car for reagents is available and lists stock; at the least 30 non-recycled slides available for testing		
8.11.2	External Quality assurance protocol for PTB testing available and implemented: slides sampled and sent for quality control according to protocol, and latest report, as per protocol, is available and shows results as per cut-off point of the protocol		
	Total Points (17)	../17	
9	**In-patient Wards [max 6 points]**	**YES**	**NO**
9.1	**Guard duty roster clearly visible for staff and followed up**	**0.5**	**0**
9.1.1	Supervisor verifies guard duty's report - names and signatures match		
9.2	**Furniture available and in good state**	**1**	**0**
9.2.1	Each bed has a (i) non-torn plastic covered mattress, (ii) mosquito net, (iii) clean sheets, (iv) night table		
9.3	**Patient comfort and hygiene**		
9.3.1	The wards are clean: no debris on the floor; and wards smell of disinfectant	**0.5**	**0**
9.3.2	Space between the beds is at the least one meter	**0.25**	**0**
9.3.3	Each ward has access to drinking water	**0.25**	**0**
9.3.4	Each ward has running water or water dispenser with water, soap and a clean towel	**1**	**0**
9.4	**Light available in each ward**	**0.5**	**0**
9.4.1	Electricity; solar light or rechargeable battery lamp		
9.5	**Confidentiality**	**0.5**	**0**
9.5.1	Women in separate ward from men; the inside of the wards are not visible from the outside		
9.6	**In patient register available and is well maintained**	**0.5**	**0**
9.6.1	check identity and hospital bed days		
9.7	**Recording forms for hospitalizations available and well filled and well stored**	**1**	**0**
9.7.1	At least 10 blanks; supervisor verifies 5 filled forms		
9.7.2	Weight, temperature, and eventual laboratory exams recorded		
9.7.3	Treatment monitoring checked		
	Total Points (6)	../6	
10	**Essential Drugs Management [max 20 points]**	**YES**	**NO**
10.1	**Staff maintains stock cards for ED showing security stock levels = monthly average consumption (MAC) * 2 (two months monthly average consumption)**	**4**	**0**
10.1.1	Supply in register corresponds with physical supply: random sample of three essential drugs		
10.2	**Health facility purchases drugs, equipment and consumables from the Pharmaceutical Council of Nigeria certified distributor, approved by SMOH/SPHCDA**	**3**	**0**
10.2.1	Latest Pharmaceutical Council of Nigeria certified distribution center list for the State available		

10.2.2	Last procurement list is shown which shows the certified distributor which sold the drugs		
10.2.3	All drugs and medical consumables are (i) NAFDAC certified and (ii) Generic		
10.3	**Main pharmacy store delivers drugs to health facility dispensary according to requisition**	**10**	**0**
10.3.1	Supervisor verifies whether quantity requisitioned equals quantity served		
10.3.2	Drugs to clients are uniquely dispensed through prescriptions. Prescriptions are stored and accessible		
10.3.3	Drugs and medical consumables prescribed, are all in generic form		
10.4	**Drugs stored correctly**	**2**	**0**
10.4.1	Clean place, well ventilated with all drugs on cupboards, labeled shelves		
10.4.2	Drugs and medical consumables stored on alphabetical order, first in - first out basis		
10.5	**Absence of out of date drugs or drugs with unreadable labels**	**1**	**0**
10.5.1	Supervisor verifies randomly three drugs and 2 consumables		
10.5.2	Out of date drugs well separated from stock		
10.5.3	Destruction protocol for out of date drugs available and applied		
	Total Points (20)	../20	
11	**Tracer Drugs (min. stock = Monthly Av. Consumption times 2) [max 20 points]**	YES > MAC x 2	NO < MAC x 2
11.1	**Paracetamol 500 mg tab**	**1**	**0**
11.2	**Ibuprofen 200 mg caps**	**0.5**	**0**
11.3	**Chlorpheniramine 2 mg**	**1**	**0**
11.4	**Oxytocin 10IU/ml vial**	**1**	**0**
11.5	**Mebendazole 100 mg tab**	**1**	**0**
11.6	**Ferrous Sulfate 325 mg tab**	**1**	**0**
11.8	**Amoxicillin 500 mg caps**	**1**	**0**
11.9	**Amoxicillin 125 mg/5ml suspension**	**0.5**	**0**
11.10	**Co-trimoxazol 480 mg tab**	**1**	**0**
11.11	**Co-trimoxazol 40mg/200mg - 5ml susp**	**0.5**	**0**
11.12	**Doxycycline 100 mg caps**	**1**	**0**
11.13	**Erythromycin 250 mg tab**	**1**	**0**
11.14	**Co-artemeter 20/120 mg tab (1; 2 3 and 4)**	**1**	**0**
11.15	**Sulfadoxine/pyrimethamine 500 mg tab**	**1**	**0**
11.16	**ORS sachet**	**1**	**0**
11.17	**Condom**	**0.5**	**0**
11.18	**Metronidazol 200 mg tab**	**1**	**0**

