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September 10, 2018

Closing Date: Thursday, September 27, 2018 at 6:00 p.m.

FROM: Vice President and Corporate Secretary

Central African Republic - Health System Support and Strengthening Project (SENI)

Project Appraisal Document

Attached is the Project Appraisal Document regarding a proposed grant to Central African Republic for a Health System Support and Strengthening Project (SENI) (IDA/R2018-0309), which is being processed on an absence-of-objection basis.

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Report No: PAD2877

INTERNATIONAL DEVELOPMENT ASSOCIATION

PROJECT APPRAISAL DOCUMENT
ON A
PROPOSED IDA GRANT

IN THE AMOUNT OF SDR 30.7 MILLION
(US$43 MILLION EQUIVALENT)

TO THE

CENTRAL AFRICAN REPUBLIC

FOR A

HEALTH SYSTEM SUPPORT AND STRENGTHENING PROJECT (SENI)

September 6, 2018

Health, Nutrition and Population Global Practice
Africa Region

This document is being made publicly available prior to Board consideration. This does not imply a presumed outcome. This document may be updated following Board consideration and the updated document will be made publicly available in accordance with the Bank's policy on Access to Information.

CURRENCY EQUIVALENTS

(Exchange Rate Effective July 31, 2018)

Currency Unit =	C.F.A Franc (XAF)
XAF 569.3 =	US$1
US$ 1.405 =	SDR 1

FISCAL YEAR
January 1 – December 31

ABBREVIATIONS AND ACRONYMS

ASSOMESCA	Association of Medical Interventions of the Churches for Health in CAR (*Association des Œuvres Médicales des Eglises pour la Santé en RCA*)
BAQ	Quality Improvement Bonus (*Bonus de l'Amelioration de la Qualité*)
CAR	Central African Republic
CERC	Contingent Emergency Response Component
CPA	Complementary Package of Activities
DA	Designated Account
DALY	Disability-Adjusted Life Year
DHIS2	Demographic Health Information System 2
DHS	Demographic and Health Survey
ESMF	Environmental and Social Management Framework
EU	European Union
FCV	Fragility, Conflict, and Violence
FM	Financial Management
GAVI	Global Alliance for Vaccine Initiatives
GBV	Gender-based Violence
GDP	Gross Domestic Product
GF	Global Fund
GFF	Global Financing Facility
GRM	Grievance Redress Mechanism
HIV/AIDS	Human Immunodeficiency Virus - Acquired Immune Deficiency Syndrome
HMIS	Health Management Information System
HRH	Human Resources for Health
HSSP	Health System Support Project
ICRC	International Committee of the Red Cross
IFR	Interim Financial Report
IPPF	Indigenous Peoples Policy Framework
IT	Information Technology
M&E	Monitoring and Evaluation

MCH	Maternal and Child Health
MICS	Multiple Indicator Cluster Survey
MOH	Ministry of Health, Public Hygiene and Population
MPA	Minimum Package of Activities
MSF	Doctors without Borders (*Médecins sans Frontières*)
MWMP	Medical Wastes Management Plan
NGO	Nongovernmental Organization
NHIS	National Health Information System
NTU	National Technical Unit
ODA	Official Development Assistance
PBF	Performance-based Financing
PDO	Project Development Objective
PFM	Public financial management
PHC	Primary Health Center
PIM	Project Implementation Manual
PIU	Project Implementation Unit
PPA	Performance Purchasing Agency
PPP	Public-Private Partnership
PPSD	Project Procurement Strategy for Development
RCPCA	Recovery and Peacebuilding Plan of the Central African Republic
RMNCAH-N	Reproductive, Maternal, Neonatal, Child, Adolescent Health and Nutrition
SCD	Systematic Country Diagnostic
SDG	Sustainable Development Goal
SENI	Health System Support and Strengthening Project
STEP	Systematic Tracking and Exchanges in Procurement
STI	Sexually Transmitted Infection
UHC	Universal Health Care
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WFP	World Food Programme
WHO	World Health Organization

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DATASHEET

BASIC INFORMATION

Country(ies)	Project Name	
Central African Republic	Health System Support and Strengthening Project	
Project ID	Financing Instrument	Environmental Assessment Category
P164953	Investment Project Financing	B-Partial Assessment

Financing & Implementation Modalities

[ ] Multiphase Programmatic Approach (MPA)	[✓] Contingent Emergency Response Component (CERC)
[ ] Series of Projects (SOP)	[✓] Fragile State(s)
[ ] Disbursement-linked Indicators (DLIs)	[ ] Small State(s)
[ ] Financial Intermediaries (FI)	[ ] Fragile within a non-fragile Country
[ ] Project-Based Guarantee	[✓] Conflict
[ ] Deferred Drawdown	[ ] Responding to Natural or Man-made Disaster
[ ] Alternate Procurement Arrangements (APA)	

Expected Approval Date	Expected Closing Date
27-Sep-2018	31-Dec-2021

Bank/IFC Collaboration

No

Proposed Development Objective(s)

To increase utilization and improve the quality of essential health services in targeted areas in the territory of the Recipient.

Components

Component Name	Cost (US$, millions)
Improving the quality and utilization of essential health services at facility and community levels through performance-based financing (PBF)	36.00
Reinforcing the capacity of the Recipient's health system and addressing Gender-Based Violence	18.00
Contingent Emergency Response	0.00

Organizations

Borrower:	Ministry of Economy, Planning and Cooperation
Implementing Agency:	Ministry of Health, Public Hygiene and Population

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
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

IDA Resources (in US$, Millions)

	Credit Amount	Grant Amount	Total Amount
National PBA	0.00	43.00	43.00
Total	**0.00**	**43.00**	**43.00**

Expected Disbursements (in US$, Millions)

WB Fiscal Year	2019	2020	2021	2022
Annual	6.00	14.00	16.00	7.00
Cumulative	6.00	20.00	36.00	43.00

INSTITUTIONAL DATA

Practice Area (Lead)

Health, Nutrition & Population

Contributing Practice Areas

Fragile, Conflict & Violence, Social Protection & Labor

Climate Change and Disaster Screening

This operation has been screened for short and long-term climate change and disaster risks

Gender Tag

Does the project plan to undertake any of the following?	
a. Analysis to identify Project-relevant gaps between males and females, especially in light of country gaps identified through SCD and CPF	Yes
b. Specific action(s) to address the gender gaps identified in (a) and/or to improve women or men's empowerment	Yes
c. Include Indicators in results framework to monitor outcomes from actions identified in (b)	Yes

SYSTEMATIC OPERATIONS RISK-RATING TOOL (SORT)

Risk Category	Rating
1. Political and Governance	High
2. Macroeconomic	Substantial

3. Sector Strategies and Policies	High
4. Technical Design of Project or Program	Moderate
5. Institutional Capacity for Implementation and Sustainability	Substantial
6. Fiduciary	High
7. Environment and Social	Moderate
8. Stakeholders	Moderate
9. Other	High
10. Overall	Substantial

COMPLIANCE

Policy

Does the project depart from the CPF in content or in other significant respects?

[ ] Yes [√] No

Does the project require any waivers of Bank policies?

[ ] Yes [√] No

Safeguard Policies Triggered by the Project	Yes	No
Environmental Assessment OP/BP 4.01	✔	
Performance Standards for Private Sector Activities OP/BP 4.03		✔
Natural Habitats OP/BP 4.04		✔
Forests OP/BP 4.36		✔
Pest Management OP 4.09		✔
Physical Cultural Resources OP/BP 4.11		✔
Indigenous Peoples OP/BP 4.10	✔	
Involuntary Resettlement OP/BP 4.12		✔
Safety of Dams OP/BP 4.37		✔
Projects on International Waterways OP/BP 7.50		✔
Projects in Disputed Areas OP/BP 7.60		✔

Legal Covenants

Sections and Description
The Recipient shall, not later than six (6) months after the Effective Date, cause the PBF TU to customize its existing accounting software to ensure that its accounting software has been updated to comply with the SYSCOHADA accounting system, which shall be applied to the Project.

Sections and Description
Not later than six (6) months after the Effective Date, the Recipient shall appoint an external auditor with terms of reference, qualifications and experience satisfactory to the Association.

Sections and Description
The Recipient shall, not later than six (6) months after the Effective Date, cause the PBF TU to recruit, and thereafter retain, an internal auditor with qualification and experience satisfactory to the Association.

Sections and Description
The Recipient shall, not later than six (6) months after the Effective Date, cause the PBF TU to recruit, and thereafter retain, an accountant and a procurement specialist with qualification and experience satisfactory to the Association.

Sections and Description
Counterpart Funding (i):
The Recipient shall, not later than one (1) month after the Effective Date, open and maintain until the completion of the Project, a separate account for the exclusive purpose of financing activities under the Project ("Counterpart Funding"), to deposit amounts of up to one million United States Dollars (US$1,000,000) in the aggregate.

Sections and Description
Counterpart Funding (ii):
The Recipient shall, not later than six (6) months after the Effective Date, commit to deposit the sum of (three hundred thousand) United States Dollars (US$300,000) in Project Account.

Sections and Description
The Recipient shall establish, and at all times during Project implementation, maintain the PBF Technical Unit ("PBF TU") within the MOH.

Sections and Description
Counterpart Funding (iii):
The Recipient shall, no later than June 30, 2020 (or June 30 of the second year of Project implementation, if after the year 2020), deposit the sum of (four hundred thousand) United States Dollars (US$400,000) in Project Account.

Sections and Description
Counterpart Funding (iv):
The Recipient shall, no later than June 30, 2021 (or June 30 of the third year of Project implementation, if after the year 2021), deposit the sum of (three hundred thousand) United States Dollars (US$300,000) in Project Account.

Sections and Description
The Recipient shall at all times during Project implementation maintain, the National Health Steering Committee ("NHSC") with composition and mandate acceptable to the Association.

Sections and Description
The Recipient shall, not later than three (3) months after the Effective Date, cause the PBF TU to recruit, and throughout Project implementation, retain Independent Verification Agencies, with qualifications, experience, and terms of reference satisfactory to the Association, for purposes of carrying out independent verification of the services to be financed by the PBF Payments under Part 1.1 of the Project.

Sections and Description
The PBF TU shall, at all times during Project implementation, retain the following staff, inter alia, each with terms of reference, qualifications and experience satisfactory to the Association: (i) a coordinator; (ii) a procurement specialist; (iii) a financial management specialist; (iv) a monitoring and evaluation specialist; and (v) a social and environmental specialist.

Sections and Description
The Recipient shall ensure that all terms of reference for any technical assistance or studies carried out under the Project are consistent with the Bank's social and environmental safeguard policy requirements, as well as the Recipient's own environmental and social laws and regulations.

Sections and Description
The Recipient shall ensure that all technical assistance under the Project, shall only be undertaken pursuant to terms of reference reviewed and found satisfactory by the Association, such terms of reference to ensure that the technical assistance takes into account, and calls for application of the Association's environmental and social safeguards policies and the Recipient's own laws relating to the environment and social aspects.

Sections and Description
The Recipient shall ensure that employees, agents, service providers, contractors and subcontractors carry out the Project in conformity with acceptable environmental and social standards, practices and codes of conduct (which shall, inter alia, contain measures that prohibit, endeavor to prevent and address Project-related gender based violence and sexual exploitation and abuse), the provisions of the Recipient's environmental and social laws.

Sections and Description
The Recipient shall ensure that relevant environmental and social mitigation measures and clauses are included in the tender documents in accordance with the Safeguards Instruments.

Sections and Description
The Recipient shall, throughout Project implementation, cause the PBF TU, to maintain and publicize the availability of a Project-level grievance redress mechanism and a feedback mechanism, in form and substance satisfactory to the Association, in order to hear and determine fairly and in good faith all complaints and feedback raised in relation to the Project, and take all measures necessary to implement the determinations made by said grievance feedback and redress mechanism in a manner satisfactory to the Association.

Sections and Description
The Recipient shall furnish to the Association, not later than November 30 of each year, the annual work plans and budgets approved by the Steering Committee for the Association's review and approval; except for the annual work plan and budget for the Project for the first year of Project implementation, which shall be furnished no later than one (1) month after the Effective Date.

Conditions

Type	Description
Effectiveness	The Recipient has updated the PIM and the PBF Manual in form and substance acceptable to the Association.
Effectiveness	The Recipient has integrated the PIU into the PBF Technical Unit.
Effectiveness	The Global Financing Facility Grant Agreement has been executed and delivered and all conditions precedent to its effectiveness or to the right of the Recipient to make withdrawals under it (other than the effectiveness of this Agreement) have been fulfilled
Disbursement	IDA Funding: Notwithstanding the provisions of Part A, no withdrawal shall be made under Category 3 unless the following conditions have been met: (i) the Recipient has determined that an Eligible Crisis or Emergency has occurred, has furnished to the Association a request to include such activities in the Project in order to respond to said Eligible Crisis or Emergency, and the Association has agreed with such determination, accepted said request and notified the Recipient thereof; (ii) the Recipient has adequate staff and resources for the purposes of said activities; and (iii) the Recipient has adopted the Emergency Response Manual in form, substance and manner acceptable to the Association.
Disbursement	GFF Funding: Notwithstanding the provisions of Part A, no withdrawal shall be made under Category 3 unless the following conditions have been met: (i) the Recipient has determined that an Eligible Crisis or Emergency has occurred, has furnished to the Association a request to include such activities in the Project in order to respond to said Eligible Crisis or Emergency, and the Association has agreed with such determination, accepted said request and notified the Recipient thereof; (ii) the Recipient has adequate staff and resources for the purposes of said activities; and (iii) the Recipient has adopted the Emergency Response Manual in form, substance and manner acceptable to the Association.

I. STRATEGIC CONTEXT

A. Country Context

1. **The Central African Republic (CAR) has suffered from decades of repeated conflicts and political instability.** Nearly half of the country's population depends on humanitarian assistance for basic needs, and one-fifth of the population is forcibly displaced out of a total population of 4.5 million. An international alert was raised on March 23, 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, against the Muslim populations, amplifying the scale of forced displacements and human rights violations. Even before the upsurge of the large-scale violence in 2013, the CAR State 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 interethnic agitations.

2. **Security improvements have been accompanied by international support.** Previously considered an aid orphan, CAR is heavily reliant on support from the international community and, even with the international support, the levels of financing in health are much lower than needed. 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. Various United Nations (UN) agencies, international organizations, bilateral donors, and more than 100 international nongovernmental organizations (NGOs) offer emergency relief and humanitarian assistance.

3. **Poverty has worsened after the crisis and violence.** The poverty rate in CAR was estimated at 62 percent (2008), with 50 percent of the urban population and 69 percent of the rural population living in poverty. Recent estimates based on observed trends in gross domestic product (GDP) suggest that the poverty rate has surged to more than 75 percent in 2016 (World Bank CAR Systematic Country Diagnostic [SCD], P160971, forthcoming, October 2018).

4. **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 45 percent in Bangui to 78 percent in the Yadé region. High levels of displacement have further aggravated poverty. In August 2016, more than half of the households in the country indicated that they have experienced displacement of some or all their household members since 2012. A total of 68 percent of households in urban areas and 61 percent of households in rural areas experienced displacement. Access to basic social services is already limited in Bangui and 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 rural areas has always been a challenge to service delivery in CAR.

5. **After 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 some parts.** The Government and several development partners have consequently begun to reorient social sectors, especially health interventions, away from emergency relief and toward 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. Fragility and the potential for renewed conflict continue to pose a serious risk throughout the country—this situation needs to be considered when planning for future projects. Broadly, the imperative now is not just to rebuild institutions and systems that are broken and almost inexistent but also continue strengthening the Government's capacity to provide essential health services to its population, focusing especially on women, children, and the vulnerable population.

B. Sectoral and Institutional Context

6. **Instability and violence in CAR has resulted in substantial deterioration of human capital and social services, including health.** The under-five mortality rate is estimated at 129 per 1,000 live births, ranking the country as 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. The adult literacy rate is 37 percent and life expectancy at birth is 52 years. Less than half (46 percent) of children under one year obtained their third dose of the combined diphtheria-pertussis-tetanus vaccine. In CAR, malnutrition is an underlying cause of almost half (48 percent) of the deaths of children under five years. Children under five years have high levels of malnutrition, with 41 percent suffering from chronic malnutrition or stunting and 7 percent acutely malnourished. Additionally, only 3 percent of children under five years receive the full coverage of routine vitamin A supplementation (twice per year). Almost half (46 percent) of reproductive age women ages 15–49 suffer from anemia. Unsurprisingly, the country ranks last on the 2017 Human Development Index, 188 out of 188, with an average per capita GDP of US$382 (2016 estimate). 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. The perpetual impoverishment, compounded by the political crisis in CAR has led to a situation where the health system is not fully functional.

7. **Uncoordinated fragmentation of the health sector among the numerous actors working in health is exacerbating the crisis in the health system.** Multilateral organizations and 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. Key UN agencies working in the health domain in CAR, such as the World Health Organization (WHO), United Nations Children's Fund (UNICEF), United Nations Population Fund (UNFPA), Joint United Nations Programme on HIV/AIDS, World Food Programme (WFP), Global Fund (GF), and Global Alliance for Vaccine Initiatives (GAVI), work in silos.

8. **A cohort of large-scale international NGOs specialized in humanitarian health care service delivery**, such as Doctors without Borders (*Médecin Sans Frontières*, MSF) and the International Committee of the Red Cross (ICRC) and dozens of US-government-funded NGOs and numerous others, play an immense role in CAR providing maternal and child survival services to communities in 60 percent of the country's conflict areas. However, most of the work is on a short-term basis and often leaves the communities without sustained health care after the departure of these organizations. The Government

has little contact with the humanitarian actors and, currently, has little idea of who is doing what or how much is being spent on the provision of basic health services to the population.

9. **CAR's health system suffers from severe constraints across all pillars of the health system,** such as (a) lack of access to essential medicines and a dilapidated pharmaceutical supply chain; (b) shortage of a health workforce; (c) low and inequitable health financing; (d) lack of health-related data, including household surveys and health financing data, and a nonexistent national health information system (NHIS); (e) poor and lack of service delivery (both facility based and community based); and (f) weak governance.

(a) A 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 lack of quality control, high prices, inaccessibility of affordable essential drugs, absence of an efficient supply chain, high transportation costs, and high out-of-pocket spending for families remain intractable challenges related to the pharmaceutical supply chain. The national pharmaceutical procurement center (transfer unit of drugs [*Unité de cession des medicaments*, UCM]) has become inoperative and is considered bankrupt with financial debts to suppliers estimated at CFAF 2.4 billion (US$4 million) and does not have any stock of medical commodities.

The distribution network to health facilities, through 16 prefectural drug dispatchers, is also mostly nonfunctional. The religious sector, through the Association of Medical Interventions of the Churches for Health in CAR (*Association des Œuvres Médicales des Eglises pour la Santé en RCA*, ASSOMESCA), established itself in about seven towns in rural areas and provided quality generic essential medicines in health facilities at a slightly higher cost because of transport and security measures. However, this distribution system is now closed because of insecurity in the country. The private pharmaceutical sector consists of several wholesalers (Rofarma, Shalina, and Nand Phrama), which are only located in the capital Bangui, providing little access to drugs to those in rural areas. The country has no control laboratory or any level of quality assurance, which makes CAR susceptible to counterfeit drugs. In this situation, while the Government attempts to stimulate the private purchasing of drugs by the health facilities themselves, the Government also needs to identify alternative mechanisms to ensure the supply of basic and selected essential drugs to the health facilities and maximize the presence of UN agencies and large-scale NGOs to support immediate pharmaceutical supplies to the health facilities.

