PROJECT INFORMATION DOCUMENT (PID)
APPRAISAL STAGE

Report No.: PIDA24122

Project Name	GN PRIMARY HEALTH SERVICES IMPROVEMENT PROJECT (P147758)
Region	AFRICA
Country	Guinea
Sector(s)	Health (100%)
Theme(s)	Child health (20%), Other communicable diseases (20%), Health system performance (20%), Nutrition and food security (20%), Malaria (20%)
Lending Instrument	Investment Project Financing
Project ID	P147758
Borrower(s)	Ministry of Finance
Implementing Agency	Ministry of Health
Environmental Category	B-Partial Assessment
Date PID Prepared/Updated	09-Apr-2015
Date PID Approved/Disclosed	09-Apr-2015
Estimated Date of Appraisal Completion	10-Apr-2015
Estimated Date of Board Approval	28-May-2015
Appraisal Review Decision (from Decision Note)	1. The chair authorized the team to appraise the project. The team will: 1) review the budget allocations and costing for each component, make adjustments as needed to ensure components are adequately covered by budget; 2) submit a US$2m proposal to the Ebola Recovery and Reconstruction Trust Fund; 3) review the results framework in detail, and ensure latest PDO and some intermediary indicators are in line with standard HMIS indicators already being collected; and 4) discuss with key partners, in particular USAID and the GIZ, their post-Ebola investment strategies to ensure that they remain complementary to the interventions supported under the project. 2. The Overall Risk Rating of the Project remains Substantial -- OP10,00 para 12 was triggered due to capacity constraints and urgent need of assistance given the Ebola crisis. 3. Based on the latest reconciliation of FY15 IDA flows, the proposed project will be a mixed instrument – composed of US$ 6.8 million in grant funding and US$ 8.3 million in credit funding.

	4. The project time-line will be as follows: Appraisal: April 6-10; Negotiations: April 15; Board delivery: May 28, 2015. 5. The PM will ensure that sufficient, in-country support is provided to oversee implementation of the project. This will require sufficient CMU budget allocation during the Work Program Agreement exercise.

I. Project Context

Country Context

Despite its recent transition to democracy, Guinea remains one of the poorest countries in the world. Emerging from political isolation, instability and military rule, Guinea has recently embarked on a path of long-term development. However, a legacy of political instability, insecurity and governance challenges has limited the potential for shared prosperity with respect to Guinea's vast natural wealth. Guinea's per capita income was approximately $497 in 2011, less than half regional average, and the majority of the population continues to live in extreme poverty - given elusive and volatile economic growth. Poverty in Guinea has been increasing despite its rich agricultural and mineral resources. In 2012, 55.2 percent of the Guinean population lived under poverty compared with 53 percent in 2007 and 40.3 percent in 1995 respectively. Out of 182 countries in the world, Guinea is ranked 170th in 2005 and 178th in 2012 on UNDP Human Development Index.

Although Guinea's population (11.5m) has been steadily urbanizing, more than 2/3rd of the population still live outside of Conakry, which is the sole 'developed' city, with better access to services (in particular private sector services); the rest of the economy is largely informal, rural-based with the majority living from subsistence agriculture: agriculture represents about 80 percent of employment, but less than 20 percent of the GDP. Disparities are also very high across regions, especially comparing Conakry's performance in both economic activity and government services with the rest of the country. Rural poverty (outside of Conakry) is more widespread (64.7 percent) compared with urban poverty (32.1 percent). The rural regions of Nzerekore, Faranah and Labe are the poorest in the country (see poverty analysis by region in Annex 2).

