PROJECT INFORMATION DOCUMENT (PID)
CONCEPT STAGE

Report No.: PIDC18535

Project Name	GN Community 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	10-Dec-2014
Date PID Approved/ Disclosed	02-Feb-2015
Estimated Date of Appraisal Completion	27-Mar-2015
Estimated Date of Board Approval	25-Jun-2015
Concept Review Decision	Track II - The review did authorize the preparation to continue

I. Introduction and 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. Out of 182 countries in the world, Guinea is ranked 170th in 2005 and 178th in 2012 on UNDP Human Development Index. 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. Rural poverty is more widespread (64.7 percent) compared with urban poverty (32.1 percent).

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. Ebola response efforts have absorbed much of the public sector capacities, and are largely implemented by international organizations and NGOs in parallel to the public health system. This reflects the severe capacity constraints of Guinea to deliver services using its own structures. The health system and the delivery of services, already weak prior to the epidemic, has now weakened even further by the epidemic itself. Many health facilities are no longer operational due to desertion and health personnel death and the disruption in supplies and commodities. 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% due to the need to focus funding on the Ebola response effort and/or the reluctance of the general population to access the health system during this time (for fear of contamination, lack of trust and/or lack of available services).

<< Table 1 >>

Public Disclosure Copy

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, 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 post-Ebola Guinea. Accordingly, this project will provide urgent support towards strengthening the delivery and utilization of maternal and child health services for those communities most in need, whilst simultaneously laying the foundation for broader health systems and service delivery reform. The project should be seen as an initial phase in a broader and longer term strategy by the Bank to strengthen the health sector, and improve maternal and child health, in Guinea.

Sectoral and Institutional Context

The health system in Guinea remains largely centralized and severely 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 health system is largely funded by out of pocket expenditures and whereas some donor contributions are channeled through the MOH, a significant amount is directly channeled to NGOs (US) or the health facilities (such as WHO, UNICEF, UNFPA funding etc). The Ebola crisis has further limited the funding available for non-ebola services: service delivery disruptions have reduced income generation from user fees, and existing government and donor funds have been redirected towards the Ebola response effort. The private sector picks up some of the non- Ebola related service delivery needs, 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 public sector funds are linked to, and spent on, a bloated centralized bureaucracy and health worker salaries, largely benefiting Conakry. 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 important 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).

<<table 2>>

The government's priority health programs are severely underfunded despite some donor support in the past. Since 2005, expenditures for health programs constitute less than 7 percent of the MSHP budget, with some funding provided by development partners. Prior to the Ebola outbreak, the Global Fund was partially financing the HIV/AIDS, malaria, and TB programs, while the US Government has been financing the malaria program through NGOs with a program called "STOPPALU". Funding was already extremely limited and running out prior to Ebola, with many of the remaining resources re-directed towards the Ebola response effort. Furthermore, some of the most important 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) have never received much funding and support. 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.

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 . A period of macro-economic and fiscal instability that followed stifled some of this progress. 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>>

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 haveslept 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 subject to malnutrition (2012 data), and nearly half of this group, about 13.7 percent, are severely malnourished. 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 remaining 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, 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 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 height-for-age rate (a proxy for severe malnourishment) is more than twice as high in rural areas as urban areas (16 percent versus 7 percent), with the rate in Conakry (5.5 percent) two to four times lower than in the other regions. 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>>

A key bottleneck to the delivery of services is the shortage of sufficiently skilled 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 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 and community health workers which are better represented at health center and community levels . Despite the respect they hold in the community (PER, 2014), they remain few in number, stretched in their competencies, and their roles are not adequately optimized to deliver more comprehensive and targeted care. The human resource challenge is compounded by the frequent shortages of MCHN commodities and supplies in part 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).

<<table 5>>

In addition, 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), illiteracy (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. Another problem is the long distances to functioning health facilities and lack of transportation that often limit access to services. In total, 7 percent of health centers and 9 percent of health posts across the country are non-operational: all of them outside of Conakry. 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, community based health care financing schemes (so called Mutuelles) have been developed across the country for coverage against catastrophic costs, partly supported under the previous WB project. The government plans to develop and operationalize more to reach its target (to date 53 of a planned 89 schemes have been initiated), but global evidence also suggests that they require consistent management and financial support, levels of expertise not usually found at the community level, and public subsidies to cover the poorest of the poor.

The government is committed to strengthening service delivery at the community level, with overall health systems strengthening needed in the long term. 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 community 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 populations even more vulnerable than before, and made community level strengthening as identified in the PRSP and strategic document ever more important. With the expectation that Ebola will be contained at the time of project effectiveness (September 2015), the project aims to provide immediate support to those most in need, by strengthening the delivery and utilization of maternal and child health services in remote parts of the country in Guinea. Substantial and far reaching systems strengthening at all levels of the health system will be required in parallel and in subsequent phases.