(b) Shortage of human resources for health (HRH) is a major concern for CAR's health system. CAR's HRH are severely lacking in numbers, undermining the WHO's target ratio benchmark of 4.5 doctors, nurses, and midwives per 1,000 population (associated with countries that have achieved Universal Health Care [UHC]) (table 1), who are unequally distributed geographically and lack technical qualifications. CAR has strong dependencies on development partners' funding not only to sustain its health sector but to also identify, train, and pay the salaries of health staff working within the development partners' projects. The number of community health workers is unknown, but they have been working to support immunization campaigns; however, they currently remain inadequately used, trained, and incentivized.

Table 1. HRH by Health Professionals (professional: population ratio)

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

Source: Directorate of Resources of the Ministry of Health (MOH) and Population.

(c) **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 are not available. National health accounts do not exist in the country. However, the total health expenditures per person per year is estimated at US$17, with the Government's contribution being US$2 per capita per year. Most health expenditures come from households' out-of-pocket spending (40 percent), which reflects the prevalence of potentially high catastrophic expenditures. There is also a marked gap between the funding assigned to the capital Bangui and other regions. Furthermore, the funding provided by the state to the health sector does not target the poorest. According to the National Health Development Plan (2006–2015), more than half of the funds were allocated to the capital, which only has 17 percent of the population. The rest of the population—the majority in rural areas where poverty is higher and basic health services particularly pressing—barely received any support from the Central Government until early 2017. There are, however, some bilateral donors and partners (such as European Union [EU], France, the United States, Japan, Germany, and NGOs) (table 2), who could eventually collaborate in supporting the health sector, so that the building of the national health platform is key. Table 2 will be updated with more details after the resource mapping is conducted within the Investment Case (Component 2 of the Health System Support and Strengthening Project [SENI]). The Investment Case is a strategic, operational, feasible, and costed plan which focuses on key priority interventions to reduce maternal and child mortality, with clear results and a detailed plan of action.

Table 2. Development Partners and Donors for CAR (general outline, July 2018)

Organization	
Multilateral Organizations	
EU	Expansion of the performance-based financing (PBF) project from 2 health districts to 13, supporting 344 health facilities (as of July 25, 2018) through the Bekou Trust Fund
French Cooperation	CAR is a priority country. Supports health professional training and health service delivery through the French Red Cross and the Global Fund to fight AIDS, tuberculosis, and malaria.
U.S. Government and USAID	CAR is not a priority country. Contribution of US$47 million (2017 estimate) to the health sector in CAR is only for humanitarian assistance through humanitarian NGOs. USAID supports only humanitarian NGOs. USAID's office is in Kinshasa, Democratic Republic of Congo.
Japan	The Japanese consulate for CAR is managed from Yaoundé, Cameroon. Funding may be channeled through the embassy itself. There would potentially be interest to support

	health for CAR, as the Japanese Government announced its new funding to the Global Financing Facility (GFF) in December 2017.
NGOs	
MSF	MSF has one of their largest operations in CAR with a total of €60 million (US$74 million+, 2017), and it is a key player in provision of free health care for all at the clinical level. Works mainly in humanitarian conflict areas. Showed interest in collaborating with the Government and has actively participated in the GFF in-country consultations in March 2018. The MSF group is composed of MSF in Belgium (coordinator of all MSFs), France, the Netherlands, Spain, and the United States, with over 270 international staff and 2,500 locally hired staff. The MSF group is interested in being involved in the Investment Case elaboration.
ICRC	Large operation and presence in humanitarian conflict zones. A total of US$40 million contribution in 2017. Plays a significant role in providing mental and medical care, food, water, and livelihood rehabilitation to internally displaced populations (IDPs) and population in need of humanitarian assistance. The ICRC also was actively involved in the GFF in-country consultation in March 2018.
UN Organizations	
WHO	The WHO in CAR works on health information system capacity building, disease surveillance, policies of HRH, health facilities infrastructural rehabilitation, and provision of pharmaceuticals.
UNICEF	Large focus on immunization, nutrition, gender-based violence (GBV), water, sanitation, and hygiene and has a strong logistics and supply chain system. Key driver for mass immunization, deworming, and vitamin A campaigns, which have reached more than 80 percent of the under-five population. Currently coordinating Multiple Indicator Cluster Survey (MICS) 2018–2019.
UNFPA	Family planning, GBV cluster lead in the UN-led GBV working group. Potential provider of post-exposure testing and treatment for GBV victims.
United Nations High Commissioner for Refugees	Works with IDPs and support to health care provisions for IDPs, which form 50 percent of the population
WFP	Has strong supply logistics capability, both in humanitarian and development health facilities in CAR
Joint United Nations Programme on HIV/AIDS	Anti-retroviral treatment for pregnant women and pediatric HIV treatment, treatment and counseling for GBV victims on HIV/AIDS

Note: HIV/AIDS = Human Immunodeficiency Virus - Acquired Immune Deficiency Syndrome; USAID = United States Agency for International Development; IDP = internally displaced population.

10. **Only limited health-related data and information are available and most databases are outdated and no longer relevant.** The latest Demographic Health Survey was conducted in 1994–1995 and the latest MICS in 2010 focused only on HIV/AIDS. A Health Management Information System (HMIS) does not exist. Hence, reproductive maternal and child health (MCH) and nutrition data derived from the health facilities are not routinely reported to the central level except for donor-chosen and -demanded data for verification. There is also no information regarding demand-side barriers that families face in accessing services, which makes it difficult to estimate the bottlenecks to solve. UNICEF is currently coordinating the MICS 2018–2019, to which the World Bank has contributed. The ongoing project, Health System Support Project, (HSSP) (P119815), however, is working with the GF and GAVI to harmonize data entry with relevant indicators, which could form the basis to harmonize the HMIS with various projects. However, data generation and management need to be consolidated and systematized. Establishing

robust data collection mechanisms using all the available stakeholder sources is an area that merits further consideration for supporting health system strengthening in the country.

11. **Most of the population cannot access essential health care services at the health facilities, especially in the communities where more deaths occur and where preventive health care services are needed most.** In such an extremely impoverished and fragile context as CAR, it is evident that a high number of maternal, infant, and child deaths occur outside the reach of the health facilities 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 and cost-effective MCH services to the maximum number of women and children to avoid more deaths. Sensitization and reminders for pregnant women and children to obtain their basic essential services will be conducted by community workers. Efforts will also be made for early identification of victims of GBV and to refer them to integrated health facilities where they can access free medical care, psychosocial assistance and, if possible, be engaged in income-generating empowerment and financial support activities. It is important to note that the community health workers will be the key link between the community and the health system, especially in mobilizing the community and raising awareness for women and children to obtain key essential health services, as well as delivering low-skill, preventive, high-impact, and cost-effective health services (such as vitamin A supplementation, deworming, and exclusive breastfeeding promotion), as well as identification of victims of GBV in the communities.

12. GBV in CAR has become more evident during the political and military crises that have devastated the country since December 2012, leading to an astronomical number of reported GBV victims, surpassing 11,110 incidents in one single year (2016) (box 1). Given this situation, the UN Security Council, UN agencies such as UNICEF, United Nations High Commissioner for Refugees, and UNFPA (the designated lead UN agency for GBV), the Office of the European Commission, and other donors and NGOs such as the International Rescue Committee and MSF have mobilized to rescue the Central African populations through multisectoral humanitarian actions through various projects, including providing holistic care for GBV survivors. CAR has ratified almost all international conventions, such as 'for the Equality and the Welfare of all', and has developed a national legislation on human rights and elaborated the 'National strategy to combat GBV in CAR 2018–2022'. However, all efforts up to the present day are not enough to protect the tens of thousands of girls and women from being victims of GBV.

Box 1. GBV by Armed Groups in CAR

During the five years of conflict since 2012, two opposing armed groups—the Muslim Séléka and the Christian anti-Balaka—have continued to commit sexual slavery and rape across the country, brutalizing women and girls, mostly of opposing religions. Just in 2014 alone, the UN recorded over 2,500 cases of sexual violence, but most cases go unreported.

A 2017 report from Human Rights Watch presented detailed cases of rape, sexual slavery, physical assault, and kidnapping of women and girls between the ages of 10 and 75 occurring in the capital, Bangui, and in and around the towns of Alindao, Bambari, Boda, Kaga-Bandoro, and Mbrès. The report finds that GBV is being used both by Séléka and anti-Balaka forces as weapons of war.

In most cases documented in the Human Rights Watch report, multiple perpetrators raped the women and girls—sometimes 10 men or more during a single incident. These women and girls are often tortured, resulting in injuries ranging from broken bones and smashed teeth to internal injuries and head trauma, and in some cases additional violence, including rape with a grenade and a broken bottle. They are often whipped, tied up for prolonged

periods, burned, and threatened with death.

The proposed project intends to design interventions to use community health workers to identify victims of GBV and refer them to the health facilities where they can receive free, comprehensive medical and psychosocial services. At the health facility level, the project aims to establish GBV-integrated district hospitals where GBV victims will be provided free health care treatment, including post-exposure testing, treatment, and counseling on HIV/AIDS and sexually transmitted infections (STIs), as well as fistula surgery. Where possible, income-generating activities will be considered to empower women to gain economic independence.

13. **Since 2016, the Government has slowly been able to initiate supporting the reinforcement of public health facilities** by recruiting back health workers and rehabilitating health facilities and supplying medical commodities, which has become more systematic with the introduction of PBF. With the return of some peace and stability in some areas, the national authorities are establishing public health systems by prioritizing reinstatement of all public health facilities and strengthening of national institutions. More investment is needed to overcome these unaddressed health systems constraints and some prioritization is needed to address the biggest binding constraints. There needs to be an analysis of the key priorities or a proposal of how these priorities could be determined. Bringing this perspective would help unify all partners toward supporting the Government in optimizing health service delivery.

World Bank's Engagement in the Health Sector and PBF

14. **The World Bank has been engaged in CAR's health sector for several decades.** Before the crisis (2014), a US$28.2 million HSSP, supported by the World Bank, was to be launched. Initial funding for the HSSP was a combined US$17 million IDA credit and grant (IDA-51340 and IDA-H7840), approved on May 17, 2012, and a US$11.2 million grant from the Health Results Innovation Trust Fund (TF13380) approved on July 31, 2012. But as the worsening security situation in 2014 obstructed the implementation of the HSSP, the Government requested that the HSSP reallocate US$15 million from IDA to support delivery of emergency health services. UNICEF, UNFPA, and WHO were contracted to deliver health services to communities affected by the crisis. As the security situation improved in 2015, an additional financing grant of US$12 million (IDA-D0610), approved May 22, 2015, was added in 2017 to support the HSSP to relaunch PBF activities that were almost completely halted during the crisis. Under the HSSP, the World Bank has supported the Government to implement the PBF, which currently covers 40 percent of the national population, is being implemented in five regions of the country, and is serving more than 1.8 million people.

15. **The PBF mechanism in CAR, which has shown promising results, enabled the Government to ignite the health system engine to get it up and running.** The PBF served as a key modality for financing the health system, as it enabled the operationalization of health facilities, including health centers, health posts, and district hospitals, with strong focus on structural improvements, improved clinical practice, health worker recruitment and motivation, and improved management capacity and governance. The PBF program is being implemented by the ongoing HSSP supported by the World Bank in five regions since January 2017 (health regions 2, 3, 4, 5, and 6). International NGOs such as Cordaid and AEDES-HDP-CSI were selected to assist the Government to implement the program. An external counter-verification agency is assessing the performance of the contracting and purchasing agencies. As of June 2018, contracts have been signed with 13 health districts, 13 district hospitals, and 359 health centers.

16. **The PBF program is flexible and adaptable to CAR's emergency situation**. The PBF program:

(a) Pays bonuses related to health services in health posts, health centers, and district hospitals for preventive care; MCH services; and treatment for malaria, HIV/AIDS, tuberculosis, and family planning;

(b) Offers temporary compensation to health facilities that exempt some or all of their patients from user fees in the event of a renewed crisis (box 2);

(c) Enables facilities to continue to serve their communities despite the financial strain imposed by a deteriorating security environment;

(d) Offers an incentive or 'equity bonus' to health care providers operating in remote regions or addressing the needs of underserved populations; and

(e) Focuses on a developmental approach even during the humanitarian crisis by strengthening facilities' autonomy and governance.

17. The MOH has recognized that the PBF program should be used to govern health system management at the district level in its current strategic plan.

Box 2. Unified Approach in Providing Free Health Care Services to Pregnant Women and Children Under Five Years in Addition to the Poorest and the Indigenous Population in CAR

The MOH's PBF strategy of public health facilities is designed to reach the poorest and the most vulnerable. In relatively secure zones, the PBF program is designed so that 20 percent of the underserved and poor population receive free health care services. The program has also developed a strategy to ensure that in the case of an upsurge of violence in certain parts of the country, the program can immediately finance fully subsidized health care and ensure that all beneficiaries receive services free of charge. The results are then verified in the following month and reimbursements are made. The PBF approach has proven to be effective (as shown in 2017) even when conflicts and fighting erupted in several parts of the country (in regions 3, 4, 5, and 6).

However, the lack of a unified free health care policy was causing issues at health facilities to identify the eligible population in a country where poverty is almost universal.

There are several approaches used in CAR by different partners to provide 'free health care':

- Blanket free health care for all
- Free health care for pregnant women and children
- 'Free health care' provision with in-kind support

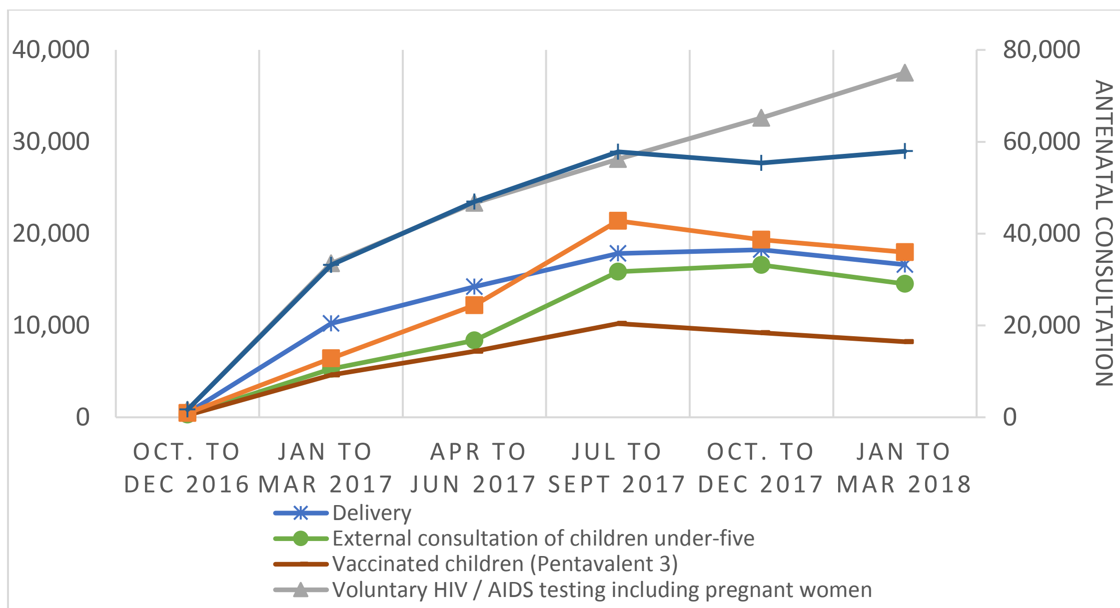
Blanket free health care PBF model in CAR has impediments because of the lack of domestic resources, which the Government cannot yet commit to allocating to health and to the lack of external aid and potential donor fatigue, which cannot guarantee the provision of universal free health care in the country. Even with targeted free health care, 80 percent of the nonpoor population would struggle to pay for health care costs among a population that lives on less than US$1.90 per day per capita.

In this new project, because of the increase in funding allotted to the health sector, SENI is able to support free health care for pregnant women and children under five years in all 15 health districts (totaling 392 health centers which includes 20 district hospitals), which totals approximately 44 percent of the population. As the EU with Bekou funds has recently joined the World Bank's efforts to adopt and expand the PBF to 13 health districts, both the World Bank's and EU's efforts combined would cover approximately 86 percent of CAR's total population. Further resource mapping will exemplify the total coverage of free health care for women and children when taking other large-scale NGOs' efforts, such as MSF and ICRC.

18. **The PBF is an integrated financial and service delivery model designed not only to incentivize health service delivery at the facility level but also strengthen governance and operational management at the central and district levels.** The availability of qualified staff, essential medicine, and medical commodities and equipment purchased from local pharmacies and retailers has increased in the project zone because of 'quality improvement bonuses' (*Bonus de l'Amelioration de la Qualité,* BAQs) provided to facilities through the PBF program. The program identified, tested, and scaled up innovative ways of using micro-credit and credit union networks and faith-based networks to ensure payments for verified results. The payments are deposited directly into the health facilities' bank accounts on a monthly basis. These PBF payments are one of the essential sources of revenue in a context where most service providers have little to no resources, either from the Government or users. In the first year of the program, the project has disbursed more than US$4 million directly to frontline providers based on their performance and results.

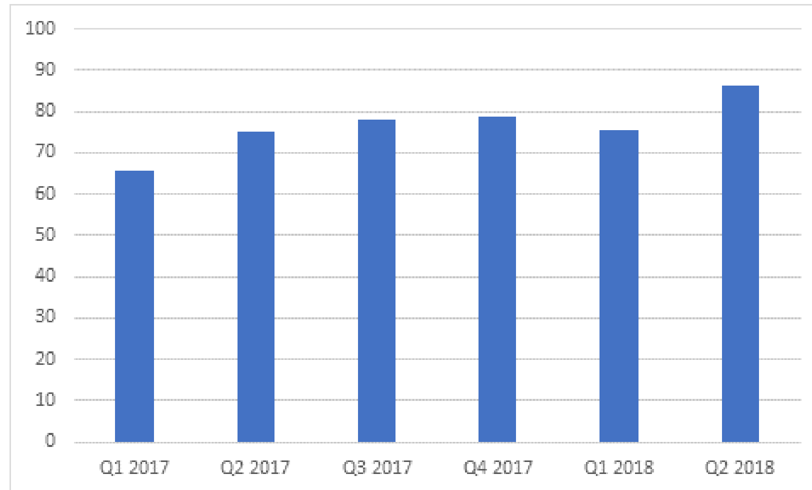
19. **Since the initiation of the PBF program in January 2017, incremental and positive results have been achieved by health facilities.** After one year of operation (January 2017 to December 2017), key essential health services, including MCH services have started to increase significantly, in addition to the quality of health services through proper use of health protocols and improved supervision (figures 1 and 2). Official data from health facilities provided by the purchasing and contracting agencies show a positive increase in the utilization of health services (see www.fbr-rca.com).

