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Project Information Document (PID)

Appraisal Stage | Date Prepared/Updated: 14-Aug-2024 | Report No: PIDIA00884

Public Disclosure Authorized

BASIC INFORMATION

A. Basic Project Data

Project Beneficiary(ies)	Region	Operation ID	Operation Name
Guinea	WESTERN AND CENTRAL AFRICA	P506072	Guinea Enhancing Health System Transformation (GUEST) Project
Financing Instrument	**Estimated Appraisal Date**	**Estimated Approval Date**	**Practice Area (Lead)**
Investment Project Financing (IPF)	29-Jul-2024	23-Sept-2024	Health, Nutrition & Population
Borrower(s)	**Implementing Agency**		
Ministry of Budget, Ministry of Economy and Finance	Ministry of Health and Public Hygiene		

Proposed Development Objective(s)

To improve the utilization of quality reproductive, maternal, neonatal, child, and adolescent health and nutrition services in selected regions.

Components

Supply of quality basic RMNCAH-N services
Stimulating demand for basic RMNCAH-N services
Project coordination and Management, and Monitoring and Evaluation
Contingent Emergency Response Component

PROJECT FINANCING DATA (US$, Millions)

Maximizing Finance for Development

Is this an MFD-Enabling Project (MFD-EP)?	No
Is this project Private Capital Enabling (PCE)?	No

SUMMARY

Total Operation Cost	**95.00**
Total Financing	**95.00**
of which IBRD/IDA	**85.00**

Financing Gap	**0.00**

DETAILS

World Bank Group Financing

International Development Association (IDA)	85.00
IDA Credit	85.00

Non-World Bank Group Financing

Trust Funds	10.00
Global Financing Facility	10.00

Environmental And Social Risk Classification

Moderate

Decision

Other Decision (as needed)

B. Introduction and Context

Country Context

1. **Guinea has abundant natural resources and a strategically advantageous geographic location.** With a population of 14 million, the country possesses approximately one-third of the world's known bauxite reserves (7 to 8 billion tons), the largest untapped iron ore deposits worldwide (3.2 billion tons), and significant reserves of gold (estimated at 700 tons), diamonds (ranging from 30 to 40 million carats), and various other minerals. Its coastal access grants it a strategic position for business development.[1,2] Additionally, ample rainfall creates excellent Agro-climatic conditions for cultivating a diverse range of agricultural products.

2. **Despite the robust growth driven by the mining sector, poverty levels in Guinea remain high.** Between 2012 and 2022, the country achieved an average growth rate of 5.8 percent, significantly surpassing the Sub-Saharan African average of 2.8 percent.[1] The mining sector witnessed rapid expansion in recent years, with a growth rate of 35 percent in 2020.[2] Nevertheless, the poverty rate declined slowly from 55 percent in 2012 to 44 percent in 2019,[3,4] while extreme poverty remained high at 13 percent in 2019.[4] Shared prosperity, measured as the annualized

[1] World Bank Group. World Development Indicators. https://databank.worldbank.org/source/world-development-indicators.
[2] World Bank. Guinea: Policy Notes to Support the Transition, 2022.
[3] Republic of Guinea. Ministry of Planning and Economic Development. National Institute of Statistics. 2018-2019 Harmonized Survey of Household Living Conditions.
[4] Republic of Guinea. Ministry of Planning and Economic Development. National Institute of Statistics. 2012 Lightweight Poverty Assessment Survey.

consumption growth of the population in the bottom 40 percent, was negative from 2014 to 2018, indicating that economic growth did not benefit the poor.[2] Major challenges that hindered poverty reduction and shared prosperity include political instability, insecurity, governance challenges, inadequate infrastructure and services for poor households, low agricultural productivity, and demographic challenges.

3. **Guinea's economic growth is expected to be impacted by its high vulnerability to climate change.** The country faces increasing frequency and severity of droughts, floods, and extreme heat. The Notre Dame Global Adaptation Index ranks Guinea 157th out of 185 countries in terms of adaptive capacity for climate shocks, demonstrating low resilience and high vulnerability to climate risks. Rainfall varies considerably across the country, with the highest annual rainfall in the north and along the coast, gradually decreasing towards the south and inland.[5] Coastal and southern regions are prone to floods and have a monsoon climate with rainfall exceeding 100 mm per month, a shorter dry season, and a narrower temperature range than the interior. Like the Sahelian climate, Northern or Upper Guinea is characterized by higher temperatures and greater temperature ranges, a shorter rainy season, and a longer dry season (December-May). With 97 percent of cultivation being rainfed, climate change has significantly impacted crop yields and the agriculture sector. Agriculture, along with natural resources such as mining and hydropower, as well as the manufacturing and services sectors, are key economic sectors for Guinea. Approximately 57 percent of rural households rely on agriculture for subsistence, and the sector employs 52 percent of the workforce.[6] Furthermore, the Simandou project, the world's largest undeveloped iron ore deposit set to start by the end of 2024, could negatively impact nature, biodiversity, water resources, and local communities.

4. **Guinea ranked 178th out of 189 countries in terms of gender inequality in 2019**. Pervasive gender gaps continue to hinder Guinea's long-term development. Education and health investments for women and girls are disproportionately low compared to men and boys, and girls have lower enrollment and attendance rates than boys, with only 22 percent of girls and 78 percent of boys attending secondary school in 2018. Female labor force participation was 56 percent in 2018 compared to 76 percent among men. On the health front, Guinean women, especially in rural areas, experience difficulties in accessing adequate health services, particularly obstetric care, and family planning. Women are deterred from delivering in health facilities in part because services are not respectful[7] and women-friendly and women lack resources, mobility, and decision-making autonomy (59 percent of women report that their husband or partner makes decisions about their health).[8] In addition, 47 percent of women get married before the age of 18.[9] Furthermore, women and girls face concerning conditions due to practices like child marriage, female genial mutilations/cutting, and intimate partner violence.[10] Gender-based violence (GBV) is particularly prevalent in Guinea, with an estimated 63 percent of women experiencing intimate partner violence. There is no clear and coordinated referral system for GBV survivors, and available services lack a survivor-centered approach that provides adequate support through an affordable and quality response system. Finally, regarding employment, female labor force participation was 56 percent in 2018, compared to 76 percent among men.[11]

[5] USAID. Climate Risk in Guinea: Country Profile. 2018.
[6] World Bank. Climate Change Knowledge Portal. Guinea. https://climateknowledgeportal.worldbank.org/country/guinea.
[7] WHO defines respectful care as a care that is organized and provided in a manner that maintains the patient's dignity, privacy and confidentiality, respects their rights, ensures freedom from harm and mistreatment, and enables informed choice and continuous support.
[8] Republic of Guinea. National Institute for Statistics. Demographic and Health Survey report. 2018.
[9] Republic of Guinea. National Institute for Statistics. Demographic and Health Survey report. 2018.
[10] The World Bank. Unlocking Women's and Girls' Potential- The status of women and girls relative to men and boys in Guinea report. 2022.
[11] The World Bank. Unlocking Women's and Girls' Potential- The status of women and girls relative to men and boys in Guinea report. 2022