11.19	**Sterile gloves**	**1**	**0**
11.20	**Venflon 18G**	**0.5**	**0**
11.20.1	Min stock = 10; MAC applies only when higher than 10		
11.21	**Venflon 22G**	**0.5**	**0**
11.21.1	Min stock = 10; MAC applies only when higher than 10		
11.22	**IV giving set**	**0.5**	**0**
11.22.1	Min stock = 10; MAC applies only when higher than 10		
11.23	**Ringers lactate 1L**	**0.5**	**0**
11.23.1	Min stock = 5L; MAC applies only when higher than 5L		
11.24	**Dextrose 5% 1L**	**0.5**	**0**
11.24.1	Min stock = 5L; MAC applies only when higher than 5L		
11.26	**Syringe 5ml**	**0.5**	**0**
11.27	**Syringe 10ml**	**0.5**	**0**
11.28	**Scalp vein needle**	**0.5**	**0**
	Total Points (20)	..../20	
12	**Maternity [max 24 points]**	**YES**	**NO**
12.1	**Sufficient water with antiseptic soap *and* liquid antiseptic in delivery room**	**2**	**0**
12.1.1	A functioning water source or at the least 20L		
12.2	**Light in delivery room 24 hours**	**1**	**0**
12.2.1	Electricity, solar light or rechargeable battery lamp or kerosene lamp filled with kerosene		
12.3	**Waste from Maternity correctly handled**	**1**	**0**
12.3.1	Bin with lid *and* lining and safe needle disposal container, specific for the maternity room use only		
12.4	**Delivery room is well-maintained**		
12.4.1	Walls with durable materials and painted	**1**	**0**
	(Section 12: Maternity)		
12.4.2	Curtain between delivery bed and door	**1**	**0**
12.4.3	Delivery room smells of disinfectant	**1**	**0**
12.4.4	Floor level cement, without fissures and ceiling not damaged	**1**	**0**
12.4.5	Windows with curtains and functional door	**1**	**0**
12.5	**Availability and use of the Partographs**	**2**	**0**
12.5.1	At the least 10 forms available for use		
12.5.2	Verify three randomly selected Partographs whether filled according to the norms		
12.6	**Deliveries performed by skilled personnel**	**2**	**0**