Ebola has taken a major toll on families, communities and the economy and current efforts are geared to support Guinea contain the virus. The Ebola crisis which first emerged in December 2013 is further escalating poverty and suffering, as livelihoods and businesses are disrupted. The crisis has led to lower-than-projected economic performance, with economic growth revised downward from 4.5 percent to 2.4 percent of GDP in 2014. The Bank has already mobilized funds to help Guinea contain the virus as part of an international support effort. A multi-million dollar Ebola Emergency Response Operation was approved by the World Bank's Executive Board on September 16, 2014,with funds underway to support Guinea finance Ebola-containment efforts and help families and communities cope with the economic impact of the crisis. In addition, a macroeconomic and fiscal support operation was also recently approved and is structured around two pillars: (i) building resilience to combat Ebola and (ii) strengthening budget management to improve government capacity to manage Ebola spending.

The Ebola crisis was a direct result of an extremely weak health system, now weakened further by

the epidemic itself. The Ebola crisis and corresponding recovery effort has affected regular maternal and child health services, absorbing much of the funding originally allocated towards such services, and significantly stretching management and service delivery capacity of the Ministry of Health. Preventable deaths of mothers and children are occurring because of the immediate need to focus all financial and human resources on the Ebola response effort and the reluctance of the general population to access the health system (for fear of contamination, lack of trust, lack of affordability due to impoverishment, and lack of available services). Table 1, shows the detrimental impact of Ebola on a number of service delivery indicators in Guinea, with regular consultations for example having declined by more than 50%.

<Table 1 – Impact of Ebola on utilization of select health services>

Whilst overall health systems strengthening in a post Ebola environment will be critical in the long run, the immediate health needs of mothers and children cannot be ignored. For Guinea to build resilience to future epidemics and associated economic shocks, health systems strengthening will be critical in such areas as governance, building capacity under decentralization, service delivery (including engagement of the private sector), human resources for health, supply chain management, and diagnostic and laboratory systems. The success of such efforts are dependent on government commitment to implement country wide reform and significantly increase public sector funding (fiscal space for health), as well as better leverage private sector funding (particularly from the mining sector), towards the health sector. What is critical is that these ambitious, longer term reform strategies and efforts are complemented by targeted interventions that address immediate service delivery needs for mothers and children in Guinea. The government recognizes this and is seeking international support towards a gradual transition from Ebola response to Ebola recovery, with a focus on targeting first and foremost those populations most in need.

Sectoral and institutional Context

The health system in Guinea is severely capacity constrained and underfunded. Despite a move towards decentralization, sub-national authorities including regional health directorates and district level health authorities (prefectures) lack the funding, incentives and motivation to be effective. Sub-national administrative bodies and health facilities are headed by civil servants, tied to government process rigidities with little capacity. Per capita spending on the health system is extremely low and has varied between 0.2-6.9 percent in 2005, with only 2.7 percent of the national budget allocated to health in 2012 (PER 2014). Using 2010 WDI data, which slightly overestimates the total share of the health sector, shows that Guinea is one of the worst performers on per capita spending in the region (Table 2). The 2014 PER highlights the lack of funds invested into the health sector in Guinea as the underlying issue in the delivery of health services. The health system is largely funded by out of pocket expenditures (public facilities largely act like private providers). Some donor contributions towards the delivery of services are channeled through the MOH, however a significant amount is directly channeled to NGOs (US) or the health facilities directly.

<Table 2 – International comparisons of per capita health spending for Guinea, 2010>

2. Combining all sources of health expenditures in Guinea in 2012 was approximately GNF 1.7 trillion, or 4.3 percent of GDP. Of this amount, funds budgeted at MSHP and other ministries, and paid for by general tax revenue—that is Guinean central government's own sources—was approximately GNF 211 billion. This accounted for only half a percent of the GDP and 13 percent

of all health expenditures in Guinea. International funding and technical assistance was the second largest source of resources at GNF 467 billion, which amounted to 28 percent of all health expenditures and 1.2 percent of the GDP. Bulk of these funds were technical assistance going to specific projects and under the control of the donor entities; only 4 percent of the international funds were recorded on MSHP's budget as external finance. The lion's share of resources was supported by households as out-of-pocket health expenditures. Households spent nearly GNF 1 trillion on health related expenditures, which is 60 percent of all health expenditures in Guinea in 2012, and 2.6 percent of the GDP (Figure 1).