5. **The human capital of Guinea remains critically low.** In 2020, the Human Capital Index of the World Bank (WB) for Guinea was just 0.37, meaning a child born today is expected to reach only 37 percent of their productive potential by age 18 years. This is below the Sub-Saharan African average of 0.40 and the lower middle-income countries average of 0.48. This low index is primarily due to poor health and education outcomes. For health, only 90 percent of newborns survive to age 5, 76 percent of 15-year-olds survive to age 60, and 70 percent of children under 5 are not stunted. For education, children starting school at age 4 complete only 7 years of schooling by age 18, with learning-adjusted years of schooling at just 4.6 years. Additionally, students in Guinea score only about 33 percent on internationally harmonized tests. Without any intervention, this situation is likely to persist or worsen, with its impact expected to grow. Currently, the total economic cost of eradicating extreme poverty in Guinea is US$360 million (or US$192 per extreme poor), with US$66 million (or US$11 per extreme poor) attributed to health out-of-pocket expenditures (OOPs).[12]

Sectoral and Institutional Context

6. **Health outcomes in Guinea are among the lowest globally.** In 2021, life expectancy was 59 years, the under-five mortality rate was 99 per 1,000 live births, and the maternal mortality ratio was 553 per 100,000 live births.[1] In 2018, only 35 percent of pregnant women received four or more prenatal check-ups, 53 percent delivered in health facilities, 46 percent of women and 39 percent of newborns received postnatal care within a day of birth, and 24 percent of children aged 12 to 23 months got all recommended vaccines.[13] Malaria remains a significant health threat, with prevalence increasing from 15 percent in 2016 to 17 percent in 2021 among under-five children,[14] partially due to climate change.[15] Lack of access to clean water and sanitation exacerbates waterborne illnesses, resulting in a diarrhea prevalence of 15 percent among under-five children. Additionally, 11 percent and six percent of children suffered from moderate acute malnutrition and severe stunting, respectively, and only 4 percent of breastfed children aged 6 to 23 months received a minimum acceptable diet in 2018. Furthermore, the total fertility rate was 4.1 children per woman in 2021 and 37 percent of women aged between 20 and 24 years had given birth at least once before the age of 18 in 2016.[11] High fertility rates and prevalence of adolescent deliveries could be associated with a low prevalence of modern contraception, which stands at 10.9 percent among women aged 15-49, and 10.6 percent among adolescents.

7. **In addition, Ebola and COVID-19 have significantly deepened poverty, disrupted the supply and use of health services, and contributed to a large share of recent deaths.** The 2014–16 Ebola epidemic is estimated to have increased poverty by 2 percentage points, while the COVID-19 pandemic raised it by 4 percentage points.[16] During the Ebola outbreak, the health workforce was severely impacted, reducing the number of nurses and midwives per 1,000 people from 0.56 in 2014 to 0.12, and the number of physicians per 1,000 people from 0.163 to 0.082 within the same period.[17] The Ebola epidemic also led to a decline in health service utilization, with a monthly reduction of 240 deliveries attended by health professionals and 363 pregnant women with three or more

[12] Kpegli,Yao Thibaut; Porgo,Teegwende Valerie; Konkobo Kouanda,Zenab. Impact of Out-of-pocket Health Payments on Poverty and Alignment of Public and External Health Financing in Guinea (English). Health, Nutrition, and Population Global Practice Washington, D.C. : World Bank Group.
[13] Republic of Guinea. National Institute for Statistics. Demographic and Health Surveys. 2018.
[14] Republic of Guinea. Ministry of Planning and International Cooperation National Institute of Statistics. Malaria Indicator Survey. 2021.
[15] Intergovernmental Panel on Climate Change. 2014. Chapter 11 - Human health: impacts, adaptation, and co-benefits.
[16] World Bank. Guinea: Policy Notes to Support the Transition, 2022.
[17] World Bank Group. World Development Indicators. https://data.worldbank.org/indicator/SH.MED.NUMW.P3?skipRedirection=true&view=map

antenatal care visits.[18] Full vaccination coverage for children aged 12–23 months dropped from 37 percent in 2012 to 24 percent in 2018.[19] Similarly, COVID-19 decreased the monthly average number of neonatal admissions by 64 and increased maternal deaths.[20] Overall, infectious and parasitic diseases, including Ebola, yellow fever, measles, polio, Lassa fever, Marburg virus disease, and COVID-19, accounts for 32 percent of deaths.[21]

8. **Climate change is further exacerbating poor health outcomes in Guinea, highlighting the country's limited capacity for climate adaptation and resilience.** Notably, the distribution, variability, and pathogenicity of malaria and other infectious diseases in Guinea have worsened due to climate change.[22] [23] [24] This includes diseases like Ebola, Lassa fever, Rift Valley fever, avian flu, anthrax, and zoonotic tuberculosis.[25] Marginalized communities, including the poor, the elderly, people in rural areas, and women and girls, are most vulnerable to these climate change impacts. Furthermore, climate change is expected to exacerbate food insecurity and malnutrition in Guinea, where 15 percent of the children suffer from underweight.[26] This has increased hunting for bushmeat as a source of animal protein, which has been linked to an increased risk of contracting Ebola and other zoonotic diseases.[27] Frequent floods also contribute to an increase in acute watery diarrhea cases, including cholera and typhoid, with significant impacts on health and health service delivery. Additionally, floods pose significant risks to health facilities that lack climate-sensitive water, sanitation, and hygiene (WASH) measures, and adequate biomedical waste management[28] [29]. The limited capacity for climate adaptation has exacerbated the impact of climate change on the population, with disruptions in health service delivery during climate shocks. Climate-vulnerable areas, informed by climate maps, are Boké, Faranah, Kankan, Nzerekore, and Kindia that are particularly susceptible to flooding. These areas, and Labé, are also severely impacted by extreme heat.[32] To establish climate-resilient health systems, it is crucial to address climate challenges such as flooding and extreme heat, which hinder health service delivery and access to health facilities, compromising health infrastructure. severely impacted by extreme heat.[30] To establish climate-resilient health systems, it is crucial to address climate challenges such as flooding and extreme heat, which hinder health service delivery and access to health facilities, compromising health infrastructure.

9. **The uneven distribution, low motivation, and suboptimal performance of the health workforce are critical challenges to effective health service delivery in Guinea, resulting in poor health outcomes.** In 2020, there were only 0.33 health workers per 1,000 people in the public sector, including 0.1 doctors, 0.14 nurses, and 0.08

[18] Delamou, A., El Ayadi, A. M., Sidibe, S., Delvaux, T., Camara, B. S., Sandouno, S. D., ... & De Brouwere, V. (2017). Effect of Ebola virus disease on maternal and child health services in Guinea: a retrospective observational cohort study. *The Lancet Global Health*, *5*(4), e448-e457.
[19] Republic of Guinea. National Institute for Statistics. Demographic and Health Surveys. 2012 & 2018.
[20] Delamou, A., El Ayadi, A. M., Sidibe, S., Delvaux, T., Camara, B. S., Sandouno, S. D., ... & De Brouwere, V. (2017). Effect of Ebola virus disease on maternal and child health services in Guinea: a retrospective observational cohort study. *The Lancet Global Health*, *5*(4), e448-e457.
[21] World Bank. Guinea: Policy Notes to Support the Transition, 2022.
[22] USAID. Climate Risk in Guinea: Country Profile. 2018
[23] Sylla MB, Giorgi F, Pal JS, Gibba P, Kebe I, Nikiema M (2015). Projected Changes in the Annual Cycle of High-Intensity Precipitation Events over West Africa for the Late Twenty-First Century. Journal of Climate 28:6475-6488.
[24] Tonnang HE, Kangalawe RY, Yanda PZ (2010). Predicting and mapping malaria under climate change scenarios: The potential redistribution of malaria vectors in Africa. Malaria Journal 9(1):111.
[25] USAID. Climate Risk in Guinea: Country Profile. 2018
[26] Guinee. Ministry of health and Public Hygiene. National Assessment of the Nutritional Situational using the SMART method. 2022
[27] USAID. Climate Risk in Guinea: Country Profile. 2018 ibid
[28] Green Climate Fund, 2019. Supporting the Achievement of National Development Policies by Building Climate Adaptive Capacity and Planning in Guinea
[29] Guinea National Adaptation Plan of Action (2007)
[30] Guinea. Climate maps for riverine, coastal, urban floods; heat maps, and other climate risks–Think Hazard! climate maps