Lessons learned from previous bank operations in the sector.

The Implementation Completion Report (IRC) of the previous "Health Sector Support" Project" (P065126) in Guinea which closed on December 31, 2013, highlighted that investments in

human resources for health and strengthening management arrangements had the most significant impact on improving health outcomes. The key lessons of the ICR can be summarized as the following a) keeping the design of the project simple, b) not underestimating risks c) identifying and relying on key champions to implement the project where ministry leadership may be inadequate, d) relying on the bank's comparative advantages in the design of a project including in the areas of Human Resources for Health (HRH), strengthening decentralization arrangements and health financing schemes including community health insurance, and e) working towards identifying suitable new business models, including identifying, leveraging and targeting the use of scarce resources as best as possible towards results.

Alternative considered and proposed solution.

Prior to the Ebola crisis, the team considered developing a conventional Results Based Financing Pilot Project. A feasibility study was carried out in 2013, with intent to fund an RBF pilot in the new project. These plans were re-considered following the outbreak of the Ebola crisis. The eventual development of RBF for Guinea is a promising solution to bring about improvements in the health sector in the long term. This however requires a significant amount of technical assistance and capacity building (including engaging staff in training and workshops, baseline data collection, verification visits etc), as well as serious discussions and commitment by the government on health financing reform and investment. Working with the government and partners to develop an experimental pilot may not be possible, nor desirable, at a time when capacity is overwhelmed by the Ebola-containment and immediate health needs are staggering. Accordingly, it was decided that the new project will include a sub-component to support the government lay the foundations for a future PBF pilot and expansion (to be developed in a follow up project or through additional financing), whilst focusing primarily on assisting the government to deal with the immediate post-Ebola environment by financing country owned interventions with existing implementation arrangements that bring about improvements on maternal and child health at the community and primary health care level.

Relationship to CAS

The proposed project is consistent with and aligned to strategic area of 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 Objective(s)

Proposed Development Objective(s) (From PCN)

The development objective of the proposed project would be to: Improve the utilization of maternal, child health and nutrition services at community level in target districts. This will be achieved by supporting the government roll out and implement interventions to improve the supply and demand

of maternal and child health services in areas most in need for support.

The project beneficiaries are children and pregnant and lactating women in selected districts in Guinea. The selection of target areas (selected districts to be finalized with the government during preparation) will be based on a number of criteria including (i) high poverty levels; (ii) low maternal and child health related indicators; (iii) high prevalence of stunting in under-5 children; (iv) existing Community Based Health Insurance Schemes; and, (v) the presence of geographic and program-based initiatives supported by other Partners.

By focusing on the health center, health post and community level, the project interventions will be targeted at the poor. The PER has shown that the more basic health facilities (health posts, community level providers and, to a lesser degree, health centers, are much more likely to serve females, rural residents, the young, the poor, and less educated than higher level facilities. Since these facilities are concentrated in rural areas these results are not particularly surprising. However, they do reinforce the inequities that exist in terms of utilization of services. It is this level of the health system that the project will focus on.

Key Results (From PCN)

The following outcome indicators will be used to measure the achievement of the PDOs:

- Percentage of deliveries assisted by trained health personnel
- Percentage of children fully vaccinated (DPT3+M)
- Percentage of households provided with a mosquito net
- Under-2 children received monthly growth monitoring and promotion (percent)

Some intermediary indicators

- Health Centers with essential medicines and commodities in stock (percent)
- Number of newly trained community health workers in health promotion
- Number of nurse assistants trained in new MNCHN competencies
- Health Centers offering Integrated Management of Childhood illnesses (percent)
- Number of new indigents (poor mothers and children) covered under CBHI schemes
- Number of supervision visits carried out- over health centers and health posts-by district teams
- RBF Pre-Pilot carried out and assessment report produced and disseminated.

III. Preliminary Description

Concept Description

The project will support the government implement its maternal and child health programs by strengthening the demand and supply of maternal and child health services delivered at health post and health centers in rural areas to meet immediate needs for mothers and children. At the same time, the project will lay the foundation for more comprehensive health system reform in the medium to long run. Accordingly, the project is organized around the following three components: 1) Strengthening the supply of MCHN services at primary level, by ensuring availability of commodities and supplies and relevant health worker competencies to deliver MCHN services 2) Strengthening the demand for services, by supporting coverage of the poor through CBHIs, and community demand creation by community health workers; and 3) Strengthening supervision, management and implementation capacity, and evidence generation to guide more wide ranging

future reform. Figure 1 illustrates the link between proposed interventions and PDO, with each of the sub-components discussed separately below.

