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Combined Project Information Documents / Integrated Safeguards Datasheet (PID/ISDS)

Appraisal Stage | Date Prepared/Updated: 26-Jul-2018 | Report No: PIDISDSA24592



BASIC INFORMATION

A. Basic Project Data

Country Central African Republic	Project ID P164953	Project Name Health System Support and Strengthening Project	Parent Project ID (if any)
Region AFRICA	Estimated Appraisal Date 02-Jul-2018	Estimated Board Date 28-Sep-2018	Practice Area (Lead) Health, Nutrition & Population
Financing Instrument Investment Project Financing	Borrower(s) Ministry of Economy, Planning and Cooperation	Implementing Agency Ministry of Health, Public Hygiene and Population	

Proposed Development Objective(s)

To increase utilization and improve the quality of essential health services in targeted areas of the Central African Republic.

Components

Improve utilization and quality of essential health service delivery at the facility and community levels through performance-based financing
 Reinforcing institutional capacity for health system strengthening including establishing district hospitals integrated with GBV services
 Contingent Emergency Response

PROJECT FINANCING DATA (US\$, Millions)

SUMMARY

Total Project Cost	54.00
Total Financing	54.00
of which IBRD/IDA	43.00
Financing Gap	0.00

DETAILS

World Bank Group Financing

International Development Association (IDA)	43.00
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IDA Grant	43.00
Non-World Bank Group Financing	
Counterpart Funding	1.00
Borrower	1.00
Trust Funds	10.00
Global Financing Facility	10.00

Environmental Assessment Category

B-Partial Assessment

Decision

The review did authorize the team to appraise and negotiate

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Other Decision (as needed)

B. Introduction and Context

Country Context

- 1. Central African Republic (CAR), with a population of 4.5 million inhabitants, suffers from decades of repeated conflict and political instability, where half of the country's population depends on humanitarian assistance for basic needs, and one-fifth of the population is forcibly displaced.** International alert was raised on 23 March 2013, when a coalition of armed and predominantly Muslim groups (Séléka) overthrew the government in Bangui and began violent attacks against civilians. The mostly Christian militias (anti-Balaka) that arose in response launched retaliatory attacks against the Séléka and, by association, Muslim populations, thereby amplifying the scale of forced displacements and human rights violations. Even before the upsurge of the large-scale violence in 2013, the Government of CAR had somewhat abandoned its responsibilities in providing social services in the interior of the country. This neglect and exclusion of certain segments of the country contributed in framing the deep-seated grievances against the central government in Bangui, serving as a justification for the Séléka incursion into the capital in 2013. The former Séléka coalition has since splintered into several ex-Séléka groups which exercise control over half the country. Additionally, the country has experienced a long history of sporadic violence relating to natural resource disputes and inter-ethnic agitations.



2. **Security improvements have been accompanied by unprecedented international support.** Previously considered a neglected country, CAR is heavily reliant on support from the international community. While a French and African-led military intervention managed to put an end to the conflict in 2013, much of the security today is provided by international security forces led by the Multidimensional Integrated Stabilization Mission in CAR (MINUSCA). Various UN agencies, international organizations, bilateral donors, and more than 100 international NGOs offer emergency relief and humanitarian assistance. According to CAR's National Survey of Municipal Monographs (2016), access to potable water and sanitation services remain a daunting challenge across the country with only 36% of municipalities equipped with potable water access points that are mostly restricted to municipal capitals, and only 6% of municipalities are provided with sanitation systems.
3. **These poverty rate is estimated to be worse after the crisis and violence.** The poverty rate in CAR was estimated at 62% (2008), with 50% of the urban population and 69% of the rural population living in poverty. Recent estimates based on observed trends in GDP suggest that the poverty rate has surged to more than 75% in 2016 (WB, CAR SCD, 2017).
4. **After the holding of peaceful presidential polls in 2016 and the election of a new president, stability appears to be gradually returning to the country despite continuous violent confrontations in the interior.** The government and several development partners have consequently begun to reorient social sectors, especially health interventions, away from emergency relief and towards actions that aim at rebuilding the collapsed health system. However, despite positive developments and optimism over the past year, CAR cannot yet be considered a post-conflict country (WB, SCD, Sep 2017). Fragility and the potential for renewed conflict continue to pose a serious risk throughout the country which needs to be considered when planning for consequential action. Broadly, the imperative now is not just to rebuild institutions and systems that are broken and now almost inexistent, but to also figure out how to extend essential social services to marginalized areas and populations especially those with limited physical accessibility, focusing especially on women and children.
5. **Poor households are overwhelmingly located in rural areas.** In 2008 nearly two-thirds of CAR's population lived in rural areas, which were home to about 70 percent of the country's poor. Regional poverty rates ranged from as low as 45 percent in Bangui to as high as 78 percent in the Yadé region. High levels of displacement have aggravated poverty. In August 2016, an estimated 15 percent of household members were displaced, while more than half of the households indicated to have experienced displacement of some or all of their household members since 2012. In urban areas, 68 percent of households experienced displacement and in rural areas 61 percent of households experienced the same. Access to basic social services already limited in Bangui, is even more limited outside the capital. A preference for spending in Bangui and the difficulty of serving a highly dispersed population living in low density areas has always been a challenge to service delivery in the CAR.