Figure 1. Progress on Key Health Services in PBF-Supported Countries



Source: PBF database

Figure 2. Evolution of Average Quality Scores[a] in PBF Districts (by quarter), March 2017–June 2018



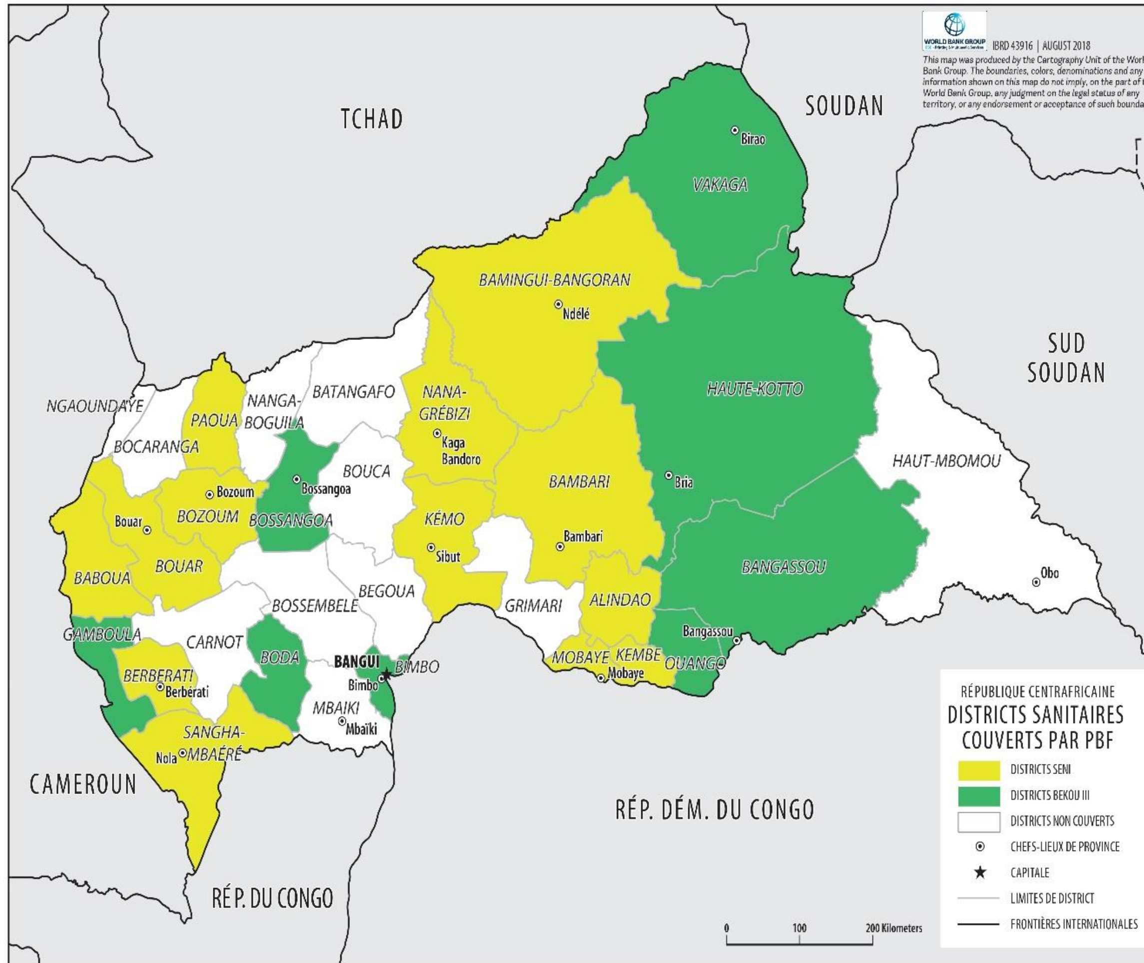
Note: a. Quality score is a composite indicator that takes into consideration the average quality scores of the following:

- Childbirth deliveries
- Antenatal care
- Availability of tracer drugs
- Hygiene and sterilization
- Laboratory
- Management committee
- Financial management (FM)
- Sick patient care
- Tuberculosis care
- Family planning
- Childhood immunization coverage
- Availability of health personnel
- General indicators
- Business plan

Source: PBF database

20. **The PBF will now go full scale because of the collaboration with the EU.** Because of the increase in funding allotted to the health sector, SENI is now able to provide free health care for pregnant women and children under five years in all 15 health districts (totaling 392 health centers which includes 20 district hospitals), which totals approximately 44 percent of the population (figure 3). The EU recently announced (in July 2018) its commitment to expand its program coverage to 13 health districts (from 2 districts in 2017), pursuing the PBF free health care model for pregnant women and children under five years. In addition, the NGO Cordaid is managing the PBF model in region 2 since 2009, with positive results. The MSF has also approached the World Bank to learn more about the PBF model, which would be a promising step in expanding the PBF model to extreme conflict zones where nonstate actors can take a lead role.

Figure 3. Health Districts Covered by the PBF Scheme in CAR



SENI Zones and Health facilities

N°	Health zones	Health districts	Total Health facilities
1	RS 2	Berbérati	24
2	RS 2	Sangha Mbaéré	18
3	RS 2	Baboua Abba	29
4	RS 2	Bouar Baoro	39
5	RS2	Carnot-Gadzi	23
6	RS 3	Paoua	30
7	RS 3	Bozoum Bossemptélé	25
8	RS 4	Bambari	45
9	RS 4	Kémo	39
10	RS4	Kouango-Grimari	24
11	RS 4	Nana Gribizi	28
12	RS 5	Bamingui Bangoran	22
13	RS 6	Alindao Mingala	14
14	RS 6	Kembé Satéma	13
15	RS 6	Mobaye Zangba	19
	Total	**15**	**392**

Source: PBF database

21. **Because of its visibility and demonstrated positive impact on utilization and quality of care, the Government has now opted to use the PBF strategy for its core strategic template to strengthen CAR's health system.** Because of the PBF, health centers in the project regions now visibly exist and function, whereas they were once destroyed and abandoned without any medical supplies. These PBF-supported facilities are now forming a base where health professionals can now work, are paid, and are further incentivized for their performance in serving the community, thus positively addressing the health workforce. It is important to now build on this impetus and at the same time reach out to the families and communities who cannot access these facilities.

22. **Transitioning from an emergency to recovery for the health sector is one of the key government propositions in 'CAR's Interim Plan for the Health Sector (2018–2019)'.** This can be achieved by aligning development and humanitarian health-focused actors to pursue a common goal of reducing maternal and child mortality. As the PBF proposes a facility -based health financing strategy, this could be a model that the humanitarian actors can adapt to their current operations. The recent national health consultation that was orchestrated by the World Bank, building on the GFF[1] principles and partnership building, brought together, for the first time, the humanitarian and development nexus. This is tremendous progress from a crisis approach marked by the virtual absence of a national health platform.

23. **The PBF model will serve as the base of the MOH's policy of prioritization to address health system constraints with more focus on community health systems** which needs further strengthening to rapidly reduce maternal and child mortality in the country. Prioritization of action for maternal and child mortality reduction would be a prudent approach given CAR's multiple contextual constraints to overcome the unaddressed health system bottlenecks and consolidate gains obtained from the PBF scheme.

24. **GFF introduction in CAR has been a transformational platform for the health sector, as it has created a space and motive for the MOH to take a lead role in coordinating key actors working in the health sector.** CAR has been selected to be a recipient of support from the GFF, which was established to close the financing gap for reproductive, maternal, neonatal, child, adolescent health and nutrition (RMNCAH-N) efforts—not solely to generate additional funding but to allocate these resources efficiently. 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 convening technical and financial support provided by the World Bank, was inaugurated by the Prime Minister and attended by the President of the General Assembly (Parliament). 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.

25. **A value proposition of the GFF is better alignment among financers (donors) of the health sector, through the national health platform and development of the MCH and nutrition Investment Case**. The Investment Case will focus on MCH and nutrition as the Government has emphasized reduction

[1] The GFF is a multistakeholder partnership that is helping countries tackle the greatest health and nutrition issues affecting women, children, and adolescents. The GFF brings governments and partners together in a country-led plan, prioritizing high-impact but underinvested areas of health. The GFF Trust Fund acts as a catalyst for financing, with countries using modest GFF Trust Fund grants to significantly increase their domestic resources alongside the World Bank's IDA and IBRD financing, aligned external financing, and private sector resources.

in maternal and under-five mortality as its key priority. As the Government is just starting to identify key partners who could collaborate in supporting the buildup of the various health system components, the challenge now is to strengthen and expand the Government-led PBF program with a strong link to community-based health service provision to address maternal and child mortality reduction on a wide and rapid scale.

26. **Revamping the health sector coordination and effective partnerships for building the health system is crucial.** Building on and further strengthening the positive experiences with PBF, the Investment Case will also build on the various health system building blocks and focus on (a) strengthening governance and coordination of the health sector, (b) strengthening HRH at the central and district levels, (c) building up the pharmaceutical supply chain, (d) consolidating information data management, and (e) strengthening the PBF's link to the community outreach for health services. It is important to note that coordination of the health sector itself is relatively new in CAR. 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. Furthermore, a multisectoral approach is vital to improve MCH and nutrition results in CAR.

27. **This project (SENI) aims to revamp such health sector coordination by working in health system rebuilding.** The current PBF project is a fixed-site service delivery project that provided the foundation to operationalize the health system through strengthening the health centers, health posts, and district hospitals with focus on structural improvements, improved quality and quantity of clinical practice, health worker motivation, and improved management capacity and governance. The proposed project, SENI, aims to consolidate the gains of the ongoing PBF program and further create the critical link between facility-based and community-based health service delivery to a coordinated provision of basic MCH and nutrition service delivery packages with the aim of rapidly reducing maternal and child mortality. Additionally, as strengthening service provision can only improve CAR's health sector so far, SENI also incorporates health system strengthening activities in human resources, governance, information systems, and pharmaceuticals. The Investment Case that this project proposes to elaborate, along with the multiple partnerships that are being formed, will serve as a vehicle to improve the mobilization of domestic and external resources and increase efficiency, which is crucially needed in a country with such a high level of fragmentation.

C. Relevance to Higher Level Objectives

28. **The proposed project aims to increase the utilization and quality of health services with a particular focus on MCH and nutrition.** In addition to increasing utilization and quality of essential health services, the project also aims to reduce out-of-pocket expenditures in health, thereby reducing catastrophic health expenditures in the extrememly poor context. In doing so, the project contributes to Sustainable Development Goal (SDG) 3.8 which aims to reach UHC by 2030. The project also directly contributes to the attainment of SDG targets 3.1 of reduction of maternal mortality, SDG 3.2 to end preventable deaths of children under five years, and SDG 2 to reduce malnutrition.

29. **The interventions supported by the proposed project are also consistent with Pillar 2 of the 2017–2021 Recovery and Peacebuilding Plan of the Central African Republic (RCPCA), the National Health Sector Interim Plan (2018–2019), and the SCD 2018**. The CAR's SCD identifies opportunities for achieving the twin goals of ending poverty and improving shared prosperity by 2030 and emphasizes the

critical need to strengthen human capital through enhanced health, education, and social protection systems. The SCD argues that pragmatic approaches to service delivery need to be embraced, from PBF to simple project designs, implementation by nonstate actors, and a focus on urban areas. Moreover, Pillar 2 of the RCPCA stresses the importance of redeploying the administration throughout the territory and establishing inclusive local governance and providing basic services, particularly education, health, and water to the population throughout the country, by gradually transferring capacities and resources to subnational structures.

30. **Client interest and commitment in this proposed project is high.** The Government of CAR has decided to invest significantly in the PBF program because of the positive results that are emerging and the complete understanding of the relatively recently appointed Minister of Health (September 2017) of the benefits and need of the collaborative efforts in elaborating and implementing the action plan derived from the Investment Case. Through ongoing policy dialogue, the MOH has come to appreciate the merits of the PBF, especially its ability of a more efficient, equitable, and better-quality health care provision, and is willing to consolidate the PBF gains to further build its health system capacity by using the GFF-supported principles to reinforce key high-impact interventions. This highlights the Government's strong motivation in co-financing the project with US$1 million despite the current critical economic challenges in the country.

II. PROJECT DESCRIPTION

A. Project Development Objective

31. The Project Development Objective (PDO) is to increase utilization and improve the quality of essential health services in targeted areas in the territory of the Recipient.

32. In the midst of a dysfunctional and fragmented health system because of conflict, the project is putting in place, with the Government, elements to improve its capacity to have oversight and stewardship for service delivery and strategic purchasing. The project thus aims to consolidate PBF service delivery and build further on its health system capacity, guided by the GFF-supported principles of partnerships and prioritization to reinforce the delivery of key interventions for maternal and child mortality reduction.

33. SENI will cover the same regions (2, 3, 4, 5, and 6) but will increase the coverage to two additional districts, totaling 392 health centers in 15 health districts and 20 districts hospitals. It will provide free health care to pregnant women and children under five years. The project will also focus on supporting victims of GBV holistically through medical, psychosocial, and socioeconomic assistance through integrated health service delivery in selected district facilities, in addition to other activities to be identified.

34. **Component 1** provides critical MCH interventions through facility-based PBF (including verification and counter-verification) and extends free health care to pregnant women and children under five years through a performance-based payment system and community outreach. The component further provides PBF technical assistance to secondary and tertiary facilities to introduce performance frameworks in improving the performance of regulatory agencies in health.

35. **Component 2** seeks to improve the institutional capacity in health sector management and coordination to strengthen the health system. This will be done by supporting the activation and consolidation of the national health platform to elaborate and implement the Investment Case, which is to be elaborated with multiple partners and donors. The Investment Case is a strategic, operational, feasible, and costed plan which focuses on key priority interventions to reduce maternal and child mortality, with clear results and a detailed plan of action. Key priority will be given to strengthening the pharmaceutical supply system and the NHIS. More details of the various health system strengthening strategies will be defined after the finalization of the Investment Case where the Government and its development partners will work together to tackle key health system bottlenecks.

36. **Component 2** will also support free integrated health and psychosocial services for women and girls who are victims of GBV. Victims of GBV will be identified and referred to integrated health facilities where they will obtain integrated support, including free medical services at district hospitals and psychosocial and socioeconomic livelihoods support. Community sensitization efforts will take place locally as well as nationally and income-generating activities will be considered to empower women to be able to manage their lives.

37. **Component 3** will support emergencies and catastrophes under the Contingent Emergency Response Component (CERC).

Component 1: Improving the quality and utilization of essential health services at facility and community levels through performance-based financing (PBF) (US$36 million, of which US$1 million from the Government, US$28 million from IDA (SDR 20 million), and US$7 million from the GFF)

Subcomponent 1.1: Performance-based Financing and Delivery of Free Health Care

38. **Component 1 will consolidate the scope of the existing PBF-supported facilities and expand community outreach in the PBF-supported health facilities' catchment areas.** With regard to coverage, the project will consolidate and reinforce the current PBF-supported facilities and will expand to two more health districts and expand community outreach to the respective health facilities' catchment areas. The PBF-supported facilities will cover 15 health districts, 20 district hospitals, and 372 health centers in Health regions 2, 3, 4, 5, and 6. The MOH-managed PBF will be strengthened and reinforced to reach the communities of the health facilities catchment areas. The PBF scheme will focus on both preventive and curative MCH care, along with treatment for HIV/AIDS, tuberculosis, and family planning. The national PBF manual will be revised with contribution from other partners to define the specific services contracting at each level of service provisions, that is, health facilities, community, and hospitals.

39. **The PBF provides incentives to health facilities who perform well in providing the quantity of services and 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 emphasizes providing very small investment funds to health facilities to finance improvements in health service quality. Therefore, Component 1 will also focus on providing BAQs to health facilities in crisis and hard-to-reach areas that have been destroyed because of conflict. The PBF strategy serves as a principal means to incentivize providers to improve the quality of care at the health facilities level.

40. **The project will support fee exemptions for pregnant women and children under five years and marginalized and poor households.** In relatively secure zones, health facilities will be reimbursed through PBF payments to cover the full cost of services provided to pregnant women (including postnatal care, emergency obstetric care, and caesarian sections) and children under five years. In case of upsurge in violence in a certain part of the country, the program can immediately finance fully subsidized health care (beyond pregnant women and children under five years) and ensure that all beneficiaries receive services free of charge.

41. **The PBF model will be shared with other development partners and international humanitarian NGOs who have a large presence in CAR.** Under the Investment Case elaboration, enhanced payment for inputs into the PBF by partners through efforts of health system strengthening will be determined according to their area of interest, technical expertise, and financial viability. Payment of performance-based outputs is already foreseen by the EU, where they have pledged to expand the PBF under the free health care for pregnant women and children under-five scheme. Large-scale humanitarian NGOs (such as MSF, ICRC) will also be involved in the Investment Case consultative process described in Component 2. The advantage of working with large-scale NGOs is that they have a functional presence in areas where the Government-funded projects have difficulties in monitoring and accessing because of conflict and violence. Other partners could facilitate pharmaceutical supply access to the government-funded sites permitting agreements and logistics or enhance health information management. In this context, the World Bank, through SENI, will support the MOH to establish clear national criteria of identifying the poor and their vulnerability.

42. **In addition to reinforcing the current PBF-supported sites, Component 1 also links 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 the project will attempt to link them to the PBF-supported sites. For instance, community workers (*relais communautaires*) can be incentivized for community-based delivery of preventive child health services (such as childhood immunization, vitamin A, and deworming) through community mobilization with door-to-door outreach to promote routine health service delivery and periodic health service delivery campaigns. Another community outreach health service delivery mechanism could be that health facility staff travel to communities to take preventive health services to communities on a periodic [2]basis, which requires additional transportation mechanisms (motorcycles, motorized tuk-tuks, bicycles, and so on) to access the hard-to-reach communities and transport pregnant women with emergency obstetric care needs to the closest health facility.

43. **Parallel investment in health system building, especially focusing on routine delivery of essential interventions especially vaccination, is fundamental.** In countries where access to health services is problematic and the health system is weak as in CAR, a nationwide campaign outreach

[2] - Doherty T, Chopra M, Tomlinson M, Oliphant N, Nsibande D, Mason J. Moving from vertical to integrated child health programmes: experiences from a multi-country assessment of the Child Health Days approach in Africa. *Tropical medicine & international health: TM & IH* 2010.
- Wallace AS, Ryman TK, Dietz V. Experiences integrating delivery of maternal and child health services with childhood immunization programs: systematic review update. *The Journal of infectious diseases* 2012; 205 Suppl 1: S6-19.

approach has proved to be an essential health service delivery strategy to reach as many children as possible in a relatively short period (Doherty, et al, 2010; Wallace et al, 2012). For many population groups in conflict and in difficult areas of access, campaigns can represent their only contact with the health system and an opportunity to receive trusted health services (box 3). However, campaigns need to be implemented in parallel with routine service delivery of key child health interventions, and they are not meant to replace them.

44. **The link of the health facilities and the community outreach and community service delivery aspect will be enforced by incorporating it within the PBF framework of paying performance fees to community workers as an extension of the local health facilities.** The health facilities will be accountable for the performance of the community workers who go into the communities to obtain defined positive health behavioral outputs from community members. These particular actions to mobilize the community and deliver community-based services will be more clearly defined and determined within the Investment Case discussion and elaboration mentioned in Component 2. It is critical, however, to ensure that careful cost calculation is conducted before launching the strategy project wide, as the costs would increase substantially when community workers are included into the payment of each health facility within the PBF scheme.

Box 3. Periodic Integrated Campaign Outreach Approaches for CAR

As a key strategy of linking the community to health services, campaign outreach is a rapid way to deliver high-impact, cost-effective child mortality-reducing health services, especially to children under five years. Preventive health services, especially key vaccines, vitamin A, and deworming, can be either delivered through routine immunization mechanism. In countries where health systems are weak and especially in conflict zones, periodic campaign mechanisms are often used to ensure the delivery of the vaccine in the most efficient way.