midwives,[31] far below the World Health Organization (WHO) standard of 4.45 health workers per 1,000 people.[32] In addition, it is estimated that the country had only 44 percent of the nurses and 18 percent of the midwives needed for maternal and newborn health services. Most health workers are concentrated in urban areas, particularly in Conakry. The Guinean government has identified several post-Ebola reforms in health policy and management, but these have yet to be implemented.

10. **Moreover, the operational capacity of health facilities is quite low, leading to varied health care quality for users.[33]** This is primarily due to frequent stock-outs of essential medicines and inadequate infrastructure in energy, connectivity, lighting, waste management, and WASH. Only Conakry, the capital region, showed the highest operational capacity at 67 percent compared to the national average of 47 percent. The average availability of essential medicines, including those for mothers and children, was low at 19 percent, with no health facility having all essential medicines in year 2020. Only 35 percent of health facilities had a source of light and access to power. Additionally, only 20 percent of health care facilities had computers with internet access, and just 53 percent of health facilities had adequate resources for the storage and disposal of infectious waste. Access to improved water sources and sanitation facilities was limited to 42 percent and 79 percent of health facilities, respectively. Finally, 58 percent of individuals utilizing health facilities reported encountering various issues, including shortages of essential medications, concerns about cleanliness and hygiene, prolonged wait times, unqualified staff, ineffective treatment, poor reception experiences, and staff absence.[34]

11. **The utilization of reproductive, maternal, neonatal, child, and adolescent health and nutrition (RMNCAH-N) services is low, partly due to the challenges and financial barriers**. According to the demographic and health survey (2018), on average 78 percent of children under five experienced an illness in 2018, but only 64 percent of these children visited a health facility. Moreover, only 41 percentage of children aged 6-59 months received vitamin A supplements every six months in 2017. Furthermore, 60 percent of women surveyed identified financial barriers as the main reason for not seeking care at a health facility.[35] From 2010 to 2020, the health sector received 3.5 percent of total public expenditures.[36] Despite public and external health funding, Guinea faced a 62 percent shortfall to achieve health targets in the National Health Development Plan in 2018.[37] Additionally, the Ministry of Health's budget execution rate averaged 46 percent from 2018 to 2020. Public health expenditures were concentrated in Conakry, where health outcomes are comparatively better. Most public health expenditures are allocated to salaries and wages, leaving little for priority health programs. Consequently, OOPs account for the largest share of total health expenditure, reaching an average of 63 percent over the period 2000 to 2021.[38] This situation poses financial risks: in 2018-2019, 13 percent of the population experienced catastrophic health expenditures and four percent were impoverished due to OOPs.[39] The majority of OOPs (75 percent) were spent on medicines.

[31] Republic of Guinea. Ministry of Health and Public Hygiene. Health statistics yearbook. 2020
[32] World Health Organization. Global strategy on human resources for health: Workforce 2030.
[33] Republic of Guinea. National Institute for Statistics. Service availability and readiness assessment (SARA), data quality review (DQR), and quality of health care (QoC) in Guinea. 2022.
[34] Republic of Guinea. Ministry of Planning and Economic Development. National Institute of Statistics. 2018-2019 Harmonized Survey of Household Living Conditions.
[35] Republic of Guinea. National Institute for Statistics. Demographic and Health Survey report. 2018.
[36] World Bank. World Bank. Guinea Public Expenditure Review: Investing in Human Capital to Protect the Future. Washington, DC: World Bank. 2021.
[37] Guinea's Ministry of Health and Public Hygiene, the World Bank, and the Global Financing Facility. Resource mapping of health financing commitments.
[38] World Health Organization. Global Health Expenditure Database. https://apps.who.int/nha/database/Select/Indicators/en
[39] Porgo TV, Magazi I, Djallo EA. Prevalence of Catastrophic and Impoverishing Health Expenditures and Potential Protection against Financial Risks through Subsidies in Guinea. 2023. Accessed October 11. 2023.

12. **Despite commendable progress with the health management information system (HMIS) and civil registration and vital statistics (CRVS) system, significant fragmentation exists across the overall digital health ecosystem.** Very few information systems are interoperable with each other and the HMIS, creating barriers to data utilization and further weakening decision-making processes. Critical components of the health system, including human resources, community health, and CRVS, have yet to be properly digitalized, undermining their efficiency, effectiveness, and responsiveness.

Recent support from the World Bank requiring scale-up

13. **Guinea has witnessed significant health improvements over the last decade with the support of its partners including the World Bank.** The Health Service and Capacity Strengthening Project (HSCSP; P163140) was implemented over five and a half years starting on December 2018. The project aimed to improve the utilization of RMNCH services in target regions (Kankan and Kindia). In these regions, where the HSCSP was implemented, commendable achievements were noted. The project successfully improved the utilization of RMNCH services in the target regions, with all PDO indicators end target largely exceeded especially baseline data for all PDO indicators improved by one and half point to threefold. For instance, the number of children aged 6-11 months who received vitamin A supplementation every 6 months increased threefold, from 11,407 to 35,261, which accounts for 23,854 more children. Moreover, the number of deliveries supported by trained health personnel and the number of women who received modern contraception increased by more than twofold, going from 66,544 to 148,162 (representing an additional 554,911 deliveries) and 52,812 to 130,969 (indicating that 78,157 more women accessed modern contraception) respectively. Similarly, the number of pregnant women who received four antenatal care visits increased almost twofold, rising from 77,951 to 151,476, reaching 73,525 more women. Lastly, the number of fully vaccinated children aged 0–11 months multiplied by one and half points, from 94,640 to 137,209, resulting in 42,569 more fully vaccinated children. In the four health districts where the Results-Based Financing (RBF) program was implemented, there was a significant enhancement in the quality of care as the quality score rose from 45 percent to 70 percent[40] This success can be attributed to comprehensive and complementary project components: (i) ensuring the availability of essential commodities, equipment, and human resources; (ii) enhancing the quality of care through supportive supervisions and the RBF program; (iii) addressing financial barriers to RMNCH services by (a) implementing effective government-sponsored free health services programs and (b) providing indigent cards for access to health care for the most vulnerable pregnant women and children under five; and (iv) improving decision-making through the integration of health facility data into the District Health Information System 2 (DHIS2) Software for monitoring and evaluation.