Sectoral and Institutional Context

- 6. The instability and violence in CAR has resulted in the substantial deterioration of social services and the health situation of women and children.** Low immunization coverage and essential health service delivery, lack of functional structures and qualified staff, difficulties in accessing health services and medical supplies, and lack of monitoring and epidemiological surveillance capabilities are major risk factors for the health of the population. Under-five mortality rate is estimated at 129 per 1,000 live-births, ranking the 3rd worst in the world (out of 192 countries), with the maternal mortality ratio being among the highest in the world with 882 per 100,000 live-births. Adult literacy rate is 37%, and life expectancy at birth is 52 years old. Less than half (46%) of children under age one year obtained their three doses of DPT (DPT3). Malnutrition is an underlying cause of almost half (48%) of the deaths of children under-five in CAR. Children under-five have high levels of malnutrition, with 41% suffering from chronic malnutrition or stunting, and 7% are acutely malnourished. Additionally, full coverage of vitamin A supplementation (twice per year) among children under age of five is only a mere 3%. Almost half (46%) of reproductive age women aged 15-49 suffer from anemia. Unsurprisingly, the country ranks last on the 2017 Human Development Index, 188th out of 188, with an average per capita gross domestic product (GDP) of US\$ 382 (est. 2016).
- 7. The perpetual impoverishment, compounded by political crisis in CAR, has led to a situation where the health system is not fully functional.** Adding to this concern is the fragmentation of the health sector among the numerous actors working in health. Multilateral organizations and non-governmental organizations (NGOs) largely funded by bilateral agencies work in and out of arbitrary regions and health zones on various health and nutrition initiatives—the majority on a short, fixed-term basis—with little or no coordination by the government. Large-scale humanitarian assistance for health and nutrition provided by the humanitarian agencies exist, but the government has no contact with the humanitarian actors, and currently has little idea who is doing what or how much is being spent on the provision of basic health services to the population. All partners, humanitarian and developmental, work in silos. On average, 27% of health facilities are either partially or totally destroyed (HeRAMS, 2016), with only up to 40% non- or partly-functional in Health Regions 1 and 3 (HeRAMS, 2016). Comparing to 2014 where only 55% of health facilities were functional nationwide, the national average is 76%, which is promising, but varying from 60% in Health Region 1 and 3 to 91% in Health Region 7. Only 22% of health facilities have an energy source, while 43% (27% in 2015) with a potable water source.
- 8. Since 2016, the crisis-relief situation of the CAR in certain areas allows the Government to begin a transitional phase in its interventions and those of its partners in the health sector.** From a crisis situation approach marked by a virtual absence of state services, replaced by a cohort of international NGOs specialized in humanitarian care, national authorities are now orienting interventions by favoring a development approach that must prioritize the reinstatement of all public health facilities and the strengthening of national institutions strongly weakened by the crisis.



9. **In terms of health-related data and information, only limited recent analytical material related to health is available and in which most data bases are outdated and no longer relevant.** The latest Demographic Health Survey (DHS) was conducted in 1994-95, and the latest Multiple Indicator Cluster Survey (MICS) in 2010 focused only on HIV/AIDS. Health Management Information System (HMIS) also does not exist, so reproductive maternal and child health and nutrition data derived from the health facilities are not routinely reported to the central level except for donor-chosen and demanded-data required for reporting and resource verification purposes. There is also no information regarding demand-side barriers that families face in accessing services, which makes it difficult to plan out the bottlenecks to solve. The ongoing project (Health System Support Project - HSSP), however, is working with the Global Fund (GF) and the Global Alliance for Vaccine Initiative (GAVI) to harmonize data entry with relevant indicators, which could form a base to harmonize the HMIS with the various projects; but data generation and management need to be consolidated and systematized. The lack of reliable and updated key data source on reproductive, maternal, neonatal, child, adolescent health and nutrition (RMNCAH-N) and resource allocation on health that could facilitate planning and budgeting processes is an area that merits further consideration for supporting the health sector and health system strengthening in the country.
10. **Another setback in the health system is the situation of human resources for health (HRH), which remains a major concern and far from reaching the required standards.** In addition to its numerical inadequacy and unequal geographical distribution, there is a weakness in the HRH’s technical qualifications and in the management of the health system overall. CAR has strong dependencies on development partners (DP) funding not only to sustain its health sector but to also identify and pay the salaries of health staff. Per capita ratio of the various technical health professional is poor (Table 1).

Table 1 Human resources for health ratio per health professional
(per capita ratio)

General practitioners	1 : 20,534	Midwives	1 : 16,156
Health specialists (including higher level teachers)	1 : 47,722	Midwife assistants	1 : 28,475
Laboratory technicians	1 : 59,242	Health assistants	1 : 17,123
Nurses, nursing assistants	1 : 18 879		

Source: Directorate of Resources of the Ministry of Health and Population

11. **The absence of a motivational policy leads to the demotivation of the staff.** The main causes are, among other things, inadequate wages, non-recognition of work well done, lack of a career plan, inadequate working conditions, high cost of living, the remoteness and austerity of the regions, the lack of support for the transport of agents to their places of work, the lack of facilities granted to new agents for their installation and insecurity in certain localities.



12. **The lack of and inequitable health financing is also a major concern in CAR.** The government’s capacity in the Health financing domain is extremely low, and basic data on health financing is not available. National Health Accounts do not exist in the country. However, estimated total health expenditures per person per year is estimated at US\$16, with the government’s contribution, including budget support from DPs, being US\$8 per capita per year. Most health expenditures come from households’ out-of-pocket spending (46%), which reflects a potentially high catastrophic expenditure prevalence. There is also a marked gap between the funding assigned to the capital Bangui in contrast to other regions, and the funding provided by the state to the health sector is not targeting the poorest. In accordance to the National Health Development Plan (PNDS II 2006-2015), more than half of the funds were allocated to the capital which composes only 17% of the population. The rest of the population—the majority in rural areas and where poverty is greater and basic health services are particularly pressing—barely received any support from the central Government until early 2017.
13. **The national public pharmaceutical supply system does not exist,** leaving the UN and other international agencies largely responsible for the procurement and distribution of drugs and medical supplies. The national pharmaceutical supply system based on the import and distribution of products through a national procurement center called “Unité de cession des médicaments (UCM)” has become inoperative and is considered bankrupt with financial debts to suppliers estimated at 2.4 billion XAF (US\$ 4 million) with no stock available. The distribution network to health facilities through 16 prefectural drug dispatchers are also mostly non-functional. The religious sector, through ASSOMESCA established itself in about 7 towns in rural areas which provided quality generic essential medicine in health facilities at a slightly higher cost due to transport and safety, are now closed down due to the insecurity in the country. The country has no control laboratory or any level of quality assurance. CAR is subject to counterfeit drugs, exposing the lives of the population even as they pay for medicine at the pharmacies.
14. **In performance-based financing (PBF) supported sites, the government began partnering with private sector pharmaceutical wholesalers, stimulating competition between them to procure essential medicines in rural areas of the country.** The result has led to an 84% increase in the availability of drugs in the first year of the program. The private pharmaceutical sector consists of several wholesalers (Assomesca, Rofarma, Shalina and Nand Phrama) which are only located in the capital Bangui, providing little access to drugs to those in rural areas. However, many challenges remain, such as the lack of quality control, high prices, inaccessibility of affordable essential drugs, absence of an efficient supply chain, high transportation costs, and out-of-pocket spending for families even for the poor.
15. **Reconstituting the Central Medical Store or designing a new mechanism for consolidated procurement would be an important first step to rebuild the national pharmaceutical supply chain.** The government seeks to provide essential generic drugs at low cost to the population, and chose to revive the Department of Pharmacy and Medicine by overseeing necessary reforms. However, when the centralized system is being rebuilt, the authorities should identify temporary



alternative sources for pharmaceutical procurement, and maximize the presence of UN agencies and large-scale NGOs to support the supply chain especially in the conflict areas.