Measles vaccination campaigns are planned to be conducted nationwide in CAR in late 2018, targeting children under five years. During the measles campaign, vitamin A and deworming tablets are also distributed to maximize and 'piggyback' on the distribution mechanism, which attempts to reach the entire country. The first dose of measles vaccine should be given to children at the age of nine months or shortly after and the second dose between ages 4 and 6, ideally through routine immunization services. However, where routine immunization performances are poor such as in CAR, campaigns are conducted to rapidly reach those who were not vaccinated and prevent deadly disease outbreaks. It is now relatively common to deliver additional child health interventions along with the measles vaccine through campaigns. Campaign coverages are usually not considered as routine immunization figures.

Mass polio campaign. Two drops of the oral polio vaccine, a month apart, are given by community workers with minimal training, as needles and syringes are not required to provide the vaccine. Vitamin A and deworming are also provided by the community workers when conducting the campaigns.

Vitamin A supplementation nationwide campaigns to reach children ages six months to five years, which are usually conducted twice a year, six months apart. In CAR, a nationwide campaign has been conducted in early 2018. These nationwide campaign coverage figures are not yet incorporated within routine supplementation figures in the global WHO/UNICEF database for vitamin A supplementation for CAR (UNICEF SOWC 2017)[3].

45. **This component will also incentivize regulatory entities (in charge of pharmaceuticals, health information systems, community health services, inspection, and so on), with the aim of improving efficiency, transparency, and quality regulation at higher levels.** The PBF grants will be introduced at the

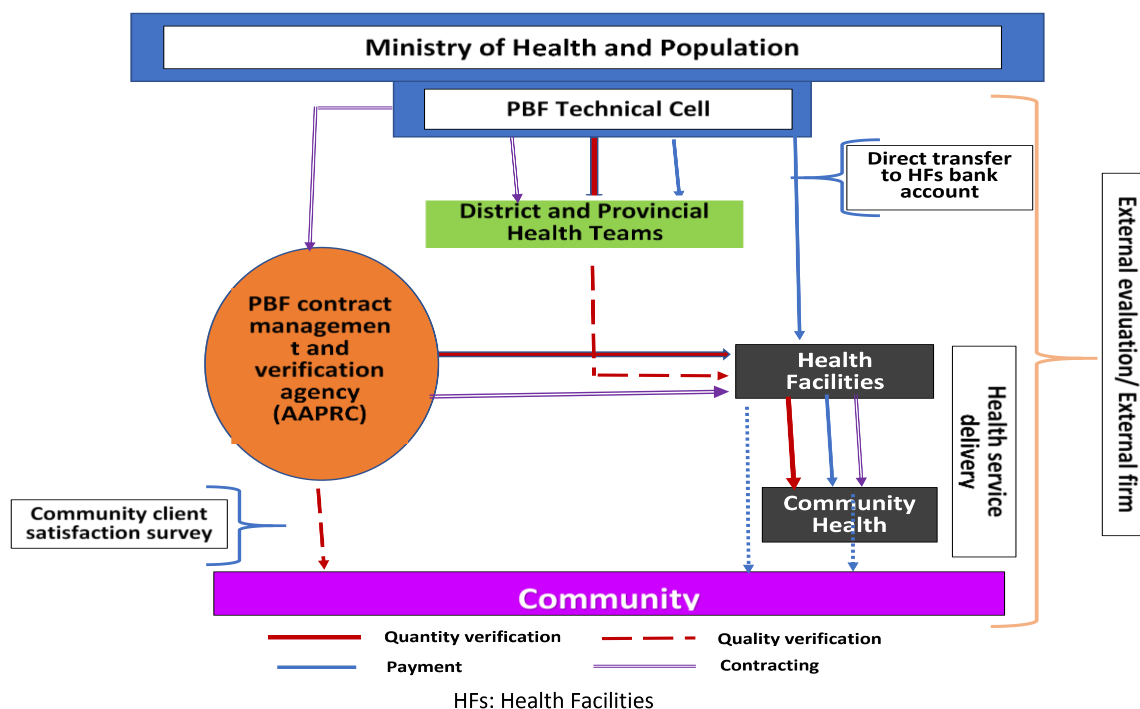
[3] UNICEF, The State of the World Children 2017. New York, 2017.

MOH directorates level with fixed budget lines and these grants will pay for performance in standard output and quality performance indicators. The PBF manual will be adjusted accordingly.

Subcomponent 1.2: PBF verification and technical assistance

46. **This subcomponent will strengthen the purchasing mechanisms that are already tested in CAR and are in place in approximately 40 percent of the country through PBF and free health care for pregnant women and children under five years.** Under the strategic purchasing approach (figure 4), public health facilities are contracted to purchasing agencies who are paid by the PBF program to deliver a predefined package of essential health services that follow national guidelines and standards. On a monthly basis, health facilities submit declared performance to the PBF contract management and verification agencies. The purchasing agencies that 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.

Figure 3. PBF Institutional Arrangements



HFs: Health Facilities

47. **Counter-verification is conducted by the national PBF unit and by the independent verification agency.** To ensure community participation and community outreach, SENI will continue to use the community monitoring and community client satisfaction feedback mechanism where community surveys are conducted every quarter. Because of the high cost of an external verification agency, an alternative strategy will be explored to build local capacity and decrease the program's administrative costs related to the PBF contract management and verification functions by using local entities for independent verifications. Local organizations will be selected and hired through a local contracting process. For strategic purchasing, the Project Procurement Strategy for Development (PPSD) was conducted in the

preparation of this new project and reassessed the capacity of local NGOs which was compared with the national market, to meet the management and verification needs of the project.

48. **In addition to supporting primary and secondary health care services, the component will expand PBF technical assistance to tertiary hospitals, without any allocation of additional funding.** The objective of supporting tertiary hospitals with PBF-technical assistance is to ensure more value for money of existing government budget lines and cost recovery revenues. At the tertiary level, the project will support the application of quarterly business plans and the index management tool to improve the transparency of FM as defined in the Government PBF manual.

Component 2: Reinforcing the capacity of the recipient's health system and addressing gender-based violence (US$18 million, of which US$15 million from IDA (SDR 10.7 million) and US$3 million from the GFF)

Subcomponent 2.1: Health system strengthening

49. **Subcomponent 2.1 will support enhancing the Government's capacity to strengthen the health system.** This will be done by the creation and consolidation of a national health platform, which will set a stage for the MOH to take a leading role in coordinating the various health-related partners. A health financing strategy will be supported under the Investment Case, with clear and defined roles of each of the partners. Strengthening the Government's capacity to coordinate, define, and develop appropriate health system policies will provide space for strengthening their leadership and help it harness the uncoordinated development partners and NGOs and possibly effectively harvest their resources into the country for health. The health system strengthening efforts provide an opportunity for the Government to realign its policies and bring partners on board to support its national health agenda.

50. **An Investment Case, an operational and feasible costed plan which focuses on key priority interventions to reduce maternal and child mortality, will be elaborated by the MOH and partners, where the partners will work in components considering their comparative advantage, technical expertise, and interest**. Priority interventions to reduce maternal and child mortality 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 and that the building of the health system structure will help the health facilities already supported by the PBF program in 44 percent of the country. There would be a common guidance note (for monitoring and evaluation [M&E], basic package of services for maternal and child mortality reduction, HRH, and so on) to be used by all partners working in the country.

51. **Subcomponent 2.1 will support the national health platform and the core steering group composed of key UN partners, specialized organizations, key NGOs, and donors to share ideas and learn from each other about providing and delivering similar services but in different modes and in different geographic contexts.** To understand who and where these partners work, resource and geographical mapping of all key agencies and donors in CAR's health sector will be conducted as a part of developing the Investment Case. This resource mapping will enable the MOH to oversee all the activities managed by development partners both in developmental and humanitarian areas. Engaging international humanitarian actors working in conflict zones will be fundamental to secure the expansion of the coverage of health and nutrition service delivery where MCH care services are most needed and where the Government may have difficulties accessing because of ongoing conflicts.

52. **Subcomponent 2.1 will support the MOH's institutional capacity at national, regional, and district levels to address critical constraints in coordination of the health sector and strengthen the health system.** It will support analytical work, bringing in technical expertise and policy dialogue to the Government to facilitate the development and implementational support for key interventions that address system bottlenecks for achieving more efficient use of health sector resources and improved health outcomes, especially for reaching maternal and child mortality reduction and building synergy within the humanitarian and development nexus. The identification of the health system bottlenecks and reforms to be supported by the project will be guided by the Investment Case, which is a strategic operational investment plan which takes key priorities from the National Health Sector Interim Plan (2018–2019) with a link to a national health financing strategy. Subcomponent 2.1 will provide support to the MOH and its partners to address the following:

(a) **Define a basic package of essential health services** to reduce maternal child health and malnutrition, which is the most important factor that will drive all other components of the health system strengthening. If an essential package is known and costed, it will be clear how much financing is needed to scale this up, which partners need to be brought in for sustainable financing, whether free services are feasible and sustainable, where and which type of human resources need to be produced, which supplies will be needed, and what to monitor.

(b) **Conduct resource and geographical mapping** of health actors, which will enable the Government to bring in key development and humanitarian partners to join in the national health system strengthening efforts.

(c) **Prepare a community health strategy**, including community outreach to ensure that women and children obtain essential preventive services, community-integrated management of childhood illnesses, and early detection of victims of GBV.

(d) **Prepare a periodic MCH campaign** strategy, especially to deliver key childhood vaccinations, vitamin A, and deworming tablets for children under five years at a massive scale both at the facility and community level through community mobilization.

(e) **Define a national health financing strategy** to identify financial gaps and resources that are available and necessary to achieve the maternal-child mortality reduction goals.

(f) **Support the implementation of national HRH strategy,** especially to ensure that adequate HRH are trained, financed, and allocated to health facilities that require them. Not only will the PBF recruit health staff back into the system—as PBF will create jobs for the health professionals in each PBF-supported health facility—the Investment Case will be a good opportunity to prioritize and consider what could be supported for HRH for the overall health system as a function of the MOH.

(g) **Improve pharmaceutical supply chain,** especially with an essential package of key pharmaceutical and medical items defined in the basic package of essential services (noted above in [a]). As a key priority for the MOH, the pharmaceutical supply chain will be coordinated with the partners to supply basic preventive medical supplies to the PBF-supported health facilities.

(h) **Improve availability of household survey data and begin the consolidation of the HMIS,** including improving the capacity of conducting nationwide household surveys along with other partners especially in the fragility, conflict, and violence (FCV) context. The project aims to have a functional HMIS by using the existing PBF cloud-based database built under the Demographic Health Information System 2 (DHIS2), in coordination with partners, namely GF, the WHO, and GAVI, to systematize the collection, data inputs, reporting, and analysis. The project also aims to continually support nationwide household surveys conducted by partners when applicable.

53. **This subcomponent will also support crisis preparedness** to prevent disease outbreaks whenever appropriate**.**

Subcomponent 2.2: Addressing gender-based violence (GBV)

54. SENI will allocate approximately 20 percent of the project allocation (US$10 million) to provide care for women affected by GBV. GBV-related activities supported by the project include establishment of integrated centers for free medical care for victims of GBV, psychosocial and socioeconomic support, safety and protection services, and awareness raising and communication at all levels. More definitive activities will be defined upon a national gathering of GBV focus group, led by the MOH, in collaboration with the Ministry of Promotion of Women, Family, and Childhood, along with the UNFPA as GBV-cluster lead, various UN agencies, and international NGOs. Sub-contracting to NGOs and obtaining GBV-related medical kits from UNFPA might be considered.

55. The GBV subcomponent will include the following:

(a) Establishment of five integrated centers for the medical care of victims of GBV, including clinical management of rape, such as morning-after pill, pregnancy testing, testing and treatment of STIs and HIV/AIDS, and tetanus toxoid vaccinations. The five health facilities (mainly district hospitals) will be located in

(i) University hospital of Bambari (UNFPA focus hospital);

(ii) Alindao district hospital;

(iii) Nola district hospital;

(iv) Kaga-Bandoro district hospital; and

(v) A health center where the largest indigenous population is concentrated (Region 2).

(b) Free medical and administrative support, involving free medical consultation fees, medical examinations, hospitalization, and surgery (such as for fistula and emergency obstetric care)

(c) Psychosocial support

(d) Socioeconomic support, involving income-generating activities

(e) Safety and protection services such as provision of safe places and temporary refuge for victims

(f) Awareness and communication activities on GBV at all levels

(g) Raising awareness on GBV for adolescents.

Subcomponent 2.3: Project implementation support

56. **Subcomponent 2.3 will finance operating costs.** SENI will also support the coordination of the project and operating costs. The PBF technical unit that will coordinate the project will receive financial and technical support, including appropriate staffing to increase capacities in free health care coupled with PBF, community health approach, and GBV and to ensure compliance with World Bank Group fiduciary requirements. This sub-component will support the project implementation through the financing of Operating Costs, Training, and equipment; paying salaries of international and national consultants; audits and communications, as well as the implementation and monitoring of Safeguards Instruments.

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

57. **In addition, a CERC will be included** for projects in Situations of Urgent Need of Assistance or Capacity Constraints. The CERC will allow for rapid reallocation of project proceeds in the event of a natural or artificial disaster or crisis that has caused, or is likely to imminently cause, a major adverse economic and/or social impact. The objective of this component is to improve the Government's response capacity in the event of an emergency, following the procedures governed by the World Bank IPF Policy, section III, paragraphs 12 and 13 (Projects in Situations of Urgent Need of Assistance or Capacity Constraints).

58. There is a moderate to high probability that during the life of the project, CAR will experience an epidemic or outbreaks of public health importance or other health emergency with the potential to cause a major adverse economic and/or social impact, which would result in a request to the World Bank to support mitigation, response, and recovery in the region(s) affected by such an emergency. In anticipation of such an event, the CERC allows CAR to request the World Bank to support mitigation, response, and recovery in the district(s) affected by such an epidemic. Following the procedures governed by World Bank IPF Policy section III, paragraphs 12 and 13 (Projects in Situations of Urgent Need of Assistance or Capacity Constraints), a CERC Operations Manual will be prepared as a condition of disbursement. Triggers will be clearly outlined in the CERC Operations Manual acceptable to the World Bank. Disbursements will be made against an approved list of goods, works, and services required to support crisis mitigation, response, and recovery. All expenditures under this activity will be in accordance with paragraph 12 of the World Bank IPF Policy and will be appraised, reviewed, and found to be acceptable to the World Bank before any disbursement is made.

B. Project Beneficiaries

59. **The main beneficiaries of the program will be the women and children of CAR**, including women and girls who have suffered from GBV. In addition, the project will support the establishment of the health system by building the health system blocks through partnerships where the World Bank will play a key

role in supporting the MOH in coordinating the health sector and supporting the Investment Case of the GFF process. The project will reinforce the PBF-supported facilities in 44 percent of the country where the PBF-supported facilities exist. Specific direct beneficiaries of the project are hence women, children under five years and the most vulnerable, and victims of GBV.

60. **To reach the poorest and the most vulnerable, the PBF strategy is designed to provide free health care to pregnant women and children under five years.** The PBF scheme has also incorporated a financing strategy to provide free health care to the most vulnerable population in semi-conflict zones, and all beneficiaries in any emergent conflict zones will have access to free health care in SENI facilities.

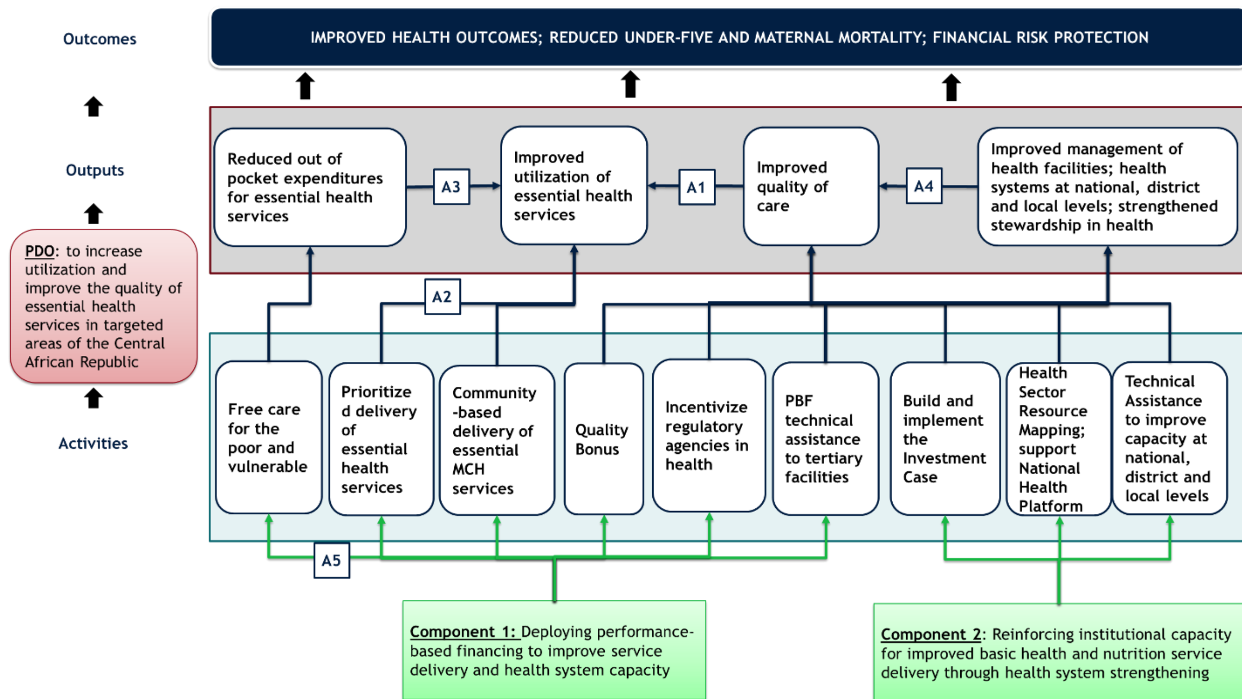
61. **Focus will also be given to victims of GBV**, as efforts will be made for early identification and support to victims of GBV and their families. Fees will be waived for any services relating to GBV.

62. **Additional beneficiaries.** From an institutional perspective, health personnel, notably nurses and community health workers, will benefit from recruitment back into the health system, as well as from training in health facility management, important community health system, and integrated delivery of health services. MOH regulatory entities and local NGOs are additional beneficiaries. Because the project also addresses the institutional capacity development for strengthening the national health system, the secondary beneficiaries are the entire population.

C. Results Chain

63. **SENI's components will jointly have a positive impact on the health system performance.** Through its support to the PBF program in tandem with free health care, SENI will contribute to improving health status for the population of CAR and building its human capital by (a) increasing health care utilization, (b) improving the quality of delivered health services, (c) enhancing financial access to these services, (d) promoting equity, and (e) increasing health system efficiencies.

Figure 4. SENI Results Chain



Note: **Critical Assumptions:**
A1: Poor quality of care is a critical bottleneck for improving utilization.
A2: Mitigating supply-side issues will improve utilization of health services.
A3: Reducing cost of health services will improve utilization.
A4: Poor management is a barrier to improving quality of care in public facilities.
A5: There is a demand for health services among the vulnerable and the poor, with costs of care being a major barrier in accessing care.