<Figure 1 – Sources of funds for the health sector, 2012>

The Ebola crisis has further limited the funding available for critical priority services beyond Ebola: service delivery disruptions and impoverishment have reduced income generation from user fees, and existing limited government and donor funds have been redirected towards the Ebola response effort. Some of the government's most important health programs, such as the Expanded Program on Immunization (EPI), Comprehensive Care for Diseases of Newborn and Children (PECIMNE), as well as the Maternal Health Program (MHP) which have never received much funding and support, are entirely underfunded today. This is particularly problematic, given that maternal health complications, communicable diseases in particular Malaria, and certain children's diseases such as respiratory infections, diarrhea and complications related to immunization and nutrition, constitute major health problems in Guinea. The private sector picks up some of the non- Ebola related service delivery needs and demands, however is located mainly in urban Conakry, benefiting richer segments of the population.

Funding for health is not only extremely limited, but its use has been highly inequitable and inefficient. Already prior to Ebola, funds were not directed to regions or health programs of greatest need. The 2014 PER found that most of the limited public sector funds are linked to, and spent on, a centralized bureaucracy and health worker salaries , largely benefiting Conakry. Since 2005, expenditures for health programs (as listed above) constitute less than 7 percent of the MSHP budget. And because cost recovery tends to be much stronger at higher levels of the health pyramid (explaining also why the private sector is mainly in Conakry), lower level facilities are particularly underfunded, and primarily reliant on external support. The potential for mining and aluminum companies to contribute towards financing the health sector, beyond their staff, remains unexplored and untapped. One bottleneck to leveraging of funds, greater equity and efficiency of spending lies in the government's budget nomenclature, which does not allow for adequate tracking of expenditures by source or program areas (PER 2014).

Despite some improvements, Guinea is among the lowest performers in the region in terms of health outcomes. Life expectancy at birth increased from 43 years to 53 years by the end of 2010, linked to improved access to medication and vaccinations. The 2013 maternal mortality ratio per 100,000 births for Guinea was 650, compared with 859.9 in 2008 and 964.7 in 1990. Although the child mortality rate has decreased from 154 per 1,000 live births in 2002 to 101 per 1,000 live births in 2013, the rate remains high when compared with the rest of the region. Improvements in health outcomes are often linked to the 1990s when Guinea experimented with community based development of health services , through the Bamako initiative. A period of macro-economic and fiscal instability that followed stifled some of this prog ress. By 2013, Guinea was amongst the worst performers in the region on key health outcomes (Table 3), all of which are likely to have significantly worsened under Ebola.

<Table 3 – Comparison of basic health outcome indicators across West African countries>

Child mortality is predominantly linked to low complete vaccination coverage, low ITN coverage and high rates of malnutrition. Although vaccination coverage rates have improved - national Vaccination against measles is a relatively high (61. Percent), - the percentage of children who have been completely vaccinated nationally is only 36.1%. The prevalence of Malaria parasites is another significant problem, with Malaria the leading cause of morbidity and mortality in health facilities today. In general, only 47 percent of households have access to insecticide treated bed nets (ITN) with only 26 percent of under-five children reported to have slept under a mosquito net (or under an ITN) the night before a recent DHS-MICS survey. The situation is made worse by the fact that nearly 31 percent of children under the age of five are showing signs of chronic malnourishment (weight for height <2SD), and nearly half of this group, about 13.7 percent, are severely stunted (table 4). 77 percent of children aged between 6-59 months old are anemic. Acute respiratory infections, fever and dehydration caused by severe diarrhea all contribute to child mortality rates.

Maternal health and mortality is linked to low levels of birth attendance and low quality pre-natal care. The Maternal mortality ratio in Guinea is high with 650 deaths per 100,000 live births, compared to the average of 510 in the SSA region. Nationally only 45 percent of births are attended by a health worker, and only half of those mothers report having delivered their baby in a health facility (PER, 2014). Although about 85 percent of mothers in 2012 reported having some form of pre-natal health consultations (at least one visit), up from about 57 percent in 1992, the quality of such consultations, follow up activities, and complementary activities remains to be assessed.