14. **In line with the Operational Efficiency and Effectiveness of the Evolution Roadmap of the Bank (scale, reproducibility, and speed)**, the Guinea Enhancing Health System Transformation (GUEST) Project aims to build on the positive outcomes of and lessons learned from the implementation of the HSCSP to extend the HSCSP's intervention in Kankan and Kindia and scale up to five additional regions. The operation is also designed for swift preparation to avoid unnecessary interruptions in ongoing interventions in Kankan and Kindia.

[40] Republique of Guinea. Ministry of Health and Public Hygiene. RBF annual implementation report. 2023

C. Proposed Development Objective(s)

Development Objective(s) (From PAD)

15. To improve the utilization of quality reproductive, maternal, neonatal, child, and adolescent health and nutrition services in selected regions.

Key Results

Improved utilization of RMNCAH-N Services

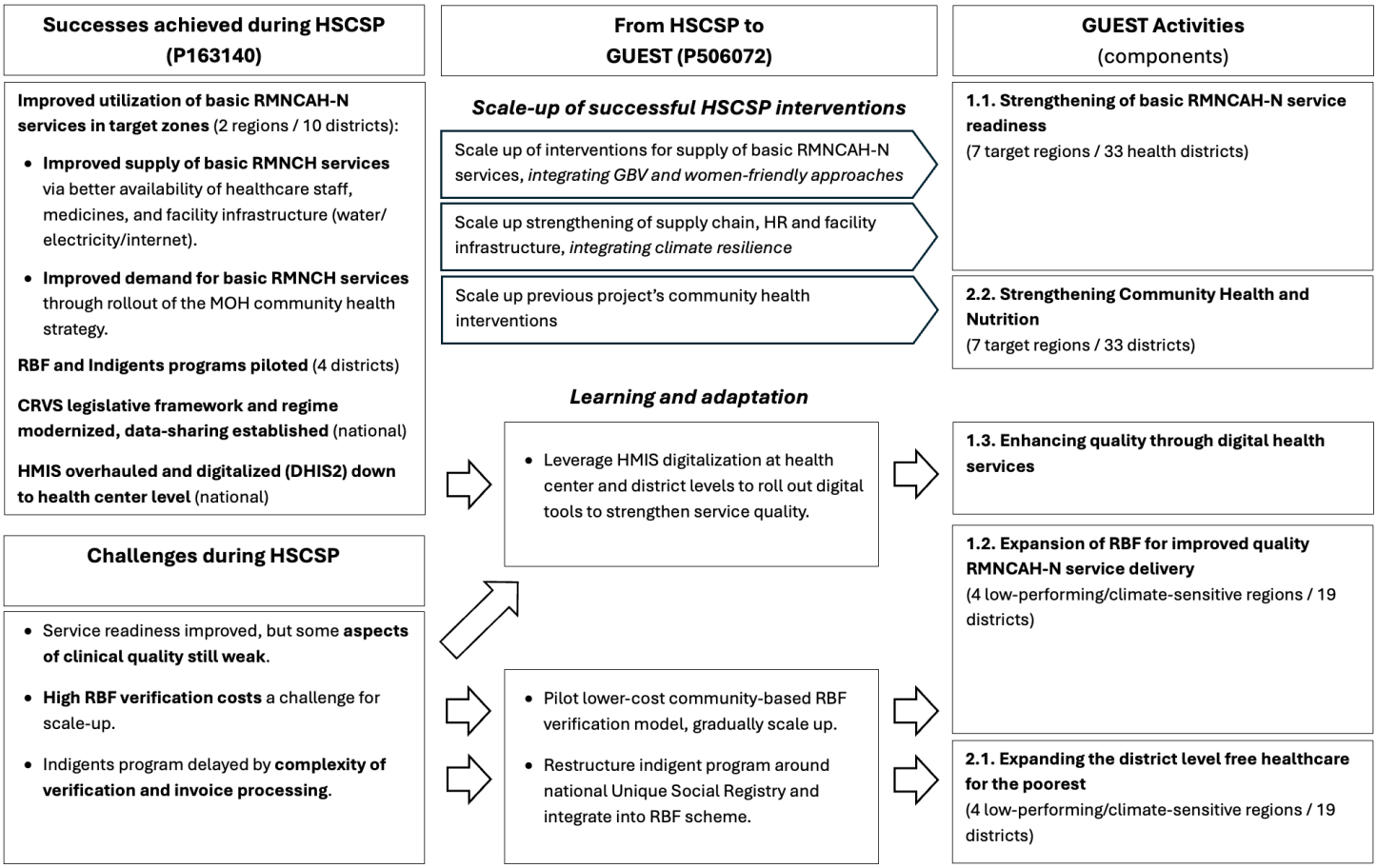
1. People receiving quality health, nutrition, and population services (Number) (Corporate Result Indicator/CRI)
   a) Women receiving deliveries attended by skilled health personnel (Number) (Corporate Result Indicator/CRI)
   b) Children immunized (Number) (Corporate Result Indicator/CRI)
   c) Women and children who have received basic nutrition services (Number) (Corporate Result Indicator/CRI)
2. Family planning Couple-Years-Protection (15-49) (CYP) (Number)

Improved quality of RMNCAH-N Services

3. Pregnant women receiving 4 antenatal care visits (Number)
4. Average score of the quality-of-care checklist (Percentage)

D. Project Description

16. This project builds on the success of the Health Services and Capacity Strengthening Project (P163140), scaling up the core elements that contributed to its success while also adjusting based on lessons learned. The diagram below shows how this new project scales up the HSCSP's successful strategies and activities, while also drawing on lessons learned to adapt approaches where necessary.



Component 1: Supply of quality basic RMNCAH-N services in climate vulnerable regions *(US$55 million of which IDA credit: $50 million &* Global Financing Facility[41] *for Women, Children, and Adolescents* *[GFF] grant: $5 million)*.

17. **This component aims to strengthen the health districts' capacity to deliver safe, quality and respectful health and nutrition services during climate shocks and emergencies**. Building on the interventions implemented in the previous health project in Kankan and Kindia, this component will enhance the operational capacity of the health facilities at the health district level in the seven regions and will provide technical and financial support to the expansion of the RBF program in five out of the seven regions. This component has three subcomponents, as described below.

Subcomponent 1.1: Strengthening of basic RMNCAH-N service readiness in target climate vulnerable regions (*US$12 million of which IDA credit: $10 million & GFF grant: $2 million*).

[41]The Global Financing Facility for Women, Children and Adolescents (GFF) supports low- and lower-middle income countries to accelerate progress on reproductive, maternal, newborn, child and adolescent health and nutrition, and strengthen financing and health systems for universal health coverage. The GFF supports government-led, multi-stakeholder platforms to develop and implement a national, prioritized health plan (called an investment case), that aims to help mobilize sustainable financing for health and nutrition. The GFF Trust Fund, hosted by the World Bank, links moderate amounts of resources to World Bank financing, and supports countries to strengthen their focus on data, quality, equity, results and domestic resources for health.