D. Rationale for Bank Involvement and Role of Partners

64. **This would be the first time that the Ministry of Health plays such an important and pivotal role in unifying the health sector actors.** The World Bank has an important role in supporting the MOH, in coordinating the various development and humanitarian actors. The UN agencies will work in the various health system components considering the agencies' comparative advantage, technical expertise, interest, and potential resource mobilization.

65. **Additionally, the World Bank is playing a convening role in reaching out to all the partners in the health sector to support donor coordination.** The World Bank is in a strategic position of being able to provide technical and financial support in conducting the Investment Case, with the support from the GFF secretariat. The World Bank's comparative advantage is also its knowledge of health financing which other partners may not possess and where the World Bank can play a pivotal role in supporting the MOH in domestic and external resource mobilization and pursuing the health financing agenda.

66. **Over the past decade, the World Bank has successfully assisted many developing countries, including CAR, to develop and implement the PBF and free health care programs**. The World Bank's evaluation (Development Economic Vice Presidency, December 2016) showed that when PBF is combined

with prepayment mechanisms promoting the demand side (asSENI is proposing), it has a better impact on the health system (as evidenced in Argentina, Burundi, and Rwanda) than stand-alone PBF programs.

67. **In addition to the Government and SENI, international partners will support PBF activities and will take part in strengthening the health system depending on their technical expertise and comparative advantages**. Along with the Government participation in the payment of PBF bonuses to health facilities, other international partners such as the EU and Cordaid are already implementing PBF health programs. Other partners—including WHO, UNICEF, UNFPA, WFP, GAVI, and GF—play a huge role in providing their technical and financial support to the health system strengthening endeavor.

E. Lessons Learned and Reflected in the Project Design

68. **The design of SENI takes into consideration lessons learned from the implementation of projects such as HSSP** and experiences of other countries implementing similar projects including all coordination efforts with the Government and international partners. The following are the lessons learned and constraints to the operationalization of the World Bank-funded PBF operations in CAR.

69. **Verification and monitoring of results across large number of facilities and then providing timely payments have been challenging.** In the extreme FCV context of CAR, project supervision could be a challenge, especially in high conflict zones. So additional security measures are not available to health workers and project coordinators. Paying facilities in remote districts on time is also a major challenge. Health project managers have reached out to the FCV and technology group to see possibilities of mobile banking, e-health, more efficient means to deliver pharmaceuticals, geo-enabling distance monitoring technology as a type of third-party monitoring, and barcode scanning on MCH cards to be used in FCV contexts where Internet and electricity are not available outside of the capital city.

70. **The lack of a unified free health care policy and a lack of clear criteria of the poor and a harmonized approach to identify them was causing issues at health facilities to identify the eligible population, in a country where poverty is almost universal.** Universal free health care was not possible. The PBF-supported health facilities have started with 20 percent of population (identified as poor) receiving free care in stable zones, and all beneficiaries in conflict zones receive free care. The classifications of ‘poor’ were conducted more on personal impressions by the community health workers than by a predetermined national protocol. But with the increased IDA funding allocated as of July 2018, the project is now able to provide free health care to pregnant women and children under five years.

71. **Extra funding, concrete positive results, and collaboration with other partners enable the project to scale up.** It was impossible to scale up beyond the 40 percent coverage of the country with the PBF because of lack of resources. However, as extra IDA grant was allocated to the project in July 2018, the project will be able to reinforce the PBF-managed facilities and include the expansion to community health services. It was important to leverage other partners such as the EU to get them further involved in consolidating the PBF and to support the MOH in strengthening the health system.

72. **The PBF lacked the link to community health services/community outreach.** The PBF focuses on operationalizing the clinical aspects of health facilities, including district hospitals, health centers, and health posts, with an initial focus on structural improvements, improved clinical practice, health worker motivation, and improved management capacity and governance. However, to reach the ultimate goal of reducing maternal and child mortality nationwide, the project needs to spread out its coverage and focus

more on reaching out to communities and even deliver essential maternal and health care preventive services at the community level where most of the maternal and child deaths occur. The key would be to prioritize interventions at the community and periphery levels where primary health care is most needed and where the most marginalized people are and to explore community-based service delivery or promote key maternal and child survival family practices. This will be done by creating incentives for health facility managers and health workers to expand the coverage of essential public health interventions and improve their quality by linking facility payments to service delivery and by offering bonuses, that are linked to facility performance, to health workers who would be responsible for overseeing coverage of essential MCH mortality prevention services in their health catchment area.

73. **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. Essential drugs are paid out of pocket by households as the health facilities cannot fully subsidize the high costs. The project will support the Government to identify alternative mechanisms to ensure the supply of basic and selected essential drugs to the health facilities and maximize the presence of UN agencies and large-scale NGOs to support immediate pharmaceutical supplies to the health facilities, especially in conflict and remote health zones.

74. **One of the strengths of SENI would be citizen involvement.** Local civil society organizations are already involved in the program and communities are informed through information campaigns as to what services to expect from health facilities. Some key examples of citizen involvement are the following:

- The PBF program organizes an annual meeting with all stakeholders, including heath care providers, district and regional directors, development partners, NGOs, and local authorities.
- Communities are also involved in assessing the quality of the health services provided and will play a larger role in ensuring that community members are aware of the preventive services and health care available to them to prevent mortality.
- In the national health platform, civil society representatives and the private sector have also been convened from the initial stage of the partnership collaboration, which will formulate a national Investment Case to reduce and prevent maternal and child deaths.
- National health consultation on the progress and elaboration of the Investment Case will be held at least twice a year. This consultation process will serve as a core health network to share and discuss a variety of implementation plans and potential conflicts that may arise as they proceed onto the implementation of the Investment Case.
- The effect of conflict and violence will affect women and girls prone to GBV in these settings in the hope that the representation by the Ministry of Women's affairs could represent their voice at all levels of project planning, implementation, and monitoring.

75. **As effective leveraging of investments from other development partners can enhance results,** greater efforts will be made to ensure partnerships among the Government, key UN and specialized agencies, bilateral donors, humanitarian NGOs, civil society, and the private sector through the elaboration and rollout of the Investment Case, which forms a large part of SENI. Coordination among the Government and development partners is essential both for the design and implementation of SENI. As

part of the development of the Investment Case, effective leveraging of funds and investments from other development partners can increase the scope of interventions and enhance achievements.

III. IMPLEMENTATION ARRANGEMENTS

A. Institutional and Implementation Arrangements

76. **SENI will build on the successful implementation experience of HSSP**, where implementation performance has been rated Satisfactory despite a challenging context. The MOH will be the main line ministry for implementation of the project. In coordination with 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 (community health post, district health facilities, and 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.

77. **The MOH has previously established a PBF National Technical Unit (NTU) 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.

78. **The NTU's performance is satisfactory and its staff are extremely responsive in communication and action.** The NTU will still be provided close technical support from the World Bank and from external partners throughout the implementation of the project.

79. **Under the proposed operation, the Project Implementation Unit (PIU) of the current project (HSSP) will be merged into the NTU which will be in charge of the coordination of the project**. Given that the NTU and the PIU currently work as one team albeit, being two unique entities, all staff from the current PIU will be transferred to the NTU to reinforce the fiduciary expertise and experience of the unit while reducing operations cost at the same time. The NTU will be tasked with overseeing both coordination of the overall PBF program as well as specific project implementation. It will be the de facto PIU for SENI. As such, the fiduciary requirements of the NTU will increase substantially as all responsibilities from the HSSP PIU will be transferred to the NTU. Because of the higher volume of funds and activities supported by SENI, the NTU needs to be further strengthened to be able to fully manage and implement the project. The following additional human resources will be recruited in addition to the existing team to strengthen its capacity to perform: one accountant, one procurement specialist, and one internal auditor (they will be housed with the existing fiduciary team).

80. **SENI will continue to support the MOH in building local expertise.** Similar to HSSP, SENI will continue to make available some local experts to the ministry in the areas of FM/accounting, procurement, M&E, environmental and social safeguards, and information technology (IT)/online databases and will coordinate with key partners in-country and globally. Moreover, a gender/GBV specialist will be recruited and housed in the Family Health General Directorate.

81. **Under the PBF program implementation,** nine 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) Care is 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 will focus on the quality of health facilities services and the performance of all entities involved in the PBF program and will ensure that the health facilities are paid according to their performance. It will be undertaken once every quarter by an independent external body and 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) Community representation will be ensured through health committees involved in facilities management as well as the abovementioned local organizations used in verification and in users' satisfaction surveys.

(h) Support to health training institutions will be provided.

(i) The Paris declaration on aid effectiveness, ownership, alignment, harmonization, and mutual responsibilities will be applied.

82. **All PBF modalities that SENI is financing will be included in an updated version of the PBF manual.** The NTU has the responsibility to produce and update the PBF manual, which is the most important tool for the PBF program. This unit is also in charge of preparing the PBF annual technical and financial reports. Finally, the NTU will improve the PBF database to include the new components of the program pertaining to the community health workers, regulatory bodies/public health programs, and NHIS/DHIS2.

83. **The existing National Health Steering Committee, chaired by the 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 a national health platform to monitor and oversee the rollout of the country's Investment Case. A core team and health system component working groups will be identified upon the rollout of the development of the Investment Case.

B. Results Monitoring and Evaluation Arrangements

84. **The Results Framework focuses on both PDO and intermediate outcomes.** The project intends to use existing indicators and data through the ongoing PBF program and those obtained from key partners to measure project progress and its contribution to the overall national program. For effectiveness and to strengthen existing data collection mechanisms, data from all programs will be migrated into DHIS2. Monthly and quarterly data collected from DHIS2 will be aggregated as annual project indicators to strengthen the national system and avoid creating a parallel system.

85. **The project monitoring system will include**

(a) Identification and consolidation of M&E indicators;

(b) Training and capacity-building initiatives at national, regional, district, and hospital levels, as appropriate;

(c) Harmonization of methods and tools to facilitate the collection, consolidation, and sharing of information with other partners;

(d) Independent reviews conducted by external technical consultants; and

(e) Annual program evaluations and strategic planning exercises for each component.

86. **Regular technical reporting.** Every semester, the MOH will submit a technical report on the implementation status and results.

C. Sustainability

87. **Sustainability is a difficult issue to address through a single project in the immediate future for CAR, given the fragile and conflict context of the country.** It is vital that the World Bank first and foremost focuses on leveraging other partners' financial and technical resources to strengthen various components of the health system using the PBF as the base. The success of this project's effort will be in (a) supporting the Government to coordinate the fragmented allocation of developmental and humanitarian resources that is currently going into health, (b) focusing toward a unified and agreed upon goal to reduce maternal and child mortality through prioritizing the delivery of key essential interventions, and (c) strengthening HRH. Sustainability, in CAR's case, comes in the form of converting the fragmented financial and technical support into substantial and unified investments in health, which will hopefully contribute to improving CAR's stability.

88. **The national PBF program (including free health care for pregnant women and children under five years) has been adopted by the MOH as the most appropriate strategy to steer and improve the performance of the health system.** The Government will create a new MOH budget line for FY2019, dedicated exclusively to the PBF program. This initiative demonstrates the Government's commitment in relation to the PBF program and its sustainability. Moreover, owing to the Minister of Health's advocacy, many development partners have expressed an interest in using the PBF-supported facilities as a base for their upcoming operations (EU, GF to fight AIDS, tuberculosis, and malaria), which will lead to a more robust national health system.

89. **The preparation of a PBF cost containment strategy will form a part of the PBF manual.** This strategy aims to reduce unit costs related to overheads expenditure. It will be based on HSSP experience and successful experiences in neighboring countries to where study tours will be supported. The cost containment strategy will help the MOH not only to optimize the utilization of project resources but also to scale up the PBF program with a reasonable cost.

90. **The technical and institutional reforms supported by the project will ensure sustainability of a strengthened health system.** The project will provide technical strengthening support to the MOH, community health workers, and NGOs. The technical support will be made not only through training activities and the international and national technical assistance included in the project but also through an additional technical assistance financed outside the project as a parallel and complementary activity (GFF funding).

IV. PROJECT APPRAISAL SUMMARY

A. Technical, Economic, and Financial Analysis

Technical and Economic Analysis

91. **SENI will contribute to CAR's development** by (a) improving health service utilization, quality, and outcomes; (b) reducing out-of-pocket expenditures for health; (c) introducing pro-poor bonuses and service fee exemption, which will promote equity and shared prosperity; (d) improving labor force productivity; (e) increasing efficiencies in health systems; and (f) building human capital and maintaining political stability.

92. **The technical design of the project draws from the best practices in improving health outcomes, service delivery, quality of care, and health systems management in fragile context.** The project builds on an existing PBF project in the country (HSSP) and targets both demand-side and supply-side barriers in health. SENI mitigates supply-side barriers by financing health services accounting for an estimated 71 percent of the disease burden in the country[4] on an output or performance basis. PBF of these essential health services rather than input-based financing sends a clear signal to frontline health care workers about the critical nature of these select services, thereby improving supply and increasing health system efficiencies. In addition to incentivizing increases in utilization of high-impact services, the quality bonus in the PBF tariff also incentivizes improvements in quality of care.

93. **The community outreach services introduced in the PBF program under this project will supply health care in communities directly and generate additional demand for basic health services, considering low facility-based service utilization in the country.**[5] Community- or primary health center (PHC)-based provision of care increases the allocative efficiency of resources for health as the capital and

[4] Global Burden of Disease Study 2016. "Global Burden of Disease Study 2016 Results." Seattle, United States: Institute for Health Metrics and Evaluation, https://http://vizhub.healthdata.org/gbd-compare/.

[5] A recent study finds that while scaling up the critical reproductive, maternal, child, and nutrition services, interventions through PHCs and community outreach have the highest impact. Care provided through PHCs and community activities could reduce 77 percent of the maternal, newborn, and child deaths and stillbirths.

recurring expenditures at the community or PHC levels are low, but the proximity to households allows for better provision of comprehensive and integrated care.

94. **The project is pro-poor.** SENI introduces fee exemptions for poor, marginalized households and people living in extremely fragile zones, and pregnant women and children under five years, which will reduce demand-side barriers to health service utilization by the poor by reducing out-of-pocket expenditures. The project further increases supply of critical health services for the poor and the marginalized by offering equity bonus to providers who operate in remote areas or provide care to underserved populations.

95. **The project strengthens health systems management.** CAR's health system is heavily dependent on service provision by non-state actors. Lack of coordination among non-state actors and the Government and lack of capacity in national priority setting and implementation are key management-related issues resulting in inefficient and ineffective health system.[6] The project's investments in institutional capacity and coordination will significantly improve resource efficiency and overall coordination of the health sector. Additionally, the CERC enables rapid reallocation of project funds to quickly ameliorate the impact of any natural or man-made disasters.

96. **The project engages non-state actors.** Despite some recent recovery, there are areas in the country where the Government services are not yet available.[7] In such areas, the project will engage non-state local and international actors with a substantial presence to enhance service delivery. In addition, the project will support the identification of temporary alternative sources or actors who can improve the currently dilapidated pharmaceutical supply chain and service delivery logistics and engage them to ensure high-quality service provision to the project beneficiaries.

97. **PBF pays for highly cost-effective interventions as SENI aims to increase utilization and quality of high-impact health services that target majority of disease burden in the country.** The interventions financed by the PBF program are highly cost-effective, based on exhaustive evidence from low- and middle-income countries (table 3).[8] Both the minimum and complementary package of activities (MPA/CPA) in the PBF program, including the quality enhancement bonus are highly cost-effective, with a median cost-benefit ratio of US$150 per disability-adjusted life year (DALY) averted, which is well below the GDP per capita of the country.[9] In addition, community-based delivery of MCH services introduced in this project is also estimated to be highly cost-effective, at the cost-effectiveness ratio of US$12–126 per DALY averted—anything under US$350 per DALY averted is considered highly cost-effective in CAR. Lack of recent household surveys prevent pro forma economic analysis of this project, which shall be revisited.

Table 3. Cost-effectiveness of Services Included in the PBF program

Intervention	Cost-effectiveness (US$/DALY averted)
Health service provision in facilities (MPA/CPA)	
Prevention of mother-to-child transmission	65–251

[6] In addition to lack of financial resources and insecurity.
[7] At the national level, 27.5 percent of facilities have been partially or completely destroyed with a wide disparity from 6.5 percent in the Health Region # 2 to 46.1 percent in the Health Region # 3.
[8] Horton, S., H. Gelband, D. Jamison, C. Levin, R. Nugent, and D. Watkins. 2017. "Ranking 93 Health Interventions for Low- and Middle-Income Countries by Cost-Effectiveness." *PloS One* 12 (8): e0182951.
[9] Interventions with cost-effectiveness ratios that are below the GDP per capita of the country are considered very/highly cost-effective; those with ratios below three times the GDP per capita of the country are considered cost-effective.

Intervention	Cost-effectiveness (US$/DALY averted)
HIV treatment: anti-retroviral therapy to all <350, or all infected	188–256
Treatment smear positive tuberculosis with first-line drugs	6–49
Comprehensive nutrition package for women and children	353
Access to modern contraceptives	150–300
Management of obstructed labor	77
Package of antenatal and postnatal care	150–1,000
Intrapartum care	200–500
Caesarean section	200–4,000
IPTp, pregnant women	4–591
Under-five illnesses	
Treatment of pneumonia	282
Treatment of malaria	18–34
Treatment of diarrhea	
Zinc	10–50
Oral rehydration salt	153
Rotavirus vaccine	100
Vaccinations[a]	103
Preventive chemotherapy for schistosomiasis and STHs	114
IPTp, infants	4–422
Micronutrient intervention for infants[b]	20–100
Community outreach	
Community-based neonatal and maternal care	13–126
Community management of severe-acute malnutrition	25–40
Community-based treatment of malaria	93
Quality of care	
Quality improvement protocol for newborns in facilities	305

Source: Horton, S., H. Gelband, D. Jamison, C. Levin, R. Nugent, and D. Watkins. 2017. “Ranking 93 Health Interventions for Low- and Middle-Income Countries by Cost-Effectiveness.” *PloS One* 12 (8): e0182951.
Note: IPTp = Intermittent preventive treatment in pregnancy; STH = Soil-transmitted helminthiasis.
a. EPI-6 plus HepB, also for pneumococcus and rotavirus.
b. Vitamin A, Iron, Vitamin B12.

98. **PBF will also improve the allocative efficiency of health spending.** Bangui traditionally receives far more resources than any other region, and the distribution of public health spending is not pro-poor. According to the second national health development plan for 2006–2015, while Bangui is home to just 17 percent of CAR’s population, it receives more than half of total public health spending.

99. **Public sector engagement in this project** is justified because of various positive and negative externalities and spillovers in health. Improving access to quality health services and health systems would not only improve health outcomes but would also ensure inclusive growth, human capital development and maintain political stability in the country.