Mothers and children in rural areas are significantly worse off than their urban counterparts. Measles vaccination rates are 74.7 percent in urban areas and 57.2 percent in rural areas respectively. In the rural areas only 33.5 percent of children have been completely vaccinated compared with 45 percent in the urban areas. The prevalence of malaria among children also varies according to geographical location of a child, with rates more pronounced in rural areas (53 percent) than in urban areas (18 percent). In Conakry, less than five percent of children have tested positive for Malaria in a recent survey, compared with 66 in the Faranah region (PER 2014). Lack of access to mosquito nets and inadequate diagnosis and treatment within 24 hours is a key problem. On nutrition, comparison across provinces also shows that 79 percent of rural children against 69 percent of urban children are affected by anemia. And the weight for height ratio is more than twice as problematic in rural areas as urban areas. On maternal health, whilst 81.9 percent of births in urban areas attended by skilled personnel, attendance in rural areas is only 31.6 percent.

<Table 4 – Select Service Delivery indicators by Place of Residence in Guinea, 2012>

A key bottleneck to the delivery of services is the shortage of sufficiently skilled and health workers and availability of commodities, particularly at community level. Guinea has long had an insufficient and inequitable distribution of skilled health workers to carry out facility-based and outreach activities especially in the prevention and management of childhood illnesses, midwifery, and obstetric complications (table 5). Whilst physicians, midwives and nurses are few in number, and largely produced for, and employed in, secondary, tertiary and private facilities in urban areas , the majority of the population and the poor depend on nursing assistants (ATS) and community health workers which are better represented at health center and community levels . ATS hold great

potential to fill key gaps of higher level cadres: Guinea has produced a large number of ATS, however the limited absorption capacity of the public sector (in terms of fiscal space) means many of them remain unemployed (or work in other sectors). Moreover, their training and thus competency remains sub-optimal particular with regards to maternal health (they lack competencies in skilled birth attendance). Similarly, community Health Workers, despite their acceptance and respect (PER, 2014), do not receive standardized training, and their roles are not adequately optimized to support MNCH (in terms of supporting a horizontal package of health promotion and basic services). The human resource challenge is compounded by the frequent shortages of MCHN commodities and supplies primarily because of limited fiscal space allocated towards health, and because of constrained income generation of primary health facilities in rural areas vis a vis larger facilities in urban areas (and now further under Ebola). The National Central Medical Store (PCG), which has received significant TA from donors in recent years, holds promise to carry out its functions with regards to procurement and delivery. It is well connected to decentralized warehouses across the country (including one in Faranah and Labe, connected by new raods). The key and critical bottleneck for the provision of medicines and supplies lies with the lack of funding for procurement and distribution.

<Table 5: Select Health Worker to Population Ratio (2012- MOH)>

Supportive supervision in particularly over district hospitals and health centers largely only happens on theory. Regular supportive supervision is globally linked to improved service delivery performance. In Guinea, despite the their mandate, the district health authority, staffed with a small team of health professionals, face a number of key bottlenecks preventing the district from actively and regularly carrying out supportive supervision, including: (a) Lack of clear action plan on supervision: There is no clear action plan on supportive supervision at district level despite the general consensus about its importance. (b)Budgetary constraints: No specific budget allocation for supervision is available; (c) Inadequate skills for supportive supervision: Most district managers with clinical, medical or nursing training have not had adequate training in health management to enable them to carry out effective supportive supervision.; (d)Low motivation: Most district health managers, like other health workers, are not sufficiently motivated to carry out supervisory functions due to low salaries, limited incentives and limited opportunities for career development as a manager.; (e)Lack of transport and logistics: District health managers often have limited access to transport and other logistics required to enable them to undertake frequent supervisory visits in their districts.; (f)Heavy workload: Many of the district managers actually perform clinical roles (as they have clinical backgrounds), which leaves them with very little time to perform their managerial and administrative functions.