16. **The majority of the population cannot access essential healthcare services at the health facilities** due to the political, geographical, physical, social and economic constraints that CAR is overwhelmingly confronted with. Access to basic social services that is already limited in Bangui, is even more limited outside the capital. In such an extremely impoverished and fragile context as CAR, it is evident that most of the high number of maternal, infant and child deaths are occurring outside of the reach of the traditional health system; the deaths are occurring in communities where preventive healthcare services are needed most but where the services are not delivered. It is vital that a community health service delivery system be maximized through community outreach with community workers, in addition to targeted integrated periodic campaigns to deliver a basic package of high impact, cost-effective, maternal and child health services to the maximum number of women and children in the country to avoid more deaths. But this must be done in conjunction with building up the health system with a longer-term developmental approach at the same time.

Bank's engagement in the health sector and performance-based financing

17. **The Bank's engagement in the health sector in CAR has been continuous for several decades.** Prior to the crisis (2014), CAR authorities were planning to launch a US\$28.2 million HSSP, supported by the World Bank. Initial funding for the HSSP was provided through a US\$17 million combined IDA credit and grant (IDA-51340 and IDA-H7840, approved May 17, 2012) and a US\$11.2 million grant from the Health Results Innovation Trust Fund (HRITF) (TF13380, approved July 31, 2012). In 2014, as a worsening security situation made implementation of the HSSP infeasible, the government requested that the HSSP be restructured to reallocate US\$15 million (from IDA) to support delivery of emergency health services. UNICEF, UNFPA and WHO were contracted to continue delivering health services to communities affected by the crisis. As the security situation improved in 2015, an additional financing (AF) grant of US\$12 million (IDA-D0610, approved May 22, 2015) was added to help the HSSP relaunch (in 2017) the PBF activities that, during the crisis, had been almost completely halted. The activities financed by the HRITF could therefore resume as the HRITF funded PBF activities exclusively. In 2017, HSSP project started focusing again on PBF. Under the HSSP, the Bank has supported the government of CAR to expand the PBF program progressively, which currently covers 40% of the national population, implemented in five regions of the country, and serving more than 1.8 million people.
18. **The PBF mechanism in CAR, supported by the HSSP project, has shown promising results in improving rural populations' access to essential health services, minimizing barriers to care while improving quality.** PBF is a key modality for financing the health system which started implementation in January 2017, after the unrest broke out in 2014. In one region (out of 5), an international NGO (Cordaid) implemented the PBF also starting in Jan 2017. A PBF program is being implemented by the ongoing HSSP project supported by the Bank in 5 regions since January 2017 (Health regions 2, 3, 4, 5 and 6). The international non-governmental organizations Cordaid-



Assomesca and AEDES-HDP-CSI were selected to assist the government to implement the program. An external counter-verification agency (ACVE) is assessing the performance of the contracting and purchasing agencies. Contracts have been signed with 13 health districts, 13 district hospitals and 359 health centers.

19. **The PBF program is flexible and adaptable to the CAR emergency situation.** The PBF program: (i) pays bonuses related to health services in health posts, health centers and district hospitals, including preventive care, maternal and child health services, along with treatment for Malaria, HIV-AIDS, Tuberculosis and Family Planning; (ii) offers temporary compensation to health facilities that exempt some or all of their patients from user fees in the event of a renewed crisis; (iii) enables facilities to continue to serve their communities despite the financial strain imposed by a deteriorating security environment; (iv) offers an “equity bonus” to healthcare providers operating in remote regions or addressing the needs of underserved populations; (v) focuses on a developmental approach even during the crisis by strengthening facilities’ autonomy and governance. A recent development is the recognition by the MOH that the PBF program should be used more extensively to govern health at the district level.

20. **The PBF is going in tandem with free health care with a focus and versatility and agility in times of crisis.** In Green and orange zones, the PBF program increases the tariffs for 20% of the population to allow them to get free health services. The program has also developed a strategy where if there is an upsurge in violence in a certain part of the country (red zones), the program can immediately finance fully subsidized health care and ensure all beneficiaries receive services free of charge. Results are then verified the following month and reimbursements made. This approach has proven to be effective several times in 2017, as conflicts and fighting erupted in several parts of the country supported by the project (Regions 3, 4, 5 and 6).

21. **The PBF program allows for paying for results in a country with almost no commercial banking system outside the capital.** The program identified, tested and scaled-up innovative ways of using micro-credit and credit union networks, faith-based networks, and mobile banking systems to ensure payments for verified results arrived directly into the bank accounts of health facilities on a monthly basis. These resources become one of the essential sources of revenue in an context where the majority of service providers have little to no resources, either from the government or users. The project has disbursed more than US\$ 4 million directly to frontline providers purely paid based on performance and results, in the first year of the program.



22. **The HSSP has been successful in assisting the Government in implementing PBF and free health care approaches that have increased access, reduced costs, and improved quality of care.** Since the initiation of PBF program since January 2017, incremental and positive results have been achieved by health facilities. After one year of operation (January 2017-December 2017), key essential health services including maternal and child health services have started to increase significantly, in addition to the quality of health services through proper use of health protocols and improved supervision. The availability of qualified staff, essential drugs, medical material and equipment has increased in the project zone due to “quality improvement bonus” provided to facilities through PBF program. Official data from health facilities provided by purchasing and contracting agencies (See www.fbr-rca.com) show a positive increase in the utilization of health services (maternal and child health services). These results are reflected in the results framework of the HSSP project that show increasing trends which led to the restructuring of the project targets. A study was carried out in Nana Mambéré prefecture (Region 2) between March 2013 and May 2014 to test the effectiveness of PBF. The study found that the flexibility of PBF enabled healthcare facilities to adapt their financing modes to reflect the conditions of the crisis. PBF is also an integrated financial and service delivery model designed not only to incentivize health service delivery at the facility level, but also to strengthen financial and operational management at both the central and district levels.