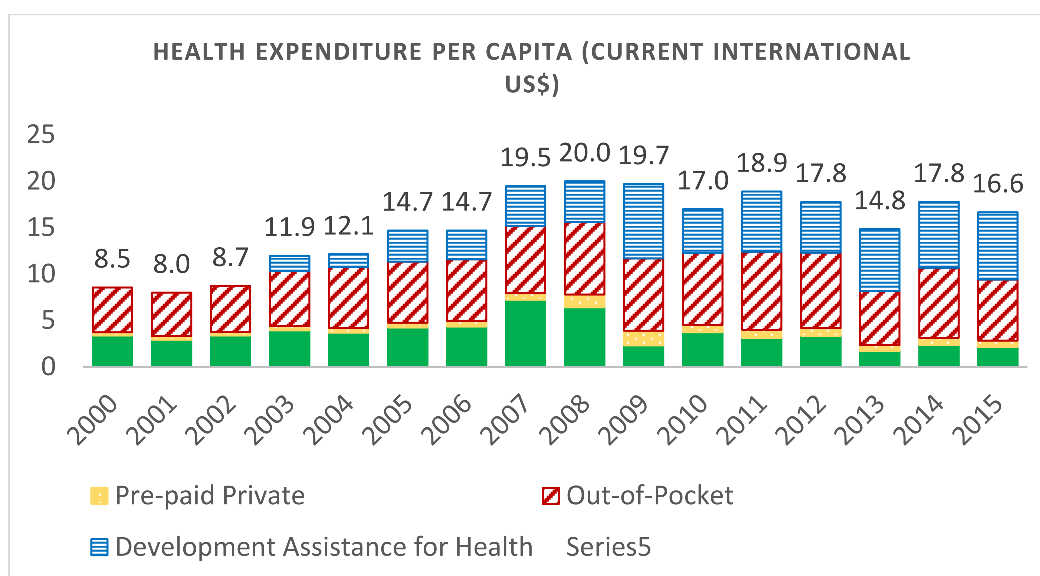
100. **Value added of the World Bank support.** The World Bank has extensive experience and knowledge of strengthening health systems across the continent, with substantial experience designing and implementing PBF in CAR and globally. Moreover, the World Bank can play a convening role in supporting the establishment of the national health platform and designing and implementing the RMNCAH-N Investment Case in addition to providing financial support.

Financial Analysis

101. **CAR is experiencing some degree of macroeconomic stability after a period of severe violence and unrest.** After a steep decline of 38 percent in 2013, real GDP has increased steadily, with an increase of 4.5 percent in 2016. Furthermore, the International Monetary Fund estimates GDP growth of about 5.5 percent between 2017 and 2021 in CAR. With the support of development partners, the country has introduced a National Plan for Recovery and Peacebuilding with estimated costs of US$3.2 billion between 2017 and 2021.

102. **The amount of international support for CAR, even with recent increases, needs to be higher than the current levels.** The country received a total of US$500 million in official development assistance (ODA) in 2016. Despite being the third poorest country in the world, the ODA per capita CAR received in 2016 (US$109 per capita) ranks at 32 among all countries that received ODA in 2016.[10]

Figure 5. Trends in Health Expenditures in CAR



Source: WHO Global Health Expenditure database (apps.who.int/nha/database).

103. **Health expenditure in CAR is much lower than in low-income countries or Sub-Saharan Africa.** In 2015, the total health expenditure in CAR was about US$16.6 per capita (current international US$), and health expenditure as a percentage of GDP was 4.8 percent.[11] As a comparison, low-income countries spent an average of US$35 per capita, or about 6 percent of their GDP, on health; Sub-Saharan African countries spent US$85 per capita, or 5.4 percent of their GDP, on health. Moreover, the major sources of health financing in CAR are development assistance for health, followed by out-of-pocket expenditures and Government spending. According to the WHO Health Expenditure database, 44 percent of all health

[10] Development Assistance Committee of the Organisation for Economic Co-operation and Development, Geographical Distribution of Financial Flows to Developing Countries, Development Co-operation Report, and International Development Statistics database.
[11] 2015 data. WHO Global Health Expenditure database (apps.who.int/nha/database).

expenditures were development assistance for health, 40 percent out-of-pocket spending, and 13 percent government spending. See figure 6 for additional details on trends in health expenditures in the country.

104. **Financial sustainability.** The project investments account for a substantial proportion of Government spending in health. In 2015, the Government spent an estimated US$9.6 million in health[12]—this project aims to invest US$21 million in three years, which would be about 42 percent of the increased Government health spending each year. As the 2017–2021 National Recovery and Peacebuilding Plan suggests, sustained support from international donors is critical in ensuring that CAR moves on an upward trajectory in social and economic development. The composition of such support is equally critical, with technical assistance and budget support to improve fiscal management, governance, and reform institutions for sustained progress. Even with the projected increases in economic growth, it is unlikely that CAR can completely finance basic health services for all its citizens in the short and medium term. Additional support from development partners is vital in ensuring continued progress in service utilization and quality in the short term, with studies that explore mechanisms to generate domestic resource mobilization for health[13] in the medium term.

B. Fiduciary

Financial Management

105. **An FM assessment of the PIU of the ongoing HSSP, which will be merged into the NTU to manage SENI, was carried out in May 2018.** The objective of the assessment was to determine whether this PIU has acceptable FM arrangements in place to ensure that the project funds will be used only for intended purposes, with due attention to considerations of economy and efficiency. The assessment complied with the World Bank Directive Financial Management Manual for World Investment Project Financing operation effective March 1, 2010, and as last revised on February 10, 2017.

106. **The NTU under the MOH will have the overall fiduciary responsibility of the project.** The FM arrangements for this new project will be based on the current HSSP. The overall performance of the ongoing project in FM is Satisfactory. Staffing has remained adequate and proper books of accounts and supporting documents have been kept with respect to all expenditures. The audit for the year ending on December 31, 2016, was submitted on time and was unqualified. The unaudited interim financial reports (IFRs) for the ongoing project are also submitted on time and acceptable to IDA.

107. **The overall FM risk is rated Substantial.** It is considered that the FM satisfies the World Bank's minimum requirements under OP/BP 10.00 and therefore is adequate to provide, with reasonable assurance, accurate and timely FM information on the status of the project required by the World Bank, as noted in Table 4.

Table 4. FM Action Plan

	Action	Responsible Party	Deadline and Conditionality
1	Update implementation manual including fiduciary procedures taking account new project	NTU	Before effectiveness

[12] In current US$, 2015 data. WHO Global Health Expenditure database (apps.who.int/nha/database).
[13] Critical that inclusive macro fiscal reforms precede domestic resource mobilization.

	Action	Responsible Party	Deadline and Conditionality
	arrangements, activities, and components		
2	Customize accounting software	NTU	Six months after effectiveness
3	Recruit internal auditor familiar with the World Bank FM procedures	NTU	Six months after effectiveness
4	Recruit an external auditor	NTU	Six months after effectiveness

108. **Internal control system.** The internal control system will comprise a Steering Committee to oversee the project activities and an FM procedures manual to define control activities. The composition, mandate, and frequency of meetings of the Steering Committee will be strengthened to ensure adequate oversight of the project. An internal auditor will be recruited and will carry out ex post reviews to evaluate the performance of the overall internal control system. The internal auditor will furnish a copy of the internal audit report to IDA, no later than 45 days following the end of each quarter, which will summarize the key findings of the reviews completed during the quarter.

109. **Planning and budgeting.** The NTU will prepare a detailed annual work plan and a budget, which should be approved by the Project Steering Committee. The NTU will submit the approved annual work plan and budget to the World Bank, for 'no objection', no later than November 30 each year.

110. **Accounting.** The assigned accounting system in West African Francophone countries (SYSCOHADA) will be applied. The NTU will customize the existing accounting software (TOMPRO) to meet project requirements.

111. **IFRs.** IFRs will be prepared every quarter and submitted to the World Bank regularly (45 days after the end of each quarter) on time. The frequency of IFR preparation as well as its format and content will remain unchanged.

112. **Annual financial reporting.** The NTU will produce project annual financial statements, which will comply with SYSCOHADA and World Bank requirements.

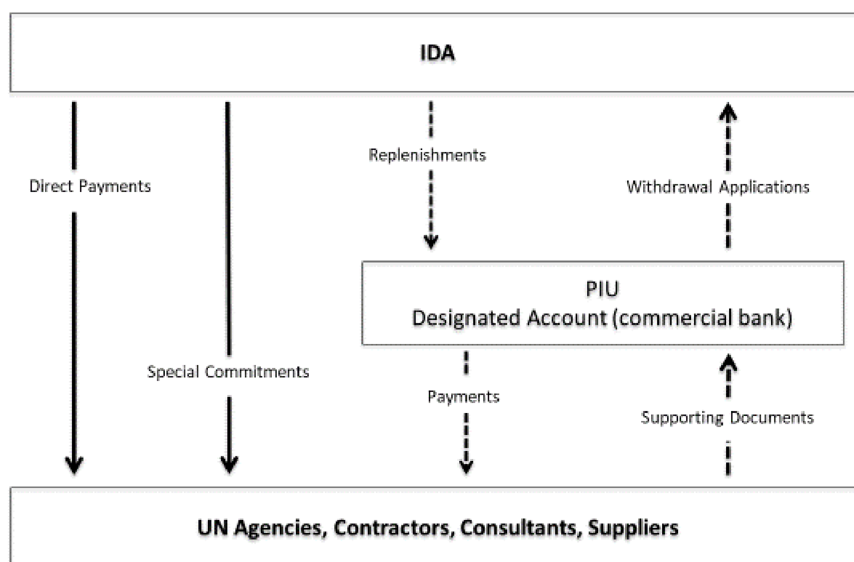
113. **Auditing.** The NTU will submit audited project financial statements satisfactory to the World Bank every year within six months after the end of the fiscal year. A single opinion on the audited project's financial statements in compliance with the International Federation of Accountants will be required. In addition, a Management Letter will be required. The Management Letter will contain auditor observations and comments and recommendations for improvements in accounting records, systems, controls, and compliance with financial covenants in the Financial Agreement. The NTU should recruit a technically competent and independent auditor by six months after the project effective date.

114. **The project will comply with the World Bank disclosure policy of audit reports** and place the information provided on the official website within one month of the report being accepted as final by the team.

115. **Disbursement.** Upon grant effectiveness, transaction-based disbursements will be used. A new Designated Account (DA) will be opened in a commercial bank under terms and conditions acceptable to

IDA. An initial advance up to the ceiling of the DA will be made and subsequent disbursements will be made against submission of Statements of Expenditures reporting on the use of the initial/previous advance. Other methods of disbursing funds (reimbursement, direct payment, and special commitment) will also be available to the project. The minimum value of applications for these methods is 20 percent of the DA ceiling. The project will sign and submit Withdrawal Applications electronically using the eSignatures module accessible from the World Bank's Client Connection website.

Figure 6. Funds Flow Chart



116. **Use of UN agencies.** The funds transferred to any UN agency will be managed by the agency, following UN Financial Regulations and Rules. As a result, the project will rely on the UN agency's external auditor's reports as necessary. The request for elimination of audit requirements was prepared and was granted during project preparation. To mitigate any risks of inappropriate use of the project funds, some alternative mechanisms should be established, including the following:

(a) At least one field-based visit being conducted during the first 12 months of the project implementation period. The supervision intensity will be adjusted over time considering the project's FM performance and FM risk level.

(b) The Government has the entire responsibility of ensuring that works, goods, and services are delivered effectively to the intended beneficiaries during project implementation. However, where deemed appropriate (for example, UN agency systems and IFRs have showed some weaknesses or deficiencies), the World Bank team may request the Government to establish adequate arrangements to conduct some physical inspections of

goods and services delivered by the UN agency; it is the responsibility of the government to follow up with the UN agency to obtain the financial reports and ensure that it is acceptable before transmitting the reports to the World Bank.

(c) The World Bank FM team will have adequate access to the financial information, documents, and records for activities implemented by the UN agency.

117. **Implementation Support Plan.** FM supervisions will be conducted over the project's lifetime. The project will be supervised on a risk-based approach. Based on the current risk assessment which is Substantial, at least two supervision missions per year are envisaged. The supervision intensity will be adjusted over time considering the project FM performance and FM risk level.

Procurement

118. **Applicable procurement rules and procedures.** Procurement for the proposed project will be carried out in accordance with the World Bank Procurement Regulations for IPF Borrowers (Procurement Regulations), dated July 2016, revised in November 2017 and August 2018; the provisions stipulated in the Financing Agreement; and the World Bank's Anti-Corruption Guidelines: Guidelines on Preventing and Combating Fraud and Corruption in Projects Financed by IBRD Loans and IDA Credits and Grants (revised as of July 1, 2016). The proposed procurement arrangements for the project meet the World Bank's minimum requirements for procurement under Policy/Directive: Investment Project Financing. All goods and non-consulting services will be procured in accordance with the requirements set forth or referred to in the Section VI. Approved Selection Methods: Goods, Works, and Non-Consulting Services of the 'Procurement Regulations', and the consulting services will be procured in accordance with the requirements, selection methods agreed in the Project Procurement Strategy for Development (PPSD), and the Procurement Plan approved by the World Bank.

119. **Procurement in Situations of Urgent Need of Assistance or Capacity Constraints.** In Situations of Urgent need of Assistance or Capacity Constraints described under paragraph 12 of the World Bank IPF Policy, the World Bank may accept the use of borrower's national procurement arrangement in accordance with the relevant provisions of the Procurement Regulations.

120. **National procurement arrangement.** In accordance with paragraph 5.3 of the Procurement Regulations, when approaching the national market (as specified in the Procurement Plan tables in STEP[14]), the country's own procurement procedures may be used. When the beneficiary uses its own national open competitive procurement arrangements as set forth in Public Procurement Code, such arrangements shall be subject to paragraph 5.4 of the Procurement Regulations and the following conditions:

(a) The procurement is open to eligible firms from any country.

(b) The request for bids/request for proposals document shall require that bidders/proposers submitting bids/proposals present a signed acceptance at the time of bidding, to be incorporated in any resulting contracts, confirming application of, and compliance with, the World Bank's Anti-Corruption Guidelines, including without limitation the World Bank's right

[14] STEP = World Bank's Systematic Tracking and Exchanges in Procurement.

to sanction and the World Bank's inspection and audit rights.

(c) Maintenance of records of the procurement process. When other national procurement arrangements besides the national open competitive procurement arrangements are applied by the beneficiary, such arrangements shall be subject to paragraph 5.5 of the Procurement Regulations.

121. **Procurement capacity assessment.** A preliminary procurement assessment was carried out in March 2018 to evaluate the adequacy of procurement arrangements under the proposed project. It appears that the MOH through its NTU and the existing PIU of HSSP has gained sufficient procurement experience in World Bank procurement, in the use of the World Bank's guidelines, procedures, and procurement documents while currently managing an existing PBF World Bank program. Based on the assessment of their capacity, both units are well established and staffed for conducting all procurement activities for the proposed project. For better integration and coordination, the fiduciary unit (PIU) will be merged with the NTU and collocated under the overall supervision of the MOH mainly the Cabinet Director. For any specific reinforcement, short-term procurement specialists may be appointed to support the technical unit at the ministry level in the preparation of terms of references, specifications, among other tasks when required. As the procurement framework regulation and STEP are new, PIU procurement staff will receive intensive training in the new procurement framework and STEP for ensuring that procurement and or activity packages have been efficiently delivered in the attainment of the PDO.

122. **Procurement implementation arrangements.** The NTU will be responsible for the coordination and implementation of the proposed project. The existing project implementation teams will integrate the NTU and be placed under the Cabinet Director at the MOH level. They have developed the skills and experience needed in managing World Bank projects for carrying out procurement related to the proposed project, in accordance with the World Bank approved procedures. There will be small procurement activities at the decentralized level. Each health facility may use part of its subsidies to improve quality of service by procuring small items within a threshold table defined in the PBF manual. Any beneficiary of PBF resources should procure small goods, works, and services in accordance with provision of Project Implementation Manual (PIM) procurement section and will be responsible for compliance with procurement procedures. All other procurement of significant, complex, and pooled nature across beneficiaries will be under the direct responsibility of the NTU.

123. **Procurement risks analysis.** Procurement main risks are inherent to the following: (a) high-risk and weak control environment; (b) CAR's ability to manage public resources undermined by volatile, instable, and sensitive environment; (c) delays in implementation because of the overall context conditions in CAR; and (d) delays in implementation from service provider's side and time/cost overruns. Based on the assessment of the implementing agency and the procurement environment in CAR, the overall procurement risk is rated High.

124. **Procurement risk mitigation measures.** The following mitigation measures have been proposed:

(a) At the fiduciary level, contract management will be the responsibility of the integrated NTU at the MOH level. It shall ensure that the PBF contracts under the project are effectively and efficiently managed; this will include contracting independent verification agency to check

health services delivery and performance for bonus payment in time and /or overall PIU oversight.

(b) The PIU shall be required to make provisions for the NTU technical specialists' support to provide technical assistance, for example, when required by the MOH directorates, drafting the terms of references for selection of consultants, technical specifications for goods, in particular, specialized goods, IT equipment specifications, and software, with prior approval from the MOH.

(c) It is also recommended that the NTU takes the lead in the MOH institutional strengthening and capacity building to bridge the gap in developing policy related to the health management sector.

125. **PIM.** The project policies and procedures will be incorporated in an implementation manual and the PBF manual based on practical experience developed from in-the-field implementation. The PIM defines the project's internal organization and its implementation procedures and will include, among other things:

(a) The administrative and financial manual that defines procedures for procurement, FM, and disbursement operational guidelines;

(b) Procurement from the PBF proceeds for each beneficiary of the PBF to procure goods, works, and services in accordance with provisions of administrative procedures described in the project; and,

(c) The internal organization for supervision, control, monitoring and safeguards procedures..

126. **Frequency of procurement supervision.** In addition to the prior review to be carried out by the World Bank, supervision missions will be undertaken at least once per year. One in five procurement packages not subject to World Bank prior review will be examined ex post on an annual basis.

127. **PPSD summary.** A Project Procurement Strategy for Development was prepared for the proposed project. Assessment related to PBF market situation in the Health sector, CAR operational context in which procurement activities is undertaken, previous experience of the MOH-PIU in implementing large WB-Investing Project Financing was carried out and major risk factors present. The objective is to improve the procurement efficiency. The supply positioning was mapped the high risk and value contracts and taking in consideration the market research and analysis conducted, appropriate selection methods and market approach were explained and defined for the implementation of the proposed project. Procurement packaging arrangements will be the followings: (i) recruitment of the management and Verification Agencies (AAPRC contracts) and procurement of significant, complex and pooled nature of goods or services will be under the direct responsibility of the MOF project management at the Central level; (ii) very small procurement activities will be performed at the decentralized district and Provincial level; (iii) each Centre and or community health facility may use part of its subsidies to improve quality of service by procuring small items within a threshold table defined in the PBF manual, (iv) Any beneficiary of PBF resources should procure scarce , small goods, works and services in accordance with provision of PIM Procurement section. Preferred arrangements for Low-Value/ Low risk Contracts have been also determined. Activities under the proposed Project will be carried out through International or National

Competition. For national Competition, MOH PIU will be responsible for compliance with procurement procedures under the “code des marchés publics”. An executive summary for the Project Procurement Strategy Development (PPSD) of the proposed project is presented in Annex 2.

128. **Procurement Plan.** The Procurement Plan for the first 18 months was prepared and finalized at project negotiations. It includes for each contract (a) a brief description of the activities/contracts, (b) the selection methods to be applied, (c) the cost estimates, (d) time schedules, (e) the World Bank’s review requirements, and (f) other relevant procurement information. The Procurement Plan will be updated through STEP by the NTU on an annual or as-needed basis to reflect actual project implementation needs and will be submitted to World Bank no-objection and the PPSD will be updated accordingly.

129. **Procurement prior review thresholds.** Procurement methods and World Bank review requirements for the procurement are summarized in tables 5 and 6.