12.6.1	Identification of the skilled provider from names in the register		
12.7	**Availability of scales for weight/length, an obstetrical stethoscope and an aspirator**		
12.7.1	Tape to measure length	**1**	**0**
12.7.2	Scale to measure weight (check functionality)	**1**	**0**
12.7.3	Aspirator plunged into a non-irritating disinfectant or functional manual/electric aspirator	**1**	**0**
12.8	**Availability of at the least 10 pairs of sterile gloves**	**1**	**0**
12.9	**Availability of at the least 2 sterilized obstetrical boxes**	**2**	**0**
12.9.1	Content at the least 1 pair of scissors, 2 pliers and one needle holder		
12.10	**Availability of at the least one episiotomy box**	**1**	**0**
12.10.1	One sterilized box with needle holder, needles, 1 anatomical plier and 1 surgical plier		
12.10.2	Catgut and nylon sutures; antiseptic, local anesthetics, sterile swaps		
12.11	**Delivery table in good state**	**1**	**0**
12.11.1	Table in two parts with removable non-torn plasticized mattress and two functional leg supports		
12.12	**Available equipment for care of the newborn**	**2**	**0**
12.12.1	Sterile tying string or clip for umbilical cord		
12.12.2	1% tetracycline eye ointment non-expired		
12.13	**Adequate in-patient rooms**	**1**	**0**
12.13.1	Mattress covered in impermeable plastic		
12.13.2	Sheets, blankets and mosquito nets on each occupied bed		
	Total Points (24)	../24	
13	**EPI and Pre-School Consultation [max 20 points]**	**YES**	**NO**
13.1	**Personnel calculates correctly target for fully vaccinated children**	**1**	**0**
13.1.1	Target = population * 4.8% / 12 : asked from any medical personnel dealing with care for clients		
13.1.2	The target population concerns the ward population (or the defined catchment pop in case ward has more PBF primary contract holders)		
13.2	**EPI fridge**	**4**	**0**
13.2.1	Presence of a fridge - temp form available, filled twice a day including the day of the visit		
13.2.2	Temperature remains between 2 and 8C in register sheet		
13.2.4	Supervisor verifies functionality of thermometer		
13.2.5	Temperature between 2 and 8C also according to the thermometer		
13.3	**Chemical Temperature Indicator**	**1**	**0**
13.3.1	Presence of a chemical temperature indicator (this is a specific piece of paper different from the thermometer) which shows temperature acc to the norms		
13.4	**Appropriate storage of vaccines**	**1**	**0**
13.4.1	Freezing compartment: Measles		

13.4.2	Non-freezing compartment: BCG, Penta + HepB, TT, thinners		
13.4.3	Absence of vaccines which are expired		
13.4.4	Readable labels on all vaccines		
13.5	**Appropriate stock of vaccines**	**1**	**0**
13.5.1	BCG, Penta, Polio, Yellow Fever, HBV, Measles, Tetanus		
	(Section 13: EPI)		
13.5.2	Presence of stock control cards for all vaccines; concordance paper and physical stock verified		
13.6	**Cold Chain maintenance**	**1**	**0**
13.6.1	If kerosene fridge: stock of at the least 14L Kerosene; if solar fridge: battery not damaged		
13.7	**Cold packs are well frozen**	**1**	**0**
13.7.1	At the least 5		
13.8	**Syringes available**	**1**	**0**
13.8.1	Auto-blocking at least 30; for dilution - at least 3		
13.9	**Waste collection availability of safe disposal box**	**1**	**0**
13.10	**Stock of U5 growth cards available**	**1**	**0**
13.10.1	At the least 10		
13.11	**Child immunization register well maintained**	**1**	**0**
13.11.1	System is capable of identifying drop outs and Fully Vaccinated Children		
13.12	**Conditions in waiting area for immunization services**	**1**	**0**
13.12.1	Sufficient benches and or chairs, protected against sun and rain		
13.13	**Patients receive numbered waiting buttons according to their arrival**	**1**	**0**
13.14	**Baby weighing scale available and in working condition**	**1**	**0**
13.14.1	Balance calibrated to zero + pants available, clean and in good condition		
13.15	**Group IEC/BCC**	**1**	**0**
13.15.1	Group meeting held before vaccinations (check the schedule of health education sessions)		
13.15.2	Existence of updated IEC report with (a) topic, (b) number of participants, © leader of activity, (d) date and (e) signature		
13.16	**Existence of a system to recover drop-outs**	**2**	**0**
13.16.1	Schedule, record of appointments, classified invidual charts		
	Total Points (20)	../20	
14	**Antenatal Care [max 12 points]**	**YES**	**NO**
14.1	**Business plan contains convincing strategies to effectively conduct ANC for all pregnant women in catchment area**	**1**	**0**
14.1.1	Fixed strategy; and advanced strategy for distant villages: catchment area covers entire ward or defined catchment population if multiple PBF primary contract holders		