18. **Health service readiness for quality RMNCAH-N service delivery refers to the overall capacity of health facilities to the health services.** It encompasses the availability of essential components required for service delivery in all seven regions with a focus on climate- affected regions and areas prone to climate shocks, and the set-up of a Basic Emergency obstetric and Neonatal Care network (BEmONC)[42] and a complementary Emergency Obstetric and Neonatal Care network (CEmONC)[43]. Drawing from the experience of the HSCSP (P163140), this subcomponent will support the procurement of essential maternal, child and nutrition products, medicines and commodities through the Central Pharmacy of Guinea, the national drugs supply chain entity. Additionally, it will procure medical and laboratory equipment including cold chain equipment, anthropometric measurement tools and equipment for the screening and management of malnutrition, logistics (15 4x4 vehicles for supervision) and IT equipment. Equipment and commodities will also be selected to ensure services for climate sensitive conditions, including commodities to address stunting and wasting; nutritional products to also help address the climate related impacts of undernutrition and improving the global nutritional status of children and pregnant women and during high heat, droughts, and floods as well. Moreover, investments will include: (a) access to climate-adapted and sustainable water supply and adaptations through the installation of climate-adapted water wells and towers and waterless toilet technologies will be implemented in remote and climate-risk and flood-prone areas; (b) Electrification of district-level health facilities considering limited power access while minimizing greenhouse gas emissions through the installation of solar power system and energy-efficient medical equipment; (c) acquisition of energy-efficient equipment, such as the Ecosteryl 250,[44] to improve medical waste management, treatment and recycling processes; (d) ensuring female-friendly WASH improvements for the safety, dignity, and health of women and girls and make facilities more accessible to them; and (e) rehabilitation of five in-patient nutritional recovery centres (*Centre hospitalier de récupération nutritionnelle en interne (CRENI)*). Moreover, the project will support a strong and inclusive local and central capacity-building for operating and maintenance.

19. **This subcomponent will also help the government fill the gap of human resource for primary health care.** The investments will include**:** (a) local recruitment of qualified frontline staff (especially midwives, nurses and general medical practitioners), with a particular emphasis on reducing barriers to entry by women into the healthcare workforce and into management roles; (b) developing a culture-change and training strategy to make maternity services more respectful and women-friendly; (c) continuous training and skills upgrading of frontline staff capacity on core competencies (to provide patient-centered and safe care practice, employ evidence-based medical practices, apply quality improvement, utilize informatics..), behavioral competencies, technical competencies on a defined RMNCAH-N training package and capacity-building (including Integrated Management of Newborn and Childhood Illnesses (IMNCI), long acting and permanent family planning methods, BEmONC and complementary Emergency Obstetric and Neonatal Care (CEmONC) network services, nutrition services including Infant and Young Child Feeding practices (IYCF), integrated management of acute and chronic malnutrition…), through initiatives including expanding clinical mentoring and coaching, delegating healthcare task, and with an emphasis on patient-centered and safe care practice, integrated GBV services and climate-sensitive delivery of health services. In addition, capacity-building in leadership and supervision competencies will be provided to heads of health facilities, health districts and regional directorates.

20. **To reduce the impacts of climate change on the readiness of health facilities to provide RMNCAH-N services in Guinea, this subcomponent will finance:** (a) rehabilitation of health facilities at risk of flooding and high heat for

[42] BEmONC encompasses a set of seven key obstetric services, or "signal functions," which has been identified as critical to basic emergency obstetric and newborn care: administration of parenteral antibiotics; administration of parenteral anticonvulsants; administration of parenteral uterotonics; removal of retained products (manual vacuum aspiration); assisted vaginal delivery; manual removal of the placenta; and resuscitation of the newborn.
[43] CEmONC includes all BEmONC services and adds surgical capacity and blood transfusion
[44] The Ecosteryl 250 will be combined with the R-steryl to facilitate waste sorting for purposes of recycling.

the purpose of making them resilient to flooding and high heat, including WASH improvements given that flooding is a primary driver of diarrheal diseases; (b) flood and high heat risk assessments of health facilities and their integration in essential RMNCAH-N services readiness in climate vulnerable areas as flood-prone Boke, Faranah, Kankan, Nzerekore; (c) development of climate change RMNCAH-N health service delivery contingency plans at health facilities during climate shocks; (d) development of delivery and pre-positioning plans during climate shocks for vector control and water treatment supplies and medicines to limit outbreaks of vector and water borne diseases (especially malaria, dengue, diarrhea) and avoid disruptions in service delivery and ancillary health staff during climate emergencies. Further details on climate-targeted activities are detailed in the climate adaptation and mitigation table in the Climate Annex 2.

21. **This support will be based on a need assessment conducted at the onset of the project implementation**. Project-supported activities will be designed to be climate sensitive, incorporating energy efficient systems and promoting the use of reusable, eco-friendly medical supplies and equipment. Waste management systems will be designed to minimize waste and reduce the carbon footprint of health facilities while ensuring patient safety, thereby ensuring continuity of care during climate and health emergencies.

Subcomponent 1.2: Expansion of RBF for improved quality RMNCAH-N service delivery in poor-performing and climate-sensitive regions *(US$40 million of which IDA credit: US$37 million & GFF grant: US$3 million*)

22. **This subcomponent will support the scale-up and strengthening of RBF model to improve the quality and quantity of RMNCAH-N services provided by health facilities in prioritized regions.** RBF will be scaled up from four health districts in two regions (Kankan and Kindia) to all 19 health districts in four prioritized regions out of the seven covering about 7.3 million inhabitants. The prioritized regions which are the less performing for RMNCAH-N outcomes and climate-vulnerable as well, are Kankan, Kindia, Labé, and Faranah (see the project Beneficiaries section for the methodology used for prioritization). This subcomponent will finance performance-based payments to health facilities (health posts, health centers, health districts and regional hospitals) in all the four regions as well as to community health workers (CHWs), relays, the National RBF Technical Unit (*Cellule National Technique - Financement Basé sur les Résultats (CTN-FBR*)) and regulation entities (health districts and regional health directorates management teams) for the indicators defined in their performance contracts and following process outlined in the RBF implementation manual. The health facilities will receive incentives for the quantity and the quality of services provided and the regulators for the quantity and quality of defined set of indicators related to their role and responsibilities for an improved quality health services delivery in their catchment areas including supervision, control and evaluation of quality of health facilities and health districts.

23. **The RBF program will prioritize indicators for the delivery of Packages of Basic Health services (PBHS) related to RMNACH+N, climate-sensitive diseases, and GBV services and the level of health pyramid.** The core set of services will continue to be based on the minimum package of RMNCAH-N services identified in the government's RMNCAH-N Investment Case and that includes GBV aspects, climate-sensitive RMNCAH-N diseases and conditions (malaria, under- and malnutrition), with analysis and modelling developed across the course of the project to help identify and respond to changes needed. Activities related to GBV response integrated into RBF will be supported by a package of in-service GBV training and mentoring of health workers and by the regular update of the mapping of GBV service providers (which was initiated by the National Observatory on the Fight Against GBV as part of the Sahel Women Empowerment and Demographic Dividend (SWEDD) Project [P150080]). The RBF program implementation manual for the HSCSP (P163140), which includes a complete list of targeted services and indicators, will be revised to incorporate these new cross-cutting themes.

24. **Verifications, training, coaching and supervision.** Based on lessons learned from the previous project, a more cost-effective verification process will be gradually rolled out for RBF**.** In the four health districts that have already implemented RBF, independent verification of qualitative and quantitative results of RMNCAH-N service delivery will be carried out locally, by regional independent verification and validation committees (RVVC), for hospitals, and prefectorial independent verification and validation committees (PVVC) for health and posts centers levels. For the health district's new to RBF, independent verification firms (*Agences de control et de verification (ACV)*) will be hired and paid under this subcomponent for at least two years to conduct quantitative data verification to ensure accountability, value for money, and improved quality of health service delivery. These firms will also carry out the coaching of the providers to improve their performance. Finally, they assist the Guinea government in setting up gradually RVVC and PVVC committees to take over the verification process. This new verification process is expected to reduce operating costs by five to ten percent of the total percent of the operating cost under the previous project.