Table 5. Procurement Prior Review Thresholds (US$, millions)

Type of Procurement	High Risk	Substantial Risk	Moderate Risk	Low Risk
Works (including turnkey, supply and installation of plant and equipment, and public-private partnership)	5.0	10.0	15.0	20.0
Goods, IT, and non-consulting services	1.5	2.0	4.0	6.0
Consultants: Firms	0.5	1.0	2.0	4.0
Consultants: Individual	0.2	0.3	0.4	0.5

Table 6. Thresholds for Procurement Approaches and Methods (US$, thousands)

Works			Goods, IT, and Non-Consulting Services			Shortlist of National Consultants	
Open International	Open National	RfQ	Open International	Open National	RfQ	Consulting services	Engineering and construction supervision
≥5,000	<5,000	≤200	≥500	<500	≤100	<100	≤100

Note: RFQ = Request for Quotation.

C. Safeguards

Environmental Safeguards

130. **With respect to the project’s development objectives, components, subcomponents, and activities to be implemented, the project is rated Category B (Partial Assessment) with a Moderate risk and one policy is triggered: OP/BP 4.01, Environmental Assessment.** The project prepared a separate Environmental and Social Management Framework (ESMF) and a Medical Wastes Management Plan (MWMP).

131. **The ESMF describes in detail the steps required to** (a) screen subprojects for potential health and occupational safety risks and social and environmental impacts, (b) assign the appropriate environmental category to Sub-Projects, (c) carry out the appropriate environmental work based on the screening results,

(d) review and approve the screening results and as required environmental Impact Assessment , (e) carry out public consultations, and (f) carry out environmental M&E and follow up on environmental monitoring indicator. It also proposes institutional arrangements, including cost estimates for the implementation of the institutional and technical measures as well as for environmental training and public awareness raising.

132. **The MWMP proposes technically feasible, economically viable, and socially acceptable waste management systems.** Both documents are approved, and published in the country and on the World Bank's external website (on July 12, 2018). The potential beneficiaries (public and private), modalities of interventions, chain of management of the MWMP, sites of discharges, transport logistics, costs of the chain of values, follow-up, and evaluation system are an integral part to align the plan with the national health vision, including capacity building for stakeholders, climate change, risks management, biodiversity, and labor influx.

Social Safeguards

133. **Overall, there are no major negative social impact expected from the proposed project.** The project's social and environmental category is currently rated B. SENI's components will increase production of health services and upgrade targeted health facilities through small rehabilitation works. This will lead to an overall improvement of the health and hygiene conditions and potential job creation for local populations. A communication campaign will be conducted to explain to both local authorities and the population at large the objectives and benefits of the project.

134. **OP 4.10 on Indigenous Peoples** is triggered as the assessment confirms the presence of indigenous communities who meet the requirements of OP 4.10 in some of the zones targeted by the previous HSSP, which are similar to the proposed project (SENI). The project has complied with the requirements of OP 4.10 by ensuring that the principle of a free, prior, and informed consultation leading to broad community support for the proposed project by the Indigenous People was adopted during the preparation of the Indigenous Peoples Policy Framework (IPPF) and disclosed (in-country and on the World Bank external website on July 12, 2018) before appraisal. The IPPF provides a framework for the preparation of one or multiple Indigenous Peoples Plans in accordance with OP 4.10.

135. **Safeguards implementation capacity.** To ensure that capacity needs are met, the current PIU has hired a safeguards staff (environmental and social specialist) to ensure proper implementation of environmental and social measures as agreed in the safeguards instruments.

136. **The grievance redress mechanism and citizen engagement.** A grievance redress mechanism (GRM) is proposed in the IPPF. The GRM was prepared in consultation with the communities and elected bodies and the Indigenous People groups that were consulted during the preparation of the safeguards instruments. In addition to a dedicated section in the MOH website and a hotline phone service, the project will also partner with civil society and NGOs in the implementation of activities and awareness raising campaigns. Specifically, all grievances received must be resolved at the local level (involving elected bodies and local authorities) within a set period. Moreover, the project will work with NGOs not only in the implementation of expansion of activities but also in the monitoring of activities and GRM.

137. **The project will strengthen citizen engagement in the project areas, drawing from PBF tools such as through the community surveys that are used for assessing the perceived quality of care by the**

beneficiaries. Users' opinions, statements, and judgements will be included in the PBF database. Community-based NGOs and local-elected officials will be engaged in the PBF program. These will be implicated in the reporting and monitoring of quality of services, community outreach, and demand promotion for better use of health services by the communities, particularly mothers and children.

World Bank Grievance Redress Mechanisms

138. **Communities and individuals who believe that they are adversely affected by a World Bank (WB) supported project may submit complaints to existing project-level grievance redress mechanisms or the WB's Grievance Redress Service (GRS)**. The GRS ensures that complaints received are promptly reviewed in order to address project-related concerns. Project affected communities and individuals may submit their complaint to the WB's independent Inspection Panel which determines whether harm occurred, or could occur, as a result of WB non-compliance with its policies and procedures. Complaints may be submitted at any time after concerns have been brought directly to the World Bank's attention, and Bank Management has been given an opportunity to respond. For information on how to submit complaints to the World Bank's corporate Grievance Redress Service (GRS), please visit http://www.worldbank.org/en/projects-operations/products-and-services/grievance-redress-service. For information on how to submit complaints to the World Bank Inspection Panel, please visit www.inspectionpanel.org.

V. KEY RISKS

139. **The fragile political environment creates an extremely volatile security situation that can pose challenges to the implementation of the project.** However, the project focuses on improving the health status of a wide coverage of the population, especially pregnant women and children, and the population will perceive the benefits of the project's efforts. This, in turn, will hopefully create a more positive context for building up stability and gaining trust from the population, which will mitigate the sensitive political situation that CAR has been facing in recent years.

140. **Attention needs to be directed to security issues for project implementation, monitoring, and supervision, and a third-party monitoring mechanism in the FCV context will be contemplated**. The World Bank health team has reached out to the World Bank Group FCV health group and will like to explore any of these initiatives in CAR, to see how innovative technology can help effect a breakthrough in the programmatic approach in working in an FCV context as in CAR.

(a) **Geo-enabling distance monitoring** technology as a type of third-party monitoring capability for monitoring project sites in extremely fragile and conflictive contexts

(b) **Usage of barcode scanning** placed on MCH cards to monitor, track. and identify if essential preventive health services are obtained for each mother and child, especially where only 40 percent of the population are literate and Internet and mobile network are not available outside of the main cities

(c) **Delivery of pharmaceuticals** and other medical products in extremely fragile context

(d) **Usage of mobile money transfers** and mobile banking in a country with weak mobile networks

(e) **Usage of e-health** and smart phones for information system purposes in a country with weak Internet and mobile networks.

141. **Macroeconomic situation is also very challenging** due to the political state of affairs in the country, where CAR is among the poorest and the most fragile countries in the world. The PBF attempts to help the government improve efficiency and public financial management, and thus enhance the efficiency of government spending. The government is also contributing their share to the project, showing that the government is eager to participate in this efficiency advancement effort.

142. **Substantial risk of low institutional capacity for implementation and sustainability exists, where sector strategies and policies are not strong.** This is where a robust technical and implementation support provided by the World Bank Group health team would be a necessity, and the World Bank support would be a huge asset for the MOH. Additionally, the more UN agencies are involved in the planning and monitoring of Investment Case implementation, the more support will be provided in ensuring that the project is closely monitored, and technical support is obtained from all angles.

143. **High fiduciary risk in financial overheads management.** Mismanagement risks will continue to be addressed throughout the project implementation period. While issues of capacity building and understanding of the nature of the proposed interventions will be used as mitigation measures, there remains a number of residual risks relating to the country situation and governance which will be addressed throughout project implementation.

144. **Tracking of results indicators.** There is a risk that targeted indicators may not be closely tracked. This is significantly reduced through the ex-ante verification by the performance purchasing agencies (PPAs) and ex post verification by the independent and external evaluation agency. To ensure a clear separation of functions and that appropriate regulatory frameworks are in place, the MOH and the PBF Technical Unit will play a key role in the validation of results declared by NGOs (for both PBF and non-PBF activities), payments to providers, validity of the counter-verification of the results, and estimation of NGOs' performance indicators by the PPAs.

145. **Sensitive relations and communication between development and humanitarian partners may affect their adoption of the PBF-based health system strengthening model.** The dialogue between development partners in the health sector and humanitarian agencies may remain fragile, as operational styles between the two sides often conflict, and the humanitarians may not necessarily take on stewardship by the Government. The risks related to FCV are high, though there is a positive direction with growing political support shown by the Minister of Health, who is taking full ownership of the PBF and the Investment Case. His stewardship of all health activities provides assurance that the project will serve the population of CAR.

VI. RESULTS FRAMEWORK AND MONITORING

Results Framework
COUNTRY: Central African Republic
Health System Support and Strengthening Project

Project Development Objectives(s)

To increase utilization and improve the quality of essential health services in targeted areas in the territory of the Recipient.

Project Development Objective Indicators

Indicator Name	DLI	Baseline	Intermediate Targets		End Target
		2019	1	2	2022
Improve utilization & quality of essential health services in facilities & communities through PBF					
People who have received essential health, nutrition, and population (HNP) services (CRI, Number)		0.00	158,021.00	316,044.00	474,066.00
People who have received essential health, nutrition, and population (HNP) services - Female (RMS requirement) (CRI, Number)		0.00	109,575.00	219,150.00	328,725.00
Number of children immunized (CRI, Number)		0.00	32,729.00	65,457.00	98,186.00
Number of women and children who have received basic nutrition services (CRI, Number)		0.00	64,165.00	128,330.00	192,496.00
Number of deliveries attended by skilled health personnel (CRI, Number)		0.00	61,128.00	122,256.00	183,384.00
Quality average score of health centers in		0.00	60.00	70.00	80.00

Indicator Name	DLI	Baseline	Intermediate Targets		End Target
		2019	1	2	2022
targeted areas (Percentage)					

Intermediate Results Indicators by Components

Indicator Name	DLI	Baseline	Intermediate Targets		End Target
		2019	1	2	2022
Improve utilization & quality of essential health services in facilities & communities through PBF					
Ante-natal care visits (at least 4) received by pregnant women (Number)		0.00	189,667.00	379,334.00	569,000.00
Children 6-59 months receiving vitamin A supplementation (twice per year) in total catchment area (Number)		0.00	22,511.00	45,021.00	67,532.00
Women and adolescents who received family planning services (Number)		0.00	67,777.00	135,554.00	203,331.00
Post-natal care visits received by women (Number)		0.00	57,986.00	115,972.00	173,958.00
Pregnant women receiving two doses of intermittent preventive treatment (SP) for malaria (Number)		0.00	35,840.00	71,679.00	107,519.00
People receiving health services free of charge (Number)		0.00	118,113.00	242,132.00	372,351.00
People referred to health facilities by community workers (Number)		0.00	92,832.00	190,305.00	292,652.00
Quality satisfaction score of beneficiaries for health services in district hospitals. (Percentage)		70.00	77.00	81.00	85.00
Quality average score of district hospitals (Percentage)		74.00	78.00	82.00	85.00

Indicator Name	DLI	Baseline	Intermediate Targets		End Target
		2019	1	2	2022
Children (1-5 years old) receiving a deworming tablet in total catchment area (Number)		0.00	22,511.00	45,021.00	67,532.00
Facilities receiving performance payments on time (Percentage)		0.00	60.00	70.00	80.00
Reinforcing institutional capacity for HSS incl. establishing district hospitals integrated GBV ser.					
Completeness of country health data in health management information system (Percentage)		3.00	60.00	70.00	80.00
Number of Districts Hospitals with integrated GBV Services (Number)		0.00	1.00	2.00	3.00
Availability of tracer drugs at health centers (Percentage)		84.00	86.00	88.00	90.00
Health professionals employed full-time in health facilities (Number)		0.00	1,366.00	2,800.00	4,306.00

Monitoring & Evaluation Plan: PDO Indicators					
Indicator Name	Definition/Description	Frequency	Datasource	Methodology for Data Collection	Responsibility for Data Collection
People who have received essential health, nutrition, and population (HNP) services		Annually	PBF Database	Routine data collection	PBF Technical unit
People who have received essential health, nutrition, and population (HNP) services - Female (RMS requirement)		Annually	PBF Database	Routine data collection	PBF Technical unit

Number of children immunized		Annually. Diphteria-pertussis-tetanus 3/Pentavalent 3 vaccine for children under 1 year old. [Child survival, community health, supply chain]	Immunization database	Routine data collection	National immunization programme
Number of women and children who have received basic nutrition services		Annually	PBF Database	Routine Data Collection Note: The PBF routine data only captures nutrition services provided to children under-five. Hence this indicator only reports nutrition services provided to children under-five, and not women.	PBF Technical Unit
Number of deliveries attended by skilled health personnel		Annually	PBF Database	Routine data collection	PBF Technical unit
Quality average score of health centers in targeted areas		Annually	PBF Database		PBF Technical unit

Monitoring & Evaluation Plan: Intermediate Results Indicators					
Indicator Name	**Definition/Description**	**Frequency**	**Datasource**	**Methodology for Data Collection**	**Responsibility for Data Collection**
Ante-natal care visits (at least 4) received by pregnant women		Annually	PBF Database	Routine data collection	PBF Technical Unit
Children 6-59 months receiving vitamin A supplementation (twice per year) in total catchment area		Annually	Immunization database	Routine data collection	National Immunization Program
Women and adolescents who received family planning services		Annually	PBF Database	Routine data collection	PBF Technical Unit
Post-natal care visits received by women		Annually	PBF Database	Routine data collection	PBF Technical Unit
Pregnant women receiving two doses of intermittent preventive treatment (SP) for malaria		Annually	National Malaria Program Database	Routine data collection	National Malaria Program - Ministry of Health
People receiving health services free of charge		Annually	PBF Database	Routine data collection	PBF Technical Unit
People referred to health facilities by community workers		Annually	PBF Database	Routine data collection	PBF Technical Unit
Quality satisfaction score of beneficiaries for health services in district hospitals.		Annually	PBF Database	Routine data collection	PBF Technical Unit
Quality average score of district hospitals		Annually	PBF Database	Routine data collection	PBF Technical Unit
Children (1-5 years old) receiving a deworming tablet in total catchment area		Annually	Expanded programme of immunization (EPI)	Routine data collection or campaign data collection	Expanded programme of immunization (EPI)

Facilities receiving performance payments on time		Every quarter.	PBF database.	Routine data collection.	PBF technical unit.
Completeness of country health data in health management information system		Annually	National HMIS database	Routine data collection	
Number of Districts Hospitals with integrated GBV Services		Annual		MoH Report	PBF Technical Unit
Availability of tracer drugs at health centers		Annually	PBF Database	Routine data collection	PBF Technical Unit
Health professionals employed full-time in health facilities		Annually	PBF Database	Routine data collection	PBF Technical Unit

ANNEX 1: Implementation Arrangements and Support Plan

COUNTRY: Central African Republic

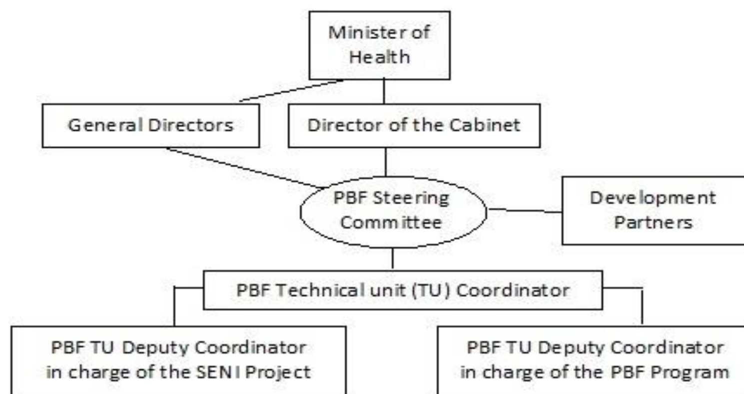
Health System Support and Strengthening Project (SENI)

Institutional and Implementation Arrangements

1. **SENI will build on the successful implementation experience of the HSSP.** 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. According to 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.

2. **To institutionalize leadership and coordination of the PBF program within the Government and across partners, the MOH established an NTU responsible for day-to-day implementation of the program and for informing the National Steering Committee of the progress achieved in implementing SENI.** The NTU's performance is satisfactory and its staff are extremely responsive in communication and action. The NTU will still be provided close technical support from the World Bank and external sources throughout the implementation of the project.

Figure 1.1. Implementation Arrangements of SENI



3. **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 and specific project implementation. As such, the fiduciary requirements of the PBF technical unit will increase substantially as all responsibilities from the HSSP PIU will be transferred to the PBF unit. Given that the PBF unit and the PIU currently work 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.

4. **SENI 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 FM/accounting, procurement, M&E, environmental and social safeguards, and IT/online databases.

5. **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) 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 will focus on the quality of health facilities services and the performance of all entities involved in the PBF Program and will ensure that the health facilities are paid according to their performance. It will be undertaken once every quarter by an independent external body and 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 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 abovementioned local organizations used in verification and in users' satisfaction surveys.

6. **All PBF implementation modalities that SENI 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 community health workers, regulatory bodies/public health programs, and the NHIS/DHIS2.

7. **As part of the GFF process, the existing concertation mechanism chaired by Minister of Health and Population and 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 the national GFF health platform and will monitor and oversee the rollout of the country's Investment Case.** A core team will be identified upon the rollout of the GFF in-country and will develop the Investment Case.

Strategy and Approach for Implementation Support

8. **The proposed implementation arrangement is consistent with the ongoing project (HSSP).** SENI will use the MOH entities for implementation of its activities. The procurement, FM, safeguards, communication, and IT functions will continue to be supported by experts hired by the project. Program implementation will be the MOH's responsibility with targeted and continuous implementation support and technical advice from the World Bank and development partners involved (mainly EU, UN agencies, and Cordaid). The World Bank's implementation support will broadly consist of the following:

- Capacity-building activities to strengthen the national and local levels' ability to implement the PBF program, covering the technical, fiduciary, and social and environmental dimensions
- Provision of technical advice and implementation support geared to attainment of the PDOs
- Ongoing monitoring of implementation progress, including regularly reviewing the key outcome and intermediate indicators and identification of bottlenecks
- Monitoring risks and identification of corresponding mitigation measures
- Close coordination with other donors and development partners to leverage resources, ensure coordination of efforts, and avoid duplication
- Capacity-building activities to strengthen the MOH's ability to steer the health system and develop and implement the RMNCAH-N Investment Case

9. **Moreover, implementation support will include the provision of capacity strengthening in procurement, FM, governance, and anticorruption.** An annual fiduciary review will be conducted for the program and adequate budget will need to be allocated for this review. This review will be supplemented by on-site visits by the World Bank's fiduciary staff at least twice a year. Reliance will also be placed on the annual audit reports. In addition, desk reviews will be carried out for audit, financial, procurement, and any other reports received during the financial year. In-depth reviews may also be commissioned by the World Bank whenever deemed necessary.