14.2	**Weighing scale present, functional and calibrated to zero**	**1**	**0**
14.3	**ANC form for HF available and well filled in: last five forms verified**	**3**	**0**
14.3.1	All: Examinations: weight - BP, Uterus height, Parity, Date of last menstruation		
14.3.2	All: Laboratory: albuminuria, glucose		
14.3.3	All: Obstetrical examination done: Fetal heart rate, Uterine height, presentation, Fetal movement recorded		
14.4	**ANC form shows the administration of Ferrous Sulphate/Folic Acid and Mebendazole and SP (for the last five forms above)**	**2**	**0**
14.5	**ANC cards for mother available: at least 10 in stock**	**1**	**0**
14.6	**ANC register available and well filled in**	**2**	**0**
14.6.1	Complete identity, state of vaccinations, date visit, whether high risk pregnancy or not/danger signs		
14.6.2	All columns well filled including the identification of problems if any, and actions taken		
14.7	**ANC conducted by qualified personnel**	**1**	**0**
14.7.1	Nurse; midwife CHO or CHEW, verified on ANC cards		
14.8	**Group IEC/BCC**	**1**	**0**
14.8.1	Group meeting held before FP consultation (check the schedule of health education sessions)		
14.8.2	Existence of updated IEC report with (a) topic, (b) number of participants, (c) leader of activity and (d) date and (e) signature		
	Total Points (12)	../12	
15	**HIV/TB [max 8 points]**	**YES**	**NO**
15.1	**Well-equipped HIV counseling room ensuring privacy:**	**1**	**0**
15.1.1	Plastered and painted wall of solid material		
15.1.2	Smooth cement floor		
15.1.3	Ceiling in good condition		
15.1.4	Windows with glass and curtains		
15.1.5	Doors that close		
15.2	**Availability of IEC/BCC material related to HIV**	**1**	**0**
15.2.1	Penis model on the table		
15.2.2	A box of condoms on the table which has at the least 50 condoms		
15.3	**Existence of a VCT/PMTCT counseling register and lab register acc norms**	**1**	**0**
15.4	**Staff trained in counseling**	**1**	**0**
15.4.1	At the least one staff trained as a councilor		
15.4.2	All counseling done by a trained councilor		
15.5	**Referral system and follow up for HIV clients**	**1**	**0**
15.5.1	Individual client cards available; planning for CD4 cell counts		

15.6	**Referral system and follow up for TB patients**		
15.6.1	Each AAFB+ PTB patient has a person attached to him/her who supervises DOTS: proof of in register; mobile phone number of such a supervisor is registered	**2**	**0**
15.6.2	Each PTB patient has a contact address and/or phone number in both the register and the individual card		
15.8	**Availability of anti-tuberculosis drugs (for at least three new clients)**	**1**	**0**
15.8.1	Rifampicine-isoniazide-pyrazinamide : cp120+50+300mg		
15.8.3	Etambutol tabs 400 mg		
	Total Points (8)	../8	

Nr	Service	Max	P	%
1	General Management	21		
2	Business Plan	9		
3	Finance	15		
4	Indigent Committee	2		
5	Hygiene	31		
6	OPD	97		
7	Family Planning	22		
8	Laboratory	17		
9	Inpatient Wards	6		
10	Essential Drugs Management	20		
11	Tracer Drugs	20		
12	Maternity	24		
13	EPI	20		
14	ANC	12		
15	HIV/TB	8		
	Total	324		

Name Supervisor	Signature:
Name Head of Clinic/Staff	Signature:
Date:	Final Score:

ANNEX 13: MAP OF DEMOCRATIC REPUBLIC OF CONGO
Health System Strengthening for Better
Maternal and Child Health Results Project (PDSS) (P147555)