25. **The project will leverage the country's RBF experiences to strengthen citizens and communities' engagement for advocacy and accountability through the semi-annual community verification led by local non-governmental organizations (NGOs).** This community audit conducted within the area of all health centers and hospitals involves implementing a household survey protocol that includes a concise questionnaire containing specific questions. The purpose of this questionnaire is to confirm whether the client or household has utilized the services provided by the health facility, evaluate the level of satisfaction of the client or household, and gather suggestions for enhancing the services. The community verification serves as a community feedback mechanism as well as the mechanisms that empower communities and make them recognized as the result of this verification is incorporated in the final quality score of the health facilities. As the RBF and the indigent Programs will be mainstreamed, the voice of vulnerable and marginalized groups will to be heard and the health services providers would consider their needs and preferences in the health services delivery. Finally, an evaluation of this scale-up of RBF will be undertaken via subcomponent 3.2, in order to establish the feasibility of taking a sustainable RBF to national scale. Eligible expenditure will cover the performance-based payment to health facilities, the CTN-FBR and regulators in an amount of US$34 million; ACV and NGOs contractual services costs, operating cost for the RVVC and PVVC, salaries for the CTN-FBR technical assistants, and other operating costs (trainings, regular meetings costs, etc...) in an amount of US$ 6 million.

26. **Retroactive financing will be provided for this subcomponent** in an amount not to exceed US$ 2.0 million for government's eligible expenditures incurred (a) in the four initial health districts that implemented RBF approach for activities that will contribute to the proposed project's PDO; and (b) on or after January 1st, 2024, and prior to the Signature Date. Eligible expenditures will include performance payments for health facilities (health centers and health districts hospitals), regulators at health districts and regional levels; (ii) training cost; (iii) per-diem and operating cost for the quantity verification process.

Sub-component 1.3: Enhancing quality through digital health services (IDA credit: US$3 million)

27. **This subcomponent will build on the success of the digitalization of the HMIS/DHIS2 at health facility level to roll out digital tools to support the quality of RMNCAH-N services.** It will cover four health districts in two priority regions (two health districts in each region of Kankan and Kindia) and will include (i) digitalization of supportive supervision processes in RBF districts, in order to better performance-manage supervision processes and exploit quality assurance data; (ii) piloting and, if appropriate, scale-up of digital tools for community health workers; and (iii) extending the existing pilot of the *Electronic Maternity Consultation Register* in order to integrate it into RBF, assess its potential for strengthening RBF quality assurance and accountability processes. The Electronic Maternity

Consultation Register tool could be expanded to other districts subject to the conclusion of the assessment and the availability of resources.

28. **Furthermore, the digitization of HMIS/DHIS2 for community health workers will also facilitate the delivery of quality services to priority regions' population (that includes climate vulnerable populations)**. These people may have difficulty accessing health services and for the provision of services during climate shocks and emergencies. This digital platform will then embed measures to maximize the reach of the community health system for climate change adaptation and ensure service continuity during climate shocks, including (i) digital communication platform to facilitate communication between community health workers and managers and within community health workers during climate shocks and emergencies; (ii) digital collection of data on climate sensitive diseases to improve availability of real time data on these conditions and its integration in RMNCAH-N service delivery in climate vulnerable areas. These measures will help the health system adapt to the health impacts of climate change and ensure service continuity during climate shocks and emergencies in Guinea.

Component 2: Stimulating demand for and access to basic RMNCAH-N services (*US$31 million of which IDA credit: US$27 million & GFF grant: US$4 million)*.

29. **This component aims to address the barriers on the demand side that impede the use of maternal, child, and adolescent health and nutrition services.** These barriers are mainly due to financial constraints, geographical limitations, climate change, climate shocks, and sociocultural inaccessibility. Given the expected supply-side enhancement under component 1 to increase the provision of RMNCAH-N services, this component will further augment usage by mitigating the financial burden on impoverished individuals and those living in climate-vulnerable areas, to access services and engaging CHWs and community in outreach and demand-generation initiatives. The component is structured into two subcomponents, as summarized below.

Subcomponent 2.1: Expanding the district level free health care for poorest in low-performing and climate vulnerable regions *(US$9 million of which IDA credit: US$7 million & GFF grant: US$2 million)*

30. **This subcomponent will finance the geographical expansion of the government financial mechanisms that aims to improve access to essential health and nutrition services for the most vulnerable impoverished households at the community and health facility levels**. The project will rely on the indigent database of the Unique Social Registry that has being developed and piloted by the Social Development and Indigence Fund (*Fonds de Développement Social et de l'Indigence; FDSI*) and the National Agency for Economic and Social Inclusion (*Agence nationale d'Inclusion Economique et Social; ANIES*). Building on the lessons learned from the implementation of two Bank operations, the Social Safety Net Program under the Emergency Response and Nafa Program Support Project (P168777) and the HSCSP (P163140), and depending on the stage of the development of the RSU in the four priority regions, the Project will: (a) focus on a local, community-led process of identifying indigents women and children under five and validating the indigents registry where needed; (b) develop and enhance the electronic database of these people and strengthen the district health authorities' capacity to manage it; and (c) provide them with an indigence card where needed to allow the poorest pregnant women and children under five to access free RMNCAH-N services. In addition, the free access to care services will be extended to survivors of GBV/Sexual Exploitation and Abuse/Sexual Harassment (SEA/SH) at primary level facilities. Therefore, the subcomponent will finance the cost related to their medical care and the medical certificate fees and enhance and national comprehensive referral care mechanism.

31. **To enhance and streamline the verification and accountability process and ensure effectiveness and efficiency, this program will be integrated with the RBF program.** Hence, the same verification process (quantity and quality

verification at the facilities level and community audit by independent NGOs) and payment/reimbursement systems will apply. Activities to be financed under this subcomponent are related to the different verification processes, trainings of health workers and CHWs, and awareness-raising campaigns on the existence on and benefit of the indigent program, and the payment of health facilities for services provided free of charge to indigent individuals. The total cost for the reimbursement is estimated to US$8 million and the other cost related the community validation process, health card distribution and the program audit are estimated to US$1 million.

Subcomponent 2.2: Strengthening Community health and Nutrition ***(US$22 million of which IDA credit: US$20 million & GFF grant: US$2 million)***.