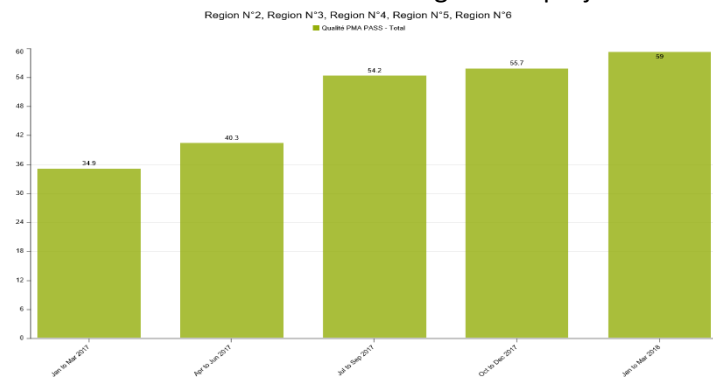


Figure 1 Evolution of average quality scores in PBF districts, 2017

23. **Due to its visibility and the positive effects that the PBF has demonstrated, the government now uses the PBF strategy as a key motivator and core strategic template for rebuilding the health system in CAR.** The infrastructural and physical buildup of health facilities is very important in CAR, where the health centers are now visibly existing and functioning, which were once destroyed and abandoned without any medical supplies. Referrals of sick mothers and children are made, and there are finally finding medical response at the PBF-supported health facilities when there were none before. These PBF-supported facilities are now forming a base where health professionals can now work, are paid, and are further incentivized for their performance both in serving the community. It is important to now build and expand this facility-based approach, but at the same time expand out to reach the families and communities who cannot access these facilities.



24. **In the more severe conflict zones, identification of partners who can replicate this mechanism in conflict areas need to be identified.** Several of CAR's development partners are also supporting PBF programs, such as the European Union which is drawing on its post-crisis Bekou fund to improve health services in Regions 3 and 6 using a modified PBF-model. In addition, the NGO Cordaid is managing the PBF model in Region 2 since 2009, currently with promising results. (Figure 2)

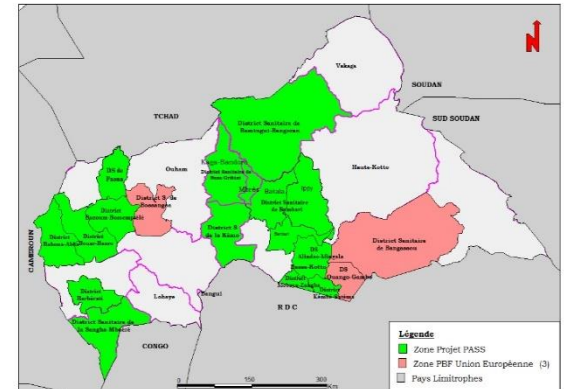


Figure 2 Project zones supported by PASS and European

25. **Constraints to the current operationalization of the PBF-project**

Despite the capacity of the PBF-scheme for the health districts to physically rehabilitate the health facilities' infrastructure and bring health professionals back into the system, the health system in CAR is not without its weaknesses with room for improvement.

- (a) At the current state (May 2018), the PBF is fundamentally a fixed-site curative service delivery project, and it lacks the link to community health services/community outreach. It focuses on operationalizing the health facilities, including district hospitals, health centers and health posts, with strong focus on structural improvements, improved clinical practice and health worker motivation and improved management capacity and governance. In such an impoverished situation like CAR, it is evident that the project is not yet investing at a more appropriate level of care where most of maternal and child deaths occur. The key would be to focus also on the lower level of primary health care (PHC), to explore community-based service delivery or promotion of key family practices, and to prioritize interventions at the community and periphery levels where primary healthcare is most needed and where the most marginalized people are.
- (b) Lack of subsidized pharmaceutical supplies and high costs for patients. As there is no efficient pharmaceutical supply chain, the health facilities rely on purchasing drugs from private pharmaceutical wholesalers stores which are located only in the capital Bangui. Out of pocket expenditure exist for drugs, even for the poor, as the health facilities cannot fully subsidize the high costs.
- (c) Lack of clear criteria of the poor and harmonized approach to identify them, as the classifications are conducted more on personal impression of the community health workers than by a predetermined national protocol.
- (d) The lack of a unified free healthcare policy is causing problems at health facilities themselves to identify who is eligible, in a country where poverty is almost universal. Due to insufficient funding and inadequate availability of medical supplies and healthcare workers, universal free



healthcare was not possible at the start of the PBF project in January 2017. Thus, the PBF-supported health facilities have initiated with only 20% full coverage of healthcare costs to the poor in green and orange zones.

- (e) The capacity to verify and monitor results across large number of facilities and then provide timely payments has proven challenging. Moreover, in the extremely fragile, conflictive and violent (FCV) context of CAR, project supervision is a problem, and security measures are not accounted for health workers and project coordinators. Transmission of funding to the hard-to-reach districts to remote health facilities have also shown to be a major constraint.
- (f) Lack of sufficient funding to go-to-scale. It was found impossible to go-to-scale beyond the current 40% coverage of the country with the PBF due to lack of resources due to the high costs of sustaining high incentive payments, high overhead costs at national and district level, and inaccessibility to high conflict (red) zones and districts. Therefore, the project will sustain and reinforce the current PBF-supported facilities only.

26. CAR has been selected to be a recipient of support from the Global Financing Facility (GFF), which was established to close the financing gap for RMNCAH-N efforts, not solely to generate additional funding, but to allocate these resources on achieving results by scaling up sustainable investments. Introduction of GFF in CAR has shown to be a transformational platform for the health sector, as it created a space and motive for the Ministry of Health to take a lead role in coordinating key actors working in health. The GFF country-level national consultation in CAR took place in early March 2018, and convened over 150 participants from various Ministries, UN technical agencies, bilateral financiers, humanitarian NGOs, civil society and the private sector. The national event, coordinated and presided by the Minister of Health and his staff, with technical and financial support provided by the WB, was opened by the Prime Minister, with the attendance of the President of the General Assembly (Parliament). For the first time in CAR's history, the MOH convened both the development and humanitarian actors in health to nationally focus on combatting maternal and child mortality and malnutrition to create a National Health Platform. As to further focus on key priority actions, the government has decided to focus on maternal and child mortality reduction, thus the focus will be on maternal and child health and nutrition (MCH-N) for the Investment Case. The Minister of Health has clarified that maternal mortality reduction will include reproductive health and nutrition, while child mortality reduction includes tuberculosis (TB), HIV/AIDS and malaria in addition to malnutrition (at the World Health Assembly special meeting on CAR, May 22, 2018).