On the demand side, lack of information, long distances to health centers, and the inability to pay for care all further constrain the utilization of services. The low level of education (33% women and 60% men), literacy (24% women, 54% men) and low levels of income and cultural taboos, particularly amongst remote communities, promote the reluctance to behavioral changes conducive to good health. Community health workers in Guinea are insufficiently used as agents of wider, horizontal health promotion for the poor. Another problem is the long distances to functioning health facilities and lack of transportation that often limit access to services. In total, already prior to the Ebola epidemic, 7 percent of health centers and 9 percent of health posts across the country were non-operational: all of them outside of Conakry. Today this number is likely to be much bigger. Private sector facilities (309 medical facilities and 274 pharmacies) are predominantly located in urban areas and cater to the demands of the urban rich. Despite the heavy reliance on

user fees and cost recovery, little support is provided to cover or subsidize care for the poor. In the absence of universal insurance coverage, few exemption schemes are available for the poor to cover them for critical maternal and child health services. Although several communities are relying on Community Based Health Insurance Scheme to cover them, these schemes are often underfunded or non functional and their annual premium remains unaffordable to the poorest of the poor.

The proposed project intends to address the supply and demand sided bottlenecks to utilization of MNCH services, and provide support towards a transition from Ebola response to Ebola recovery. Guinea was just emerging from a period of macroeconomic and fiscal instability prior to Ebola, with a renewed focus on poverty reduction. Guinea's Poverty Reduction Strategy Paper adopted in 2013, as well as its new daft national health strategy, both prioritize improvements in service delivery, in particular primary based health service delivery, to the poorest people, especially in maternal and child healthcare. Ebola has set Guinea back on all fronts, left large segments of the population even more vulnerable than before, and made primary level service delivery strengthening, as identified in the PRSP and strategic document, ever more important. With the expectation that Ebola cases will have further declined at the time of project effectiveness (September 2015), the project will provide urgent support towards strengthening the delivery and utilization of maternal and child health services in the poorest regions in Guinea, whilst simultaneously informing broader health systems and service delivery reform strategies for the future. The cost effective and high impact interventions and analyses supported under this project will provide new data and information to guide the government towards longer term, sustainable health systems strengthening strategies at the primary level, particularly in the area of human resources for health, pharmaceuticals and supplies, and health financing.

A. Higher Level Objectives to which the Project Contributes

The proposed project is consistent with, and aligned to, the strategic area of the World Bank Group's Country Partnership Strategy (FY14-FY17), which focuses on improving human development indicators in Guinea, and which also covers basic education, social protection and health. In particular the Bank would build on its experience and comparative advantage to support the health sector. Besides, the proposed project would support the CPS health targets of strengthening the capacity to provide services and quality care accessible to the entire population to reduce infant and maternal mortality, malnutrition, including intensifying the fight against communicable and non-communicable diseases. Ultimately, the proposed project will contribute towards the twin goals of the World Bank Group, and contribute towards helping to 1) end extreme poverty and 2) promote shared prosperity of the bottom 40%. The project will do this by specifically targeting the interventions on the rural poor.

II. Proposed Development Objectives

The development objective of the proposed project is to: Improve the utilization of maternal, child health and nutrition services at the primary level of care in target regions. This will be achieved by supporting the government a) strengthen supply, b) strengthen demand, and c) strengthen supervision and management capacity, for maternal and child health services in the poorest regions of Guinea.

The project target regions are two of the poorest in Guinea, Faranah and Labe, which were selected based on a number of criteria detailed in section A of Annex 2. Both regions cover a total of nine out of 34 districts in Guinea: The Labe Region encompasses five districts (Mali, Koubia, Tougue,

Lelouma, Labe) and the Faranah region encompasses four districts (Faranah, Dinguiraye, Dabola, Kissidougou).