32. **This subcomponent focuses on scaling up and improving the community health strategy to increase the coverage and utilization of evidence-based, sustainable, high-quality maternal, children, adolescent and nutrition interventions at the household, community.** This sub-component will help reduce barriers (especially geographical and communication) and augment demand for and use of RMNCAH-N services with an emphasis on nutrition and adolescent health for an improved access to primary health care. It will advance a shift toward community-based services areas and enhance the community engagement to their health needs, preferences, and health-seeking behavior especially for those who are vulnerable including to climate change, with special attention given to regions like Boke, Faranah, Kankan, Nzerekore, Kindia, and Labe facing environmental challenges such as floods and extreme heat. The sub-component will back on the government's Community Health Strategy (2023-2027) in alignment with other partners' support. Support will be provided through a combined community service delivery with community capacity strengthening and community social and behavior change healthier practices. Investments will include:

- Recruiting and strengthening capabilities of CHWs to implement a community health and nutrition services package at community level including conducting home visits. The goal of this intervention is to tackle obstacles in communication and behavior change related to gender, health equity, and issues of GBV/SEA/HS, and harmful traditional practices that hinder vulnerable people access health service. It also aims to help communities adapt to and withstand the health impacts of climate change. Specific efforts will be made to help CHW reach out to adolescents, youth and vulnerable populations and provide community services that are more female and youth friendly. The CHWs will work in conjunction with other community-based stakeholders and frontline health workers across the primary health care spectrum to provide health education and promotion, diagnose and manage illness, provide referrals, and distribute commodities in routine and during health campaigns including participating to deworming activities and distribution of some family planning methods. This will be performed by: (a) revising the community health services package that includes quality promotional, preventive and curative RMNCAH-N services; (b) recruiting roughly 300 CHWs and 2700 community relays with an emphasis on a gender-sensitive recruitment (an increased female CHWs recruitment) for a total cost of US$1.2 million and in line with the norms and standard defined in the National Community Health Strategy; (c) building their capacity through training, coaching and supervision; (d) procuring equipment, logistics (motorcycles), IT equipment (tablets), and communication tools and materials for community-based outreach activities; and (e) ensuring availability of medicines in line with the CHW's respective duties.
- Setting up and capacity-building of Early Years, nutrition, and WASH services support groups to implement community-based approach focusing on social and behavioral change to improve nutrition among young children,

pregnant and breast-feeding women. Specifically, activities will help increase exclusive breastfeeding, improve dietary diversity through locally produced, nutrient-rich foods, and promote hygiene and sanitation practices to prevent disease transmission (malaria, respiratory and enteric infections). Community groups will include among other women's groups, health facilities management committees, youth groups including youth champions initiative, and village community. They will be set up or revived, empowered using their own resources, monitored and supervised to monthly: (i) organize village-wide nutrition demonstration of nutritious food with nutrient-rich local ingredients that promote good nutrition; (ii) screen children and pregnant women for malnutrition (underweight, wasting and stunting) and take the needed action such as their referral to health centers; the initiative will be focused on drought-prone and food-insecure districts; (iii) promote nutrition-specific practices to reduce stunting such as IYCF (exclusive breastfeeding and complementary feeding for children from 0 up to 24 months), and encourage balanced energy protein supplementation for pregnant women, (iv) conduct awareness-raising conversations on gender roles and parenting responsibilities in early child care, early stimulation, nutrition, consistent practice of key WASH behaviors (good hygiene practices, such as handwashing with soap, cleanliness of environment…), climate change and agriculture.

- Conducting the same health service users' satisfaction survey every six months as in the RBF regions, in order to receive feedback from the populations of the health areas of all the health centers and hospitals in the three other regions (Mamou, Boké and N'Zérékoré) et improve health service delivery. The data captured will be analyzed and discussed with concrete recommendations integrated into revised implementation plans.
- Finally, this subcomponent will provide technical assistance for monitoring and evaluation including joint monitoring of community structures activities by the health facility management team, the local department of Women Promotion, Childhood and Vulnerable People (the Ministry of Social Affairs) and the communes, learning and adapting approach, based on accurate and timely local data to ensure the optimal fit of the community strategy to the local context.

Component 3: Project coordination and management, and monitoring and evaluation (M&E) ***(US$9 million of which IDA credit: US$8 million & GFF grant: US$1 million).***

Subcomponent 3.1: Project Coordination and Management ***(IDA credit: US$2 million).***

33. **This subcomponent will provide support for project management through the Project Coordination Unit (PCU) established under the HSCSP (P163140) and strengthened under the HSPWCA (P179078)**. It will encompass: (i) the operating cost of the PCU at the central and regional levels; (ii) the fulfillment of fiduciary and the World Bank's Environmental and Social Framework (ESF) requirements including financial management, procurement, and environmental and social tasks; and (iii) the cost of project coordination, supervision, and overall management activities.

34. **This subcomponent will also finance the strengthening of the National RBF technical Unit for an effective rolling out of the RBF program and the reforms of health financing towards UHC**. Activities will include support for an effective and sustained operation of the CTN-FBR by: (i) building the capacity of the CTN-FBR by nominating or hiring qualified human experts in RBF approach, continued training of the CTN-FBR staff, and equipping in adequate infrastructure including procuring equipment (It materiel, one 4x4 vehicle for supervision..); and (iii) ensuring a management autonomy of the CTN-FBR by financing its annual work plan and budgetCTN. Moreover, capacity-building will be extending to the MoH's Office of Strategy and Development (*Bureau de Stratégie et*

Développement [BSD]) which is the entity responsible for developing MoH policies and strategic documents, producing sectoral statistics and indicators, and ensuring program sustainability and health financing policy. These two entities of Ministry of health will lead the design, monitoring, and evaluation of the output-based financing program with the expertise of a technical assistance and ensure the transition from an inputs-based financing towards institutionalization and sustainability of a strategic purchasing as part of the reforms towards UHC.

35. **Finally, investments under this sub-component will continue to support the MoH in coordinating donor interventions, promoting harmonization and alignment of partners' activities under the "One Plan, One Budget, One Report" approach**. The project will finance the development and progressive implementation of a Health Sector Development Program Harmonization Manual. Moreover, it will enhance the functionality of the country's multisectoral platform established through GFF support and the multisectoral nutrition platform expanding their operationalization at regional and prefectorial levels. Technical and financial support will be provided for implementing action plans across different platforms.

Subcomponent 3.2: Project Monitoring and Evaluation *(US$3.5 million of which IDA credit: US$3 million & GFF grant:US$0.5 million).*

36. **This subcomponent will support monitoring and evaluation of the project.** This will be done through: (i) the support to the development of an action plan for M&E; (ii) the collection of data from MoH's directorates and other implementing agencies, including support to the surveys; (iii) the compilation of data into project implementation progress reports; (iv) the carrying out of annual expenditure reviews; (v) the support for training of the health staff in the HMIS participating in the monitoring and evaluation at all administrative levels; and (vi) support for review and assessment consultancies and workshops.

37. **The project will include an evaluation of the scale-up of a sustainable RBF and free health services for indigents programs, to establish the feasibility of rolling them out nationally.** This will ideally be undertaken using a quasi-experimental evaluative methodology (for example a stepped wedge design or matching approach across intervention and non-intervention facilities). The evaluation will incorporate capacity-building initiatives, leveraging Guinean academics and students to help strengthen the health sector's evaluation skills and experience.

Subcomponent 3.3: **Strengthening the Health Information System *(US$3.5 million of which** IDA credit: US$3 million & GFF grant:US$0.5 million)*

38. **The project will continue the health information system strengthening strategies of the previous WB project.** Building on the previous project's successful strengthening of the HMIS and complementing surveillance and data use initiatives in the Health Security Program in Western and Central Africa (HSPWCA) (P179078), this project will support the *Service de Modernisation des Systèmes d'Information* (SMSI) at the national level to enhance governance, digital infrastructure, and interoperability across key health information subsystems. A digital health system will be developed to govern, align, and rationalize the plethora of digital interventions currently being piloted or used in Guinea, and a common interoperability framework will be established. This framework will serve as the foundation for further strengthening of key information systems used for project monitoring, including revitalizing the Human Resource Information System and better integrating supply chain information systems (Logistic Management Information System [LMIS], Warehouse Management System). Innovative tools, such as the new DHIS2 Climate app, will be introduced to combine public health and meteorological data for proactive

surveillance and predictive modelling of climate and health impacts (water- and vector-borne diseases, heat sensitive illnesses, climate impacts on health infrastructure, etc.). Support will also be provided, in collaboration with other partners, for major national surveys such as the Demographic and Health Survey (DHS) and the Harmonized Health Facility Assessment (HHFA).