27. As a value proposition of the GFF, through the country platform and development of the MCH-N Investment Case, a greater alignment between financiers (donors) of the health sector would be identified. As the government is just starting to identify key partners that could collaborate in supporting the buildup of the various health system blocks, the challenge now would be to find potential financiers that could support and expand the government-led PBF program with a strong link to community health service provision.



28. **Revamping the health sector coordination and effective partnerships for health system building is crucial.** The Investment Case should be on looking at the various health system building blocks, and focus on strengthening governance and coordination of the health sector, strengthening human resource of health at the central and district levels, building up the pharmaceutical supply chain, consolidating information data management, and strengthening the PBF's link to the community outreach of health services. It is important to note that coordination of the Health sector itself is new in CAR, which therefore may appear to have less said about multi-sectoral approaches which is vital to improve MCH-N results. This initial step is crucial to ensure that the government has a grasp of the key health actors working and supporting the developmental and humanitarian actors in the country. Multi-sectoral ministries and units were invited to the GFF national consultation in March, as we expect the identification of key actors of other sectors to join in during the roll-out of the Investment Case process.
29. **This project (SENI) aims to revamp such health sector coordination by working in health system rebuilding.** This will be done through health system strengthening activities related to human resources, governance, information system and pharmaceuticals. It will be done also by reinforcing the PBF program with strong focus on creating the link to community health service delivery, to coordinate in providing basic maternal-child health and nutrition package through a system strengthening modality. With the MOH's mindset of the goals of GFF, the PBF and community health link mechanism will serve to be a vehicle and the base for expanding partnership to hopefully improve efficiency of mobilizing domestic and external resources, which is crucially needed in a country with such a prominent level of fragmentation.

C. Proposed Development Objective(s)

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Development Objective(s) (From PAD)

To increase utilization and improve the quality of essential health services in targeted areas of the Central African Republic.

Key Results

D. Project Description



Component 1: Strengthening health system capacity to progress towards universal health coverage through performance-based financing (US\$1 million from the government, US\$7 million IDA, US\$7 million GFF)

30. Component 1 will expand the scope of the PBF approach by strengthening incentives at various levels. The MOH-managed PBF will be strengthened and reinforced to provide free healthcare to the poor, and to reach the communities of the health facilities catchment areas. Incentives will continue to be provided to: i) health facilities conditional on the quantity and quality of services delivered through facility-based activities and, ii) through community-outreach activities, through the use of community health workers to maximize their engagement and performance in promoting essential and cost-effective community-based maternal-child health and nutrition service delivery and key family practices for maternal and child survival. The PBF coverage will include also regulatory entities (in charge of pharmaceuticals, health information systems, community health services, inspection, etc), with the aim of improving efficiency, transparency and quality regulation at higher levels. The PBF grants will be introduced at the MOH directorates level with fixed budget lines towards a performance-based approach with standard output and quality performance indicators. In addition to supporting primary and secondary healthcare services, expansion of the technical assistance on the PBF scheme will be provided to tertiary referral hospitals without any allocation of additional funding with the objective of making more efficient use of the already existing government budget lines and cost recovery revenues. At this tertiary level, quarterly business plans and the index management tool to improve the transparency of financial management as defined in the government PBF manual will be applied.

31. As far as coverage, World Bank support will strengthen the current PBF-supported facilities, and expand in terms of reaching out to communities of the PBF-supported health facilities' catchment areas. In terms of geographical coverage of the project, the current PBF-supported facilities are located in 13 health districts, 13 district hospitals and 359 health centers in Health regions 2, 3, 4, 5 and 6. The project will support fee-exemptions for marginalized and poor households. Health facilities will be reimbursed with a higher PBF subsidy—four to six times—based on the fragility and crisis in the area and for attending the poor in comparison to non-poor patients. Expansion of the PBF will also be promoted to international and local partners including international NGOs (iNGOs) who have a large presence in CAR working in the conflict regions that focus on providing curative, fixed-based health services. These iNGOs will be identified and confirmed in the resource mapping exercise described in Component 2. These partners could also facilitate pharmaceutical supply access to the government-funded sites if agreements are made and logistics permit. The advantage of working with some large-scale NGOs are that they have a functional presence in areas where the government-funded projects have difficulties in monitoring and accessing due to conflict and violence.

32. The key to the PBF is to provide incentives to health workers who perform well in terms of providing the quantity of services as well as good quality of care. A quantified quality checklist will continue to be used for each level of the service package and technical modifications will be introduced based on lessons learned from the ongoing PBF program. The PBF-scheme emphasizes providing very small investment funds to health facilities to finance improvements in health service quality. The

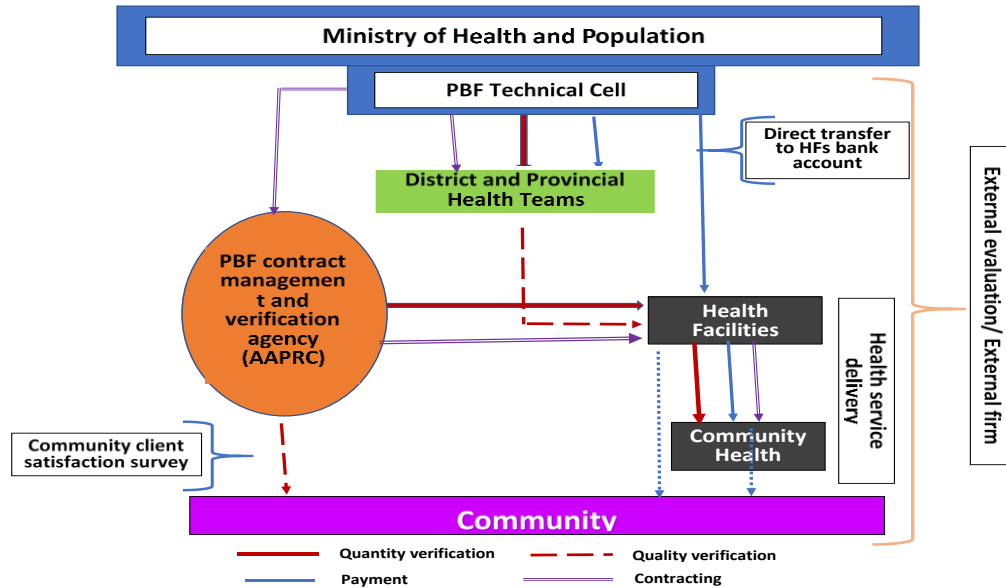


Component will also focus in providing “quality improvement bonuses” (BAQ) to health facilities in crisis and hard-to-reach areas that have been destroyed due to conflict.