III. Project Description

Component Name

Component 1: Strengthen the availability of commodities and trained human resources for the delivery of MCHN services at health center and health post level

Comments (optional)

Funding under the component will focus on 1) improving the availability of MNCH commodities and supplies required to implement neglected maternal and child health programs of the Ministry (sub-component 1.1), and 2) enhancing the numbers and competencies of health workers that are available for service delivery in rural areas (sub-component 1.2).

Component Name

Component 2: Strengthen community level demand and extend services for MNCH services for mothers and children

Comments (optional)

The PER (2014) identified that aside from critical supply side constraints, utilization of MCHN services is also affected by demand side constraints, partly because of the inability of the poor to pay for services and insufficient knowledge on prevention and care seeking by the poor. This component seeks to build on the government's efforts to 1) exempt indigent populations from costs they cannot afford for health care), and 2) engage community health workers in generating demand and service delivery uptake on maternal and child health.

Component Name

Component 3: Strengthen the capacity of the government to supervise, plan, implement and monitor activities at district level and below

Comments (optional)

This component would ensure that the above inputs translate into actual services delivered, largely by 1) Strengthen supportive supervision at district level and below, 2) support evidence generation to inform post Ebola health systems strengthening 3) strengthen capacity for project management and implementation. All interventions will ensure that inputs and concepts are adequately translated into services.

IV. Financing *(in USD Million)*

Total Project Cost:	15.00	Total Bank Financing:	15.00
Financing Gap:	0.00		

For Loans/Credits/Others	**Amount**
BORROWER/RECIPIENT	0.00
International Development Association (IDA)	15.00
Total	15.00

V. Implementation

The Ministry of Health has a long track record in implementing Bank-financed projects, with the most recent project closing in 2013. The proposed institutional and implementation arrangements draw on the implementation experience from the past project.

A Steering Committee, created by an “arrêté” (order) of the Minister of Health, will provide strategic direction and monitor the overall progress of the project. It will approve the annual work plans, as well as the annual and quarterly reports. It will be chaired by the Secretary General of the MOH and composed of MOH Department Directors, UNICEF, UNFPA, and WHO. A

The day-to-day management of the project will be the responsibility of a Project Coordinating Unit (PCU), also created by an arête, that will report directly to the Secretary General. The PCU will coordinate the project activities; (ii) carry out financial management for project activities under the 3 components; (iii) prepare consolidated annual work plans, budgets, M&E report, and the project execution report for submission to the Steering Committee and the Association (IDA).

The PCU will be comprised of a technical unit and fiduciary unit, and will be headed by a full time project coordinator. Staff will be recruited with project funds with the necessary qualifications to ensure appropriate fiduciary control and project monitoring and evaluation. The PCU will have one coordinator, and the technical unit will have three consultants, namely (1) Monitoring and Evaluation specialist; (2) Maternal and Child health care specialist; (3) Community participation specialist. The fiduciary unit with have 3 consultants (1) accountant , (2) Financial management specialist, (3) procurement specialist.

Each directorate in the Ministry of health will play its administrative role regarding the project.

VI. Safeguard Policies (including public consultation)

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

Comments (optional)

The project triggers the Environmental Safeguards Assessment Policy OB/BP 4.01. The project will mostly fund consulting, communication costs, training services, as well as fund drugs, medical supplies, and some equipment. The project will not support any investment (including civil works) that is likely to harm the environment. However, since the project activities are expected to increase the use of health services, as a result, the project is likely to increase the generation of biomedical waste. Consequently the project is classified as category B. Apart from the National Medical Waste Management Plan (NSMWP), which is currently being reviewed and updated, and which will serve to prevent the project environmental and social risks, no other specific instrument is required. The Plan will be approved on, then disclosed both in-country and the bank Infoshop not later than a month after the Board approval, because the project is being processed under the provisions of OP 10.00 para 11 and 12 a.

VII. Contact point

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