39. **This subcomponent will also continue the support provided to the Guinean government's efforts to reform, modernize, and digitalize the civil registry and identification system in the four regions where the RBF will be implemented**. It will help (i) provide technical assistance to finalize revision and strengthening of the legal and institutional framework for civil registration to align with international standards; (ii): regularize and issue authentic births certificates; and (iii) support the digitization of vital statistics reporting and its interoperability with the health management information system (DHIS2).

Component 4: Contingent Emergency Response Component (CERC) (US$0)

40. **A CERC is included in the project in accordance with Investment Project Financing (IPF) Policy, paragraphs 12 and 13, for Situations of Urgent Need of Assistance and Capacity Constraints.** This will allow for rapid reallocation of IDA grant uncommitted funds in the event of an eligible emergency as defined in OP 8.00. A CERC Manual will guide the activation and implementation of the CERC, and an Emergency Action Plan will be prepared to confirm activities and financing for a specific event.

Legal Operational Policies	Triggered?
Projects on International Waterways OP 7.50	Yes
Projects in Disputed Area OP 7.60	No

Summary of Screening of Environmental and Social Risks and Impacts

41. **The overall project environmental and social risk is Moderate. And five (5) Environmental and social standards (ESS1, ESS2, ESS3, ESS4, ESS10) are relevant for the project implementation activities.** The project activities are aimed to improve the quality and utilization of essential health services of beneficiaries. There will be minimal infrastructure building related to access to water and solar power systems and it is envisaged that mainly small upgrades infrastructure health commodities. In these activities, any physical and/or economic displacement is not expected. The activities could generate low to moderate direct and indirect environmental and social risks and adverse impacts for project workers, the community surrounding the health centers, beneficiaries in general. Several Environmental and Social (E&S) risks and impacts have been identified like exclusion, community and occupational health and safety risks, exacerbations of gender inequalities, SEA/SH risks, medical waste production, pollution etc.

42. **The potential risks and negative impacts that may result from the implementation of the project have been analyzed in accordance with the mandatory requirements set in the World Bank Environmental and Social Standards (ESSs) to prevent and mitigate any risks and negative impacts.** Based on this assessment, the Recipient has prepared the following E&S instruments: the Environmental and Social Management Framework (ESMF), a Medical Waste Management Plan (MWMP), an Environmental and Social Commitment Plan (ESCP), a Stakeholder

Engagement Plan (SEP), Labor Management Procedures (LMP) and Infection Control and Waste Management Plan (ICWMP). The ESMF and the ESCP will be adopt and disclose both n country and on the bank website before the project negotiation, The SEP and the LMP have been disclose both in the country on July 19, 2024, and on the bank website on august 8, 2024. The regional medical waste management plans developed for Kankan and Kindia will be updated, and new plans will be developed for the remaining regions. The Integrated infectious control and waste management plan (ICWMP) will be assessed, and necessary measures taken to fill any gap associated with the project. the MWMP and the ICWMP are expected to be approved by the World Bank and disclosed in-country and on the World Bank website respectively 6 months and 3 months after the project effectiveness.

43. **The PCU has experience with the social and environmental risk management and monitoring requirements under the ESF, however, E&S performance of existing health projects in the country is rating Moderately satisfactory and was Moderately Unsatisfactory before the last supervision mission in 2024**. Therefore, if their performance remains unsatisfactory after 3 months of the project effectiveness, new E&S specialists will be hired no later than 6 months after the evaluation, to manage the risks associated with the project, including operating and managing a grievance mechanism and undertaking a robust stakeholder engagement given the nature and scope of project activities, and leading the medical waste management strategy with all the associated stakeholders. The E&S team will strengthen with a GBV Specialist (full-time) and a medical waste management specialist (full-time) within three months after the Project Effective Date. And as required by the Health Security Program in Western and Central Africa MPA (P179078), four E&S specialists will be hired (two environment and two social specialists) based in Regional Health Directorates who will oversee the environmental and social aspects of the subprojects on the ground.

E. Implementation

Institutional and Implementation Arrangements

44. **The same Institutional and Implementation Arrangements that have been put in place for the HSCSP (163140) and the HSPWCA (P179078) will applied.** The MoH will serve as the implementing agency responsible for executing and managing all aspects of planning, budgeting, and reporting at all levels across the health pyramid, while also providing technical stewardship at the central level. Additionally, a steering committee set up in the previous project, will have its mandate expanded to this project no later than three months after Effectiveness. This committee will provide strategic direction, monitor progress, approve annual work plans and budget (AWPB), and semi-annual and annual reports and ensure that the project runs smoothly and achieves its objectives. The composition of the steering committee will be updated to include new stakeholders such as civil society and health private sector representatives. It will be supported by a Technical Committee composed of the focal points, mainly experts from the Directorates and other entities involved in the project. The technical committee set up by Ministerial order no later than three months after Effectiveness, will oversee the operational and technical oversight of the Project as it will follow progress, provide technical validation of AWPB, technical supervision and provide recommendations to the steering committee. Directorates at the central level, along with regional and district management teams and the National technical committee, will manage administrative duties related to the project.

45. **A well-experienced PCU will manage the proposed project.** The PCU team has already managed four World Bank projects, including the Ebola Emergency Response Project (P152359), the Regional Disease Surveillance Systems

Enhancement (REDISSE; P154807), the Guinea Post-Ebola Support Project, Mamou (P158579), and the Guinea Primary Health Services Improvement Project (P147758). Moreover, it has managed and coordinated three Bank projects in the health sector, including the Guinea Health Services and Capacity Strengthening Project (P163140), the Guinea COVID-19 Emergency Response and System Preparedness Strengthening Project (CERSPSP) and its two additional financing (P174032, P176706 & P178602), and the Guinea component of the HSPWCA (P179078). The PCU within the MoH will handle the day-to-day operational tasks of all project activities, including the preparation of a consolidated annual work plan for approval by the steering committee and comprehensive semester and annual reports for the project. As per the implementation arrangement of the HSPWCA (P179078), the current PCU includes a central PCU based in Conakry and five regional PCUs located in regional health districts. The PCU will be expanded by adjusting the number of staff to ensure smooth implementation and maintain quality management for the regional project and this project.

46. Finally, the CTN-FBR will lead the strategic management, the coordination and the day-to-day operational implementation of RBF program ensuring its institutionalization and integration at all levels of the healthcare system as further described in the RBF manual. The capacity of this entity will be bolstered in terms of human, material resources, organization, and operating procedures, enabling it to fully fulfill its assigned role. The Government will, therefore, nominate or recruit the following staff a coordinator, a deputy coordinator, a data manager, a monitoring, and evaluation specialist, two RBF experts. The CTN-FBR staff will be operational within three months of the project Effective date.

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