33. **Contract management and verification:** An innovative strategy will be explored to build local capacity and to decrease program administrative costs related to the PBF contract management and verification functions. Local organizations will be selected and hired through a local contracting process. For strategic purchasing, the project procurement strategy development (PPSD) will be conducted in the preparation of this new project and will reassess the capacity of local NGOs and compare them in relation to the national market to meet the management and verification needs of the project.
34. **In addition to focusing on the reinforcement of the PBF-supported sites, Component 1 focuses to create the link of the PBF to community health service and engagement.** Community health workers represent a key asset for the promotion of key child and maternal survival practices, and are also key actors of social mobilization for caregivers to access essential health services. Various community outreach models will be explored in collaboration with partners who are already working with community-based maternal and child survival interventions, and will attempt to link them to the PBF-supported sites. For instance, community workers (*relais communautaires*) can be incentivised for community-based delivery of preventive child health services (such as provision of vitamin A, deworming or oral polio drops, or screening for malnutrition or reminding women to obtain their ante-natal care or promoting exclusive breastfeeding) and key family practices through scheduled community outreach by community workers. Another model could be that health facility staff can bring preventive health services into communities on a bimonthly basis. The health facilities or health workers who supervises the community workers will be incentivized by ensuring that target coverages are met.
35. **This component will dedicate to strengthening the purchasing mechanisms already tested in CAR and in place in approximately 40 percent of the country through PBF and free health care.** Under the strategic purchasing approach (Figure 1), public health facilities are contracted by purchasing agencies and paid by the PBF program to deliver a predefined package of essential health services that follows national guidelines and standards. On a monthly basis, health facilities submit declared performance to PBF contract management and verification agencies. Purchasing agencies which oversee the effectiveness and quantity of services delivered undergo a rigorous verification process. The verification of the quality of health services is conducted by the purchasing agencies every quarter. Counter-verification is conducted by the national PBF unit and by the independent verification agency. This SENI project will continue to use the community monitoring and feedback mechanism where community surveys are conducted every quarter, in order to ensure community participation and community outreach.



Figure 1: PBF institutional arrangements



36. **To promote quality of care, the PBF strategy serves as a principal means to incentivize providers to improve quality of care at the health facilities level.** There is a political and conflicting debate whether free-healthcare-for-all might be more applicable in the context of the population of CAR who are living on less than \$1.25 a day. As the definition of “poor” is vaguely defined and as a national policy do not yet exist of how to distinguish the poor from the non-poor, an output of this component 1 would include a national policy of free-healthcare and the clarification of eligibility of such policy.

Component 2: Reinforcing institutional capacity for improved basic health and nutrition service delivery through health system strengthening (US\$3 million from IDA, US\$ 3 million from the GFF)

37. **Government capacity for coordination of the national health platform and the elaboration of the MCH-N investment case, to combat maternal and child mortality and malnutrition, will be provided under this component.** The national Health Platform will create several working groups, to focus on the various components of the health system, and elaborate the country’s Investment Case. Priority interventions to reduce maternal and child mortality and malnutrition will be identified through evidence-based planning and budgeting tools and consultative processes. It is anticipated that PBF will feature prominently in the country’s Investment Case.

38. **For the development of the country’s investment case, resource and geographical mapping of all key agencies and donors will be required, enabling the MOH to oversee for the first time the activities managed by development partners both in developmental and humanitarian areas.** Key development and humanitarian actors working in health will be identified in the GFF-resource



mapping process. Engagement of international humanitarian actors working in conflict zones will be fundamental to secure the expansion of the coverage of health and nutrition service delivery where maternal and child healthcare services are most needed. Further exploration will be made to contemplate third-party monitoring and supervision of project areas in the conflict areas. The GFF platform will be very useful for CAR to prioritize its investments in health and to mobilize health financing to curb the high rates of neonatal, child and maternal mortality rates in the country.

39. **Component 2 will support institutional capacity needed at national, regional, and district levels to address critical constraints in the expansion of PBF, coordination of the health sector, the elaboration and implementation of the Investment Case.** It will support analytical work, bringing in technical expertise, and policy dialogue to the government to facilitate the development and implementational support for key reforms that address system bottlenecks for achieving more efficient use of health sector resources and improved health outcomes, especially for reaching MCH-N goals and building synergy within the humanitarian and development nexus. The identification of these bottlenecks and reforms to be supported by the project will be guided by the national health strategy and agreed upon during the GFF consultation process. This component will also finance project management and comprehensive capacity-building activities. In addition to resource and geographical mapping of health actors and interventions and the preparation of the Investment Case on maternal and child health and nutrition (MCHN), it will provide support to the MOH and its partners to:

- Define a national health financing strategy.
- Define national human resources for health (HRH) policy.
- Improve pharmaceutical supply chain.
- Prepare a community health strategy, including community outreach and community-IMCI.
- Define a basic package of essential health services to reduce maternal child health and malnutrition.
- Prepare a periodic maternal and child health campaign strategy.
- Improve availability of data and the HMIS.
- Develop smart public-private partnership (PPP) in the health sector.

Component 3: Contingent Emergency Response (US\$0 equivalent)

40. A Contingency Emergency Response Component (CERC) will be included under the project in accordance with Operational Policy (OP) 10.00 paragraphs 12 and 13, for projects in Situations of Urgent Need of Assistance or Capacity Constraints. This will allow for rapid reallocation of project proceeds in the event of a natural or man-made disaster or crisis that has caused, or is likely to imminently cause, a major adverse economic and/or social impact.

E. Implementation



Institutional and Implementation Arrangements

Note to Task Teams: The following sections are system generated and can only be edited online in the Portal.