<<Figure 1: Theory of Change between intervention and project development outcome >>

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

This component will focus on funding the implementation of targeted high impact MCHN interventions through existing national health programs at the community and health center level. Particular support will be provided towards the National Malaria Program (NMP), the Expanded Program on Immunization (EPI), the Comprehensive Care for Diseases of Newborn and Children (PECIMNE) Program, as well as the Maternal Health Program (MHP). Funding under the component will focus on 1) the MNCH commodities and supplies required to implement these neglected programs (sub-component 1.1), and 2) enhancing the numbers and competencies of nursing assistants (already produced for, and present in, rural labor markets) for improved delivery of services (sub-component 1.2).

Sub-component 1.1: Strengthen the availability of maternal and child health commodities and supplies at community and primary health level. The sub-component would support financing of inputs for vaccination rounds and rapid provision of essential equipment, supplies (including bed-nets), drugs and services to support maternal and child health at the health post and health center level. Support will be provided to address the specific causes of drug and commodity shortages at the health post and health center level, including a) the weak financial capacity derived from under-financing of the public sector (in particularly smaller facilities) and/or low purchasing power of populations, b) the weak performance of the upstream procurement system, c) the irrational utilization of available drugs at the health facility level, and d) the incorrect assessment of pharmaceutical products at these levels. The sub-component may tap into the distribution and supply chain mechanisms already strengthened under the Ebola response efforts, and/or may involve government contracting with NGOs and donor agencies for the delivery of such supplies. Inputs related to referrals would also be included, including ambulances and motorbikes based on a needs assessment, fully taking into account those already procured during the Ebola Response effort.

Sub-component 1.2: Expand the number and competencies of nurse assistants to deliver enhanced, high impact maternal and child health services at the health center level. Whereas nurses, midwives and doctors largely staff higher level facilities in urban areas, the rural poor rely on nursing assistants (agent technique de santé) to deliver services and attend births. The sub-component will support the government enhance the number, and optimize the competencies, of these cadres through task shifting, so that they can play an even greater role in improving access to key maternal and newborn health interventions where need is greatest (See Box A). Shifting midwifery related competencies on auxiliary cadres who are more likely to work in rural areas is considered a more effective strategy than shifting nursing or midwifery cadres to rural areas, given the high opportunity cost linked to such a move in the Guinea Context . Investments will be geared towards a) strengthening the capacity of 3 decentralized community training schools to produce larger quantities of nursing assistants with enhanced competencies in MNCH for the rural labor market (investing into physical, technical and organizational capacity upgrading), and 2) deliver a standardized 3 month in-service training and skills upgrading on MNCH to nursing assistants

already posted in the target facilities to be linked to their recertification requirements.

<<Box A: Optimizing the role of Auxiliary Cadres in Rural areas>>

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

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) cover the poor though community based health insurance schemes (called Mutuelles), and 2) engage community health workers in generating demand and service delivery uptake on maternal and child health.

Sub-Component 2.1: Strengthen Mutuelles to cover the poor for maternal and child health services: In Guinea, Community Based Health Care Financing schemes provide an opportunity for communities to cover catastrophic and other expenditures related to maternal and child health. Under the previous WB project, the Bank has supported the development of several new Mutuelle's across Guinea. The ICR found that at the closing of the project, 53 of a planned 89 schemes had been initiated. A preliminary progress report for the community based health schemes was prepared in December 2013, highlighting the promising potential of these schemes to cover communities. Before scaling up their numbers further, existing schemes now require support and evidence on effectiveness. Global evidence suggests that they can play a role in providing coverage if they are adequately 1) subsidized, 2) provided with management support, and 3) subsidize services for the poorest of the poor. The new project would provide continuing support to the existing Mutuelle's including those that were not created under the previous WB project, provide funding for management support, finance the coverage of indigents (poorest of the poor), as well as an assessment and subsequent discussions as to whether such schemes could be scaled up and developed elsewhere.

Sub-Component 2.2: Standardize and institutionalize the training and deployment of community health workers in maternal and child health promotion. This would involve the continued engagement of community health workers, including those mobilized during the Ebola response effort, in demand generation activities alongside basic service delivery functions . The project would support the development and institutionalization of standardized maternal and child health training programs for community health workers, drawing on the training capacities of the 3 decentralized community training schools currently used for the training of nursing assistants only to deliver the new short programs for community health workers (as pre-service education) as guided by WHO standards on task shifting (see box B). This would allow the government to move away from the sporadic, non-standardized and vertical training programs currently provided by different NGOs and institutionalize the horizontal training i n MNCH promotion (in addition to delivering some primary care tasks). The project will also consider funding incentives (monetary and non-monetary) for the recruitment and deployment and supervision (by nursing assistants) of community workers at the decentrali zed level as needed (with a basic mechanism to link payment to tasks or results achieved), and technical assistance to support the development of strategies for their career progression and eventual integration into the formal health system and payroll.