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41. **The SENI Project will build on the successful implementation experience of the HSSP project.** Throughout this project, the implementation performance has been Satisfactory despite a very challenging context. The MOH will be the main line ministry for implementation of the project. Under coordination from the Minister and the Cabinet Director, technical activities will be undertaken by the relevant directorates and units within the Ministry. As per the current project, a project steering committee will oversee the achievement of the project's objectives. Project execution will take place at all levels (from community health post, district health facilities and hospitals to tertiary hospitals) of the health system. The Administrative and Financial Manual of Procedures and the PBF Manual will detail the roles and responsibilities of the various parties and make explicit any adjustments to national procedures required by IDA.
42. **To institutionalize leadership and coordination of the PBF program within the government and across partners, the MOH established a National PBF Technical Unit (NTU) (Cellule Technique Nationale FBP) responsible for day-to-day implementation of the program and for informing the PBF Steering Committee of the progress achieved in implementing the PBF approach.** The NTU's performance is satisfactory, and its staff are extremely responsive in lines of communication and action. The NTU will still be provided close technical support from the Bank and from externally throughout the implementation of the project.
43. **Under the proposed operation, the HSSP PIU will be merged with the PBF Technical Unit.** The National PBF Technical Unit will be tasked with overseeing both coordination of the overall PBF program as well as specific project implementation. As such, the fiduciary requirements of the PBF Technical Unit will increase substantially as the entirety of responsibilities from the HSSP PIU will be transferred to the PBF unit. Given the PBF unit and PIU currently work jointly as one team albeit being two unique entities, all staff from the PIU will be transferred to the PBF technical unit to reinforce the fiduciary expertise and experience of the said unit.
44. **The SENI Project will continue to support the MOH with regard to local expertise.** Similar to the HSSP, the Project will continue to make available some local experts to the ministry in the areas of financial management/accounting, procurement, monitoring and evaluation, environmental and social safeguards, and information technology/online databases.
45. **Under the PBF program implementation, eight main functions have been defined with the involvement of all levels of the health system (central, provincial, and district levels; public institutions, private entities, and civil society):**
 - (a) The provision of care is provided by public hospitals, health centers and health posts, as well as community health workers.
 - (b) Contracting and verification of services will be provided by local purchasing agencies/NGOs.



- (c) Counter verification – this function will focus on the quality of health facilities services and the performance of all entities involved in the PBF Program and paid according to their performance. It will be undertaken once every quarter by an independent external body and by local associations that conduct community surveys on perceived quality of health care.
- (d) Financing of the PBF program is ensured by the Ministry of Finance on the government side and various international partners.
- (e) The technical coordination of the PBF program at all levels is entrusted to the PBF Technical Unit (as mentioned earlier).
- (f) Regulation is ensured by the MOH central services.
- (g) The voice of the population will be ensured through health committees involved in facilities management as well as the above mentioned local organizations used in verification and in users' satisfaction surveys.

46. **All PBF implementation modalities that the SENI Project is financing will be included in an updated version of the PBF Manual.** The PBF Technical Unit has the responsibility to produce and update the Manual which is the most important tool for implementing the program. This unit is also in charge of preparing the PBF annual reports (technical and financial reports). Finally, the PBF Technical Unit will improve the PBF database to include the new components of the program pertaining to the CHWs, regulatory bodies/public health programs, and the NHIS/DHIS2.

47. **The existing National Health Steering Committee, chaired by Minister of Health,** which includes representatives from various Ministries, directorates within the MOH, key development partners and donors, civil society, and private actors involved in health, **will serve as national health platform to monitor and oversee the roll-out of the country's Investment Case.** A core team and health system component working groups will be identified upon the roll-out of the development of the investment case.

F. Project location and Salient physical characteristics relevant to the safeguard analysis (if known)

Similar to the ongoing Health System Support Project (P119815), the SENI project will be implemented in Regions 2, 3, 4, 5 and 6.

G. Environmental and Social Safeguards Specialists on the Team

Lucienne M. M'Baipor, Social Safeguards Specialist
Grace Muhimpundu, Social Safeguards Specialist
Richard Everett, Social Safeguards Specialist



Albert Francis Atangana Ze, Environmental Safeguards Specialist
Joelle Nkombela Mukungu, Environmental Safeguards Specialist

SAFEGUARD POLICIES THAT MIGHT APPLY

Safeguard Policies	Triggered?	Explanation (Optional)
Environmental Assessment OP/BP 4.01	Yes	The Health System Support Extension and Strengthening Project like the ongoing Health System Support Project (P119815) is expected to have positive effects on improving the quality of essential health services in targeted areas of the Recipient’s territory. However, certain activities such as the light rehabilitation of facilities and strengthening of infrastructure / equipment in selected health center are likely to entail health and occupational safety risks. This policy is triggered due the potential increase of both solid and liquid medical waste as a consequence of the increases in the use of health services and potential health and occupational safety risks. An ESMF and a biomedical waste management plan have been prepared for the ongoing project (HSSP) and will be updated to include: environmental challenges associated with new areas to be covered; occupational health safety guidance; waste management, working conditions and new project description.
Performance Standards for Private Sector Activities OP/BP 4.03	No	
Natural Habitats OP/BP 4.04	No	OP/BP 4.04 is not triggered. No project's activity is expected to impact Natural Habitats
Forests OP/BP 4.36	No	OP/BP 4.36 is not triggered. The project does not involve Forests or Forestry.
Pest Management OP 4.09	No	OP/BP 4.09 is not triggered. The project does not involve pest management.
Physical Cultural Resources OP/BP 4.11	No	OP/BP 4.11 is not triggered. Project interventions are not envisioned to impact sites of cultural importance neither does it involve excavations.
Indigenous Peoples OP/BP 4.10	Yes	As the areas targeted by the operation contain indigenous peoples populations, OP/BP 4.10 is triggered. An Indigenous People Policy Framework (IPPF) will be prepared in consultation with IPs and



various actors. Once the project site is clearly identified, the project will prepare an Indigenous Peoples Plan (IPP). The IPPF will be disclosed in country and on the World Bank External website prior the appraisal.

Involuntary Resettlement OP/BP 4.12	No	The project will not finance any activities that would trigger land activities.
Safety of Dams OP/BP 4.37	No	The project will not finance any dam construction or rehabilitation.
Projects on International Waterways OP/BP 7.50	No	The project will not affect any international body of water.
Projects in Disputed Areas OP/BP 7.60	No	None of the intervention sites are in disputed areas.

KEY SAFEGUARD POLICY ISSUES AND THEIR MANAGEMENT

A. Summary of Key Safeguard Issues

1. Describe any safeguard issues and impacts associated with the proposed project. Identify and describe any potential large scale, significant and/or irreversible impacts:

An environmental issue which could result from the project would be the dangers of improper disposal of medical waste, such as of used needles (syringes), contaminated cutting instruments, microbiological cultures and laboratory waste, surgical clothing and dirty compresses, tissues and human blood, excrement, expired medicines and other pharmaceuticals products.

In regards to the impact to the indigenous group, the Baka pygmies compose a minority group of approximately 15,000-20,000, where the majority live in the forests in southwest regions of CAR in Ombella-Mpoko, Lobaye, Mambéré-Kadei and Sangha-Mbaéré prefectures. The health situation of the pygmies is precarious compared to that of other Central Africans due to a part for their nomadic lifestyle , dependence on traditional medicine, and poor sanitary conditions in their homesteads . However, it must also be taken into account that they are excluded from the formal health system. As a result, they are less aware than the Bantus (the native population) of diseases and their modes of transmission, and often are have no access to health facilities or drugs. Due to this situation, it is imperative that the pygmy communities also are reached and benefit from the implementation of this project.

2. Describe any potential indirect and/or long term impacts due to anticipated future activities in the project area:

The long-term impact of improper hazardous medical waste management could result in damaging the environment, including soil in the surrounding area of the supported health facilities, injuries and harm to the health professionals and patients visiting the health facilities, spread of diseases due to unhygienic behavior of waste management and contamination of water sources if the hazardous waste is not properly disposed.

For the pygmy population, if they are not included and consulted within the project sites, there could be resentment which might cause more violence, or their health situation could deteriorate as they usually do not access healthcare.

3. Describe any project alternatives (if relevant) considered to help avoid or minimize adverse impacts.



In order to avoid and minimize the adverse impact of hazardous waste, the following will be considered to be included in the design of the project: i) Training and awareness building for proper medical-related hazardous waste management and ii) incorporation of public consultation process in terms of verifying the quality of services provided by the project. It is of vital importance to include the IP minority groups in the consultative process and obtain their feedback into quality of care from the health workers themselves when obtaining care, so as to provide culturally appropriate access to healthcare for this group.

4. Describe measures taken by the borrower to address safeguard policy issues. Provide an assessment of borrower capacity to plan and implement the measures described.

Capacity building for the environmental and social management of the project. Trainings key managers at the national and districts levels were incorporated within the Ministry of Health personnel for overseeing that waste management is incorporated into the dissemination of the project.

Public consultation process in terms of verifying the quality of services provided by the project. The last point is already in place, where there is a monthly quality assessment conducted by external verifying agency, which is linked to their performance based bonuses.

In regard to the experience gained through the implementation of the Health System Support Project, the National Technical Unit (NTU) is hiring a full time environmental and social specialist who will serve as the main persons in charge of project implementation and monitoring of safeguard aspects.

In addition, an in-depth environmental and social capacity assessment of the NTU, the health facilities, the ministry of Health (in charge of monitoring medical waste management), the Ministry of Environment (in charge of monitoring compliance with ESMPs) and other relevant stakeholders (e.g. National PBF Technical Unit, NGOs,..) will be carried out in order to identify specific areas for improvement. The project will provide resources to strengthen the capacity of key stakeholders in environmental and social management.

To ensure safeguards implementation in a timely manner, a safeguards implementation budget and calendar will be submitted to the World Bank; this will help to ensure constant and regular supervision of social and environmental measures. The NTU will prepare quarterly reports of the implementation of the safeguards instruments; monitoring will be based on the indicators set forth in the safeguards instruments. To this end, the safeguard specialist in the NTU will closely collaborate with the M&E specialist in the NTU and reflect the findings in the quarterly reports.

The project has prepared through a consultative process, an Environmental and Social Management Framework (ESMF), a Biomedical Waste Management Plan (BWMP) as well as an Indigenous Peoples Policy Framework (IPPF) which will provide a blueprint for the safeguards risks and impacts management once the specific health zones and health centers are identified.

5. Identify the key stakeholders and describe the mechanisms for consultation and disclosure on safeguard policies, with an emphasis on potentially affected people.

During the preparation and identification of the project, consultations and feedback workshops were held with various stakeholders including: prefectural technical and administrative services and at the level of the communes (including meeting with the Mayor, various municipal services, civil society organizations), local community members (including youth and women), as well as Indigenous Peoples and IP representative groups. The various stakeholders exchanged with the project in preparation of the safeguards instruments (ESMF and IPPF), and their recommendations,



suggestions and comments were taken into account in the final documents. Given the insecurity in the project area, the consultation were carried out in the city of Berberati (from 26 to 30 April 2018) with all the above mentioned stakeholders.

A grievance redress mechanism has been established in the safeguards instruments. The GRM will be widely disseminated through communication campaigns, as well as included in the MOH's website which provides updates of the project, where key stakeholders could address complaints and suggestions of the progress of the project. A monthly quality assessment of project implementation is also conducted by an external verifying agency, which is linked to their performance-based bonuses of the borrower.

B. Disclosure Requirements

Environmental Assessment/Audit/Management Plan/Other

Date of receipt by the Bank	Date of submission for disclosure	For category A projects, date of distributing the Executive Summary of the EA to the Executive Directors
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"In country" Disclosure

Indigenous Peoples Development Plan/Framework

Date of receipt by the Bank	Date of submission for disclosure
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"In country" Disclosure

C. Compliance Monitoring Indicators at the Corporate Level (to be filled in when the ISDS is finalized by the project decision meeting)

OP/BP/GP 4.01 - Environment Assessment

Does the project require a stand-alone EA (including EMP) report?

No



OP/BP 4.10 - Indigenous Peoples

Has a separate Indigenous Peoples Plan/Planning Framework (as appropriate) been prepared in consultation with affected Indigenous Peoples?

Yes

If yes, then did the Regional unit responsible for safeguards or Practice Manager review the plan?

NA

If the whole project is designed to benefit IP, has the design been reviewed and approved by the Regional Social Development Unit or Practice Manager?

NA

The World Bank Policy on Disclosure of Information

Have relevant safeguard policies documents been sent to the World Bank for disclosure?

Yes

Have relevant documents been disclosed in-country in a public place in a form and language that are understandable and accessible to project-affected groups and local NGOs?

NA

All Safeguard Policies

Have satisfactory calendar, budget and clear institutional responsibilities been prepared for the implementation of measures related to safeguard policies?

Yes

Have costs related to safeguard policy measures been included in the project cost?

Yes

Does the Monitoring and Evaluation system of the project include the monitoring of safeguard impacts and measures related to safeguard policies?

Yes

Have satisfactory implementation arrangements been agreed with the borrower and the same been adequately reflected in the project legal documents?

Yes

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