<<Box B: Optimizing the role of Community health Workers>>

Component 3: Strengthen the capacity of the government to supervise, manage and implement activities below district level in target areas

This component would ensure that the above inputs translate into actual services delivered, largely by 1) Strengthen supervision and accountability capacities at district level and below, including through testing out an RBF mechanism in one district; and 2) strengthen the capacity of the government to implement, manage and monitor interventions under the project. Both interventions will ensure that inputs and concepts are adequately translated into services.

Sub-Component 3.1: Strengthening community level supervision and accountability structures to improve service delivery in target districts.

(a) Strengthen capacity to carry out supervision of health centers and posts and community level in the target districts. Support will be provided to district health Directorates to strengthen their supervision and monitoring of district hospitals, health centers and health posts (within a broader mandate of responsibility). Supervision visits to the health facilities within their districts will be incentivized and performed by the District Health Directorates to improve the performance of personnel in the health centers under their authority. The districts will be provided with quality checklists for supervision and mentorship, with payment linked to the completion of carrying out supervisory visits. District Health committees will also be provided all-terrain vehicles to carry out their supervision. In addition, support will be provided to strengthen the capacity of management bodies like the health centers management committees and of community participation bodies for a better control of the management of various available resources, as well as the health facility managers within the target districts. Nursing Assistants will be provided with training to ensure they supervise community health workers.
(b)Carry out a pre-pilot on Results Based Financing, in one district, to produce evidence on more comprehensive service delivery reform for the future. Using the results of the feasibility study conducted in 2013, the project will set the stage for the development of a possible RBF pilot to improve utilization and quality of maternal and child health services, by funding the introductory phase and a pre-pilot experiment on RBF in one district at primary health center level near Conakry. RBF will require a significant shift in thinking about health financing in Guinea, and a significant scale up of resources allocated to the health sector. An actual larger pilot targeting rural areas could be funded through a subsequent project, additional financing, HIRTF, or other partner funds, depending on demand, available capacity and suit able timing. The introductory phase funded under the project will involve training of personnel at the national level and the pre-pilot areas, provision of technical assistance and organization of workshops for the development of the RBF pre-pilot scheme (list of indicators, RBF tools and documents, monitoring and verification modalities, institutional arrangements, costing, etc.). The pre-pilot phase supported under the project will be implemented in a rural Health district and linked to an assessment and workshopsto discuss the experience and generate more knowledge and information and a commitment on financing before a decision to embark on a larger pilot in the target facilities with possible subsequent scale up.

Sub-Component 3.2: Strengthen the capacity of the Ministry of Health in health planning (and post Ebola health assessments), project management and implementation, monitoring and evaluation. Financing will be provided towards TA to strengthen the overall planning capacity of the government in health, including 1) developing a budget system to adequately track and monitor health expenditure, and 2) carrying out analytical work and assessment related to the post Ebola health system and outcomes to generate new evidence to support broader planning efforts. In

addition, capacity will be built to support project management. At the central level, a Project management Committee was already put in place by Ministerial Decree to guide the overall development and implementation of the project. A technical committee was also identified and designated by the Minister, which will guide project preparation and will be responsible for overseeing project implementation. The component will support incremental operating costs for entities involved in project implementation. It will also support the development of the M&E framework linked to track progress specifically for this project.

IV. Safeguard Policies that might apply

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

V. Financing (in USD Million)

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

Financing Source	Amount
BORROWER/RECIPIENT	0.00
International Development Association (IDA)	15.00
Total	15.00

VI. Contact point

World Bank

Contact: Ibrahim Magazi
Title: Senior Health Specialist
Tel: 5331+3414
Email: imagazi@worldbank.org

Contact: Christopher H. Herbst
Title: Health Specialist
Tel: 458-8362
Email: cherbst@worldbank.org

Borrower/Client/Recipient

Name: Ministry of Finance

Contact: S.E.M. Mohamed Diare
Title: Ministre de l'Economie et des Finances
Tel: 224631613838
Email: modiare@yahoo.fr

Implementing Agencies

Name: Ministry of Health
Contact: S.E.M. Colonel Remy Lamah
Title: Ministre de la Sante et de l'Hygiene Publique
Tel:
Email:

VII. For more information contact:

The InfoShop
The World Bank
1818 H Street, NW
Washington, D.C. 20433
Telephone: (202) 458-4500
Fax: (202) 522-1500
Web: http://www.worldbank.org/infoshop

Public Disclosure Copy