Table 1.1.Implementation Support Plan

Time	Focus	Skills Needed	Resource Estimate (US$)
First 12 months	Capacity building	PBF and health system strengthening experts	200,000 (IDA) 300,000 (TF-GFF)
	Capacity building on FM, procurement, internal audit, and safeguard implementation and compliance	FM, procurement, and safeguards staff and consultants	
12–36 months	Implementation support	Same as above	350,000 each subsequent year

Table 1.2.Skills Mix Required

Skills Needed	Number of Staff Weeks (Annually)	Number of Trips (Annually)	Comments
Task team leader	20	Field trips as required	Washington based
Public Health and co-task team leader	20	Field trips as required	Washington and CO based
Procurement	5	Field trips as required	CO based
FM specialist	5	Field trips as required	CO based
M&E specialist	5	Field trips as required	Washington based
Environment specialist	4	Field trips as required	Regional hub
Indigenous peoples and health specialist	4	Field trips as required	Washington/regional hub
GBV Specialist	4	Field trips as required	International
PBF specialist	4	Field trips as required	Regional hub
Community health specialist	4	Field trips as required	International
Governance specialist	2	Field trips as required	Washington based
Administrative support	10	Field trips as required	Washington and CO based

Note: CO = Country Office.

ANNEX 2: Executive Summary for Project Procurement Strategy Development (PPSD) and Procurement Plan

I. Project Procurement Strategy Development (PPSD)

General: Procurement will be carried out in accordance with the "World Bank Procurement Regulations for Borrowers under Investment Project Financing (IPF)" dated July 1, 2016. As per the requirements of the World Bank's New Procurement Framework (NPF), a comprehensive Project Procurement Strategy for Development (PPSD) was carried out and identified the appropriate selection methods, market approach and type of review by the WB for the high risk and value contracts that will be executed during the implementation of the project. The objective is to improve procurement efficiency. Most activities under the proposed Project will be carried out through National or International Competition. A Procurement Plan for 18 months was also prepared. For International Competition, the MARNDR will use standard bidding documents, and National competition, sample Bidding Documents, agreed with AMRP and DGMP under the CAR "Code des Marchés Publics".

Project Procurement Development Objectives (PPDO)**:** To increase procurement efficiency and ensure value for money that contributes towards enhancing livelihood in the communities most vulnerable.

Project Procurement Result Indicators: The following indicators will measure the achievement of the PDO; i) Bidding processes initiated as per Procurement Plan with no substantial delays and no rebidding, ii) No substantial cost and time overrun of the contracts, and iii) Successful implementation of Key Performance indicators and on-time payments in AAPRC and PBF Health facility performance contract with the Centre and communities Health facilities.

Procurement institutional Arrangements: Procurement and contract management implementation will be the responsibility of the MoH with the coordination of the proposed project. Project implementation teams have been established. The project implementation teams will be supported at District, Centre and Community levels and be responsible for the overall project coordination and reporting. The MoH-PIU will be responsible to ensure proper quality of the design, procurement, contract management and supervision.

MoH Capability and PIU (Project Implementing Unit) Assessment: Project implementation will be the responsibility of MoH -PIU for the management, including contract management, financial management, disbursement, safeguards, and monitoring and evaluation of the project. The coordination is under the overall overseeing of the Direction of Cabinet at Ministry level. Project implementation Unit has been established. The PIU will be responsible for overall project coordination and reporting, including monitoring compliance with safeguards, fiduciary, legal and other covenants. It is also envisaged that the PBF NTU of MoF will take the lead on the institutional strengthening and capacity building regarding policy, strategy and PBF financing.

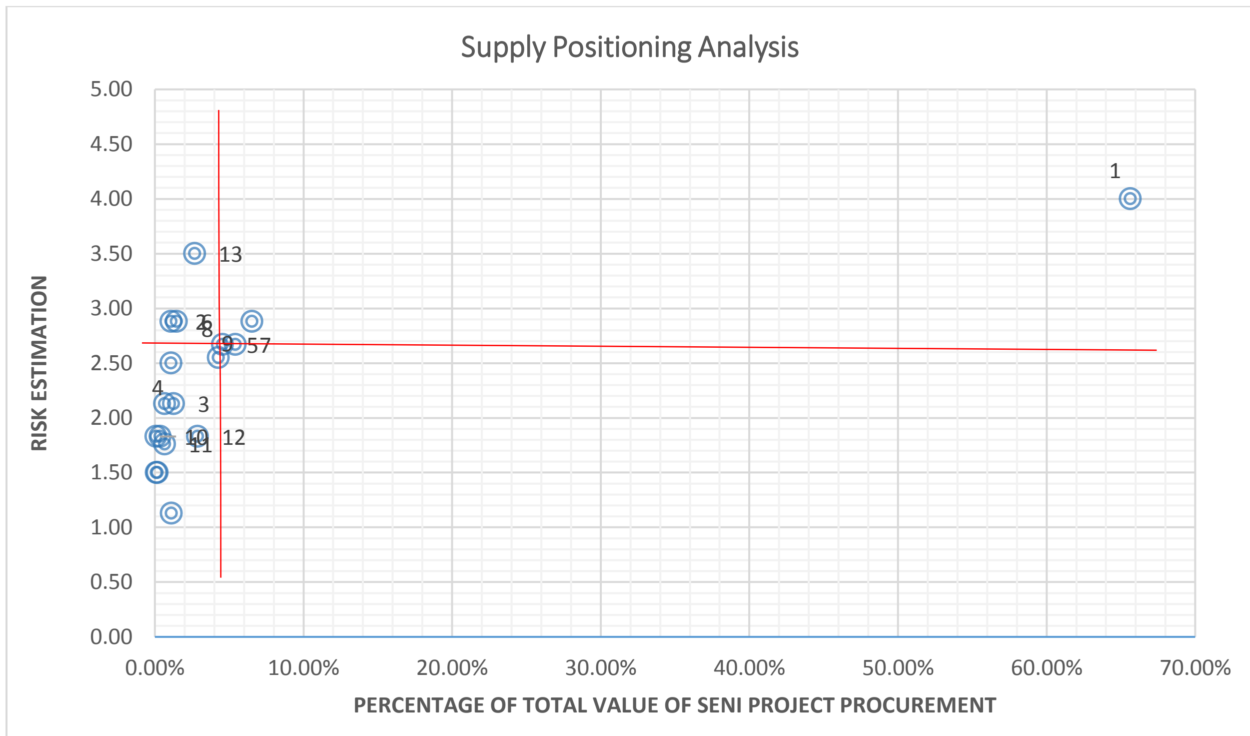
PIU staff have limited experience in handling large contracts financed by the World Bank and use of the New Procurement Framework, step as well. To help MoH-PIU managing its workload, one more full-time procurement staff will be appointed. Additionally, short term Consultant experts will be used to reinforce UPMP for better efficiency and improve its capability in the management of large and complex contracts,

when required. PIU staff involved in the implementation of the proposed project will be trained, among other topics, on the different features of NPF, STEP and contract management. Active support from the Bank will be also provided for ensuring that procurement packages have been efficiently delivered in the attainment of the PPDO.

Procurement risks analysis. Procurement risk for the proposed project is "HIGH". An analysis of risk aspects associated to the implementation of the proposed project was conducted. Potential factors identified during the proceeds of the major contracts in the proposed project are inherent to the followings: (i) high economic, political fragile business environment reducing attractiveness of potential qualified suppliers and Consultants; (ii) weak control, legal and good practices to resolve disputes under the existing national procurement regulation "code des marches publics" exacerbated CAR's business ethics ; (iii) CAR's ability to manage public resources undermined by sensitive environment, delays in implementation from MOH PIU due to its limited capacity in procuring some specialized goods and products and services or administering large and complex contracts; (iv) delays in delivery from potential supplier market and time/cost over-runs due to the market situation derived from CAR operating context. Based on a procurement risks assessment, CAR operational context is volatile and exacerbated by a fragile and unsecure environment. Therefore, the overall procurement risk for the proposed project is judged to be "HIGH"

***Procurement risk mitigation measures*.** A series of mitigation measures shall be implemented early on to tackle the major risks aspects and /or minimize their impact during on procurement performance carried out during the implementation of the proposed project. These include: (i) agreement between MOH and WB on the required qualifications of procurement staff who shall be appointed to support the proposed Project; and (ii) inclusion of all procurement procedures that should be described in the Project Implementing Manual and approved by the WB; (iii) supervision of procurement/selection transactions carried out by MOH PIU for the critical and large contracts specifically the AAFRC comprising in PBF management contracts and independent verification Agencies to ensure timeless health services delivery and bonus performance payment; MOH PIU shall be required and made provisions for recruiting short term Consultants to provide MOH PIU (NTU and Fiduciary Unit) with technical assistance e.g. when required by MOH directorates. Typical services should range, among others, to design functionality and specifying of specialized Health products, prepare terms of references for unique services or easily understood bidding documents when PIU will look to acquire some specialized health supplies or look for suppliers coming up with pragmatic solutions fitted for the CAR context; (iv) it is also recommended that MOH PIU through National Technical Unit takes the lead on the institutional strengthening and capacity building of the PIU itself and at the Ministry level for the development of Heath policy , strategy and management and PBF financing.

Market Analysis: Owing to the economic conditions and instability of the country, the possibility of attracting big reputable international companies could be limited. However, communicating/consulting with the potential bidders would be important to have national competition, domestic preference will be preferred approach for some specific programs.



(The legend to the graphic describes the contracts to which the numbers refer)

The supply positioning analysis aimed at determining the high and value contracts as shown below:

Based on the supply positioning analysis, (6) key Contracts have required a greater level of analysis. As shown on the table below, these contracts are the followings:

Label	Activity description	Cost Estimate US Million	% value Contract	Risk estimate
1	Agency Selection for managing the FBR through Contract with Health Center enrollement (including subsidy program health packages program for the whole project/23 Millions)	30.11	65.6	4.00
2	Firm Selection for Independent Evaluation Agencies for the FBR program	0.50	1.09	2.88
5	Operator selection for managing the GBV program (First beneficiaries cohort)	2.09	4.56	2.67
6	Operator selection for implementing the creation of Special Health centers with relevant primary relevant health packages dedicated to GBV victims packages with acquisition of small equipment, materials and supplies and minor facility repairing)	0.67	1.46	2.88

7	Special Acquisition (KIT, Vaccine etc.) for the GBV program	2.48	5.41	2.50
8	Training packages Acquisition for various capacity building with a large communication awareness in FBR & GBV thematic	1.96	4.27	3.13
9	Consultancy for Improvement in the circuit for the acquisition & distribution of medical and drug supplies	3.00	6.54	$ 3.00 3.00
13	Consultancy for the strengthening of the national System and various technical assistance on a need basis	1.23	2.67	3.50
Total		**42.03**	**92**	

6.54%

***Key procurement under the project*:** The total project procurement activities/contracts cost is approximated at (US$ 45.86 million), representing 85percent ot the total financing of the proposed project. High risk Contracts approximately totalizing the value of US$ 39.55 million representing 86 percent of the total value of the proposed project procurement, out of which procurement goods and non-consulting services represent US$ 37.50 million) and consulting Services (US$ 4.73 million). Works are not delivered in the scope of the proposed project.

The Key procurement contract table is summarized in the table below:

Type of procurement	Prior review High Risk Contracts (US$ million)	Percent of Total Value High Risk Contracts (%)
Goods and Non-Consulting Services (Subsidy Health care package payment, Bonus payment , training, Creation FBG health care Centers – Specialized goods acquisition ..)	37.50	89
Consulting Services (various experts for reinforcement and improvement national health system, FBR independent verification consulting services etc.),	4.73	11
Total	**42.03**	**100**

Procurement Approach and Selection method: Following the market analysis, risks identified, and contract amounts it was determined that the most important activities under the proposed Project will be carried out through International or National Competition and Direct Selection. These activities represent

(1) ***Goods and Non-Consulting Services:*** The project will finance Health Care packages to improve the benefits of the poorest population through the national PBR package arming practices with an aim to restore the likelihood of the poor rural families; and also vulnerable women that are suffering from GBV effects. These free packages will available to the eligible beneficiaries in the health centers, in the communities and in the new created GBV centers. Different operators will be in charge of the operationalization and management of the subsidy programs. As per PPSD, for high risk value contracts, appropriate procurement methods and market approach were selected and are mentioned in the procurement plan table below.

(2) ***Consulting Services:*** There are a few number of important consultancy services under component 1 and 2 for hiring consulting firms aiming at strengthening the National System, restore governance and improve medicals and drug supplies acquisition. As per PPSD, for high risk value contracts, appropriate procurement methods and market approach were selected and mentioned in the procurement plan table below.

Summary of Major contracts and selection methods from the PPSD: As per PPSD, the table below summarizes the key high-risk value and prior review contracts for the proposed project.

#	Contract Description	Budget Estimate Million US$)	Procurement method	Procurement Approach
1	**Works**	**0.00**		
2	**Goods and Non-Consulting Services**	**37.5**		
2.1	Agency Selection for managing the PBF through contracts with Health Center (including subsidy program health packages program for the whole project/23 million)	30.11	Request For Proposals/ Single Stage envelopes	Open International
2.2	Operator Selection for managing the GBV program (First beneficiaries cohort)	2.09	Request for proposals Single Stage /2 envelopes	Open International
2.3	Operator selection for implementing the Creation of Special Health centers with relevant primary relevant health packages dedicated to GBV victims packages with acquisition of small equipment, materials and supplies and minor facility repairing)	0.67	Request for proposals/ Single Stage/2 envelopes	Limited National
2.4	Special Acquisition (KIT, Vaccine etc.) for the GBV program	2.48	Request for Quotations /Single Stage/One Envelope Or Direct Contracting	Limited International Or UN Agencies
	Training packages Acquisition for various capacity building with a large communication awareness in PBF & GBV thematic	1.96	Request For Proposals Single Stage/Two Envelopes	Open/International/National
3	**Consulting Services**	**4.73**		
3.1	Consultancy for the strengthening of the national System and various technical assistance on a needs basis	1.23	Various QCBS/CI	Open/ National or International

3.2	Firm Selection for Independent verification prior to payment of Heath Centers (package delivery, performance, bonus etc.)	0.5	QCBS	Prior
3.3	Consultancy for Improvement in the circuit for the acquisition & distribution of medical and drug supplies	3.00		$ 3.00
Total		**42.03**		

Procurement Prior Review Thresholds: The Procurement Plan sets forth contracts, which shall be subject to the World Bank's Prior Review for high risk environment.

Table 3: Procurement Prior review thresholds (US$ millions)

Type of Procurement	High Risk	Substantial Risk	Moderate Risk	Low Risk
Works (including turnkey, supply & installation of plant and equipment, and PPP)	5	10	15	20
Goods, information technology and Non-Consulting Services	1.5	2	4	6
Consultants: Firms	0.5	1	2	4
Consultants: Individual	0.2	0.3	0.4	0.5

Procurement Approaches and Methods Thresholds: The Procurement Plan sets forth contracts, which is subject to the World Bank's Prior Review and methods. All other contracts are subject to Post Review by the World Bank.

Table 4: Thresholds for Procurement Approaches and Methods (US$ thousands)

Works			Goods, IT and Non-Consulting Services			Shortlist of national Consultants	
Open International	Open National	Request for Quotations	Open International	Open National	Request for Quotations	Consulting services	Engineering & construction supervision
≥5,000	<5,000	≤200	≥500	<500	≤100	<100	≤100

II. Procurement Plan (PP)

Preamble

In accordance with paragraph 5.9 of the "World Bank Procurement Regulations for IPF Borrowers dated July 2016, revised in November 2017 and August 2018 ("procurement Regulations") the Bank's Systematic Tracking and Exchanges in Procurement (STEP) system will be used to prepare, clear and update Procurement Plans and conduct all procurement transactions for the proposed project.

This textual part along with the procurement tables in STEP constitute the Procurement Plan for the proposed project. The following conditions apply to all procurement activities in the Procurement Plan. The other elements of the Procurement Plan as required under paragraph 4.4 of the Procurement Regulations are set forth in STEP.

The Bank's Standard Procurement Documents: Shall be used for all contracts subject to International competitive procurement and those contracts as specified in the Procurement Plan tables in STEP.

National Procurement Arrangements: In accordance with paragraph 5.3 of the procurement Regulations, when approaching the National market (as specify in the Procurement Plan tables in STEP), the CAR's own procurement procedure may be used.

- When the Borrower uses its Own national open competitive procurement arrangements as set forth in "Code des Marches Publics", such arrangements shall be subject to paragraph 5.4 of the Procurement Regulations

- When other national Procurement Arrangements other than national open competitive procurement arrangements are applied by the Borrowers, such arrangements shall be subject to paragraph 5.5 of the Procurement Regulations

Procurement Prior Review Thresholds: The Procurement Plan sets forth contracts, which shall be subject to the World Bank's Prior Review for high risk environment.

Table 5: Procurement Prior review thresholds (US$ millions)

Type of Procurement	High Risk	Substantial Risk	Moderate Risk	Low Risk
Works (including turnkey, supply & installation of plant and equipment, and PPP)	5	10	15	20
Goods, information technology and Non-Consulting Services	1.5	2	4	6
Consultants: Firms	0.5	1	2	4
Consultants: Individual	0.2	0.3	0.4	0.5

Procurement Approaches and Methods Thresholds: The Procurement Plan shall set forth contracts, which shall be subject to the World Bank's Prior Review and methods. All other contracts shall be subject to Post Review by the World Bank.

Table 6: Thresholds for Procurement Approaches and Methods (US$ thousands)

Works			Goods, IT and Non-Consulting Services			Shortlist of national Consultants	
Open International	Open National	RFQ	Open International	Open National	RFQ	Consulting services	Engineering & construction supervision
≥5,000	<5,000	≤200	≥500	<500	≤100	<100	≤100

3. Procurement Plan Table
Works, Goods, IT and Non-Consulting and Consulting Services (US$ Million)

	Activity Description	**Cost Estimate (US$ M)**	**Method**	**Bank 's Review (Prior/Post)**	**Starting Date**	**Signing Contract Date**
1	**Works**	**0.14**				
	Very small works for the MoH -PIU (CTN-FBR) building office repairing	0.03	RFQ	Post	11/2018	02/2019
	Very small works Building rehabilitation dedicated to new GBV center creation	0.11	RFQ	Post	11/2018	02/2019
2	**Goods and non-Consulting Services**	**4.63**				
2.1	Agency Selection for managing FBP through primarily 4 Contracts with Health Centers (subsidy health packages delivery: 3.3 M, training etc.)	3.5	RFP	Prior	11/2018	02/2019
2.2	Operator selection for the coaching program delivery of local NGOs including large communication awareness in FBR & GBV thematic	0.5	RFP	Prior	02/2019	06/2019
2.2	Special GBV (KIT, Vaccine etc.) acquisition for the implementation of the program	1 .24	DS	prior	12/2019	04/2019
2.3	Specialized Health goods (bio medical equipment) acquisition to equip new FBG centers	0.04	RFQ	Post	03/2019	07/2019
2.4	Specialized Health goods (bio medical equipment) acquisition to equip new FBG centers	0.04	RFQ	Post	03/2019	07/2019
2.5	Financial Management system (software TOMPRO and training including Licenses for 4 sites)	0.03	DS	Post	01/2019	04/2019
2.4	Office Supplies Acquisition	0.10	RFQ	Post	03/2019	05/2019
2.5	Various Logistics needed to equip the MoH at central level	0.10	RFQ	Post	03/2019	05/2019
2.6	Various office Equipment including IT equipment and consumables acquisition	0.09	RFQ	Post	02/2019	03/2019
2.7	Motorcycles for agents (first cohort) needed for the launching of GBV program and vehicle acquisition	0.13	RFQ	Post	11/2019	12/2019
2.8	Generator Acquisition as secondary	0.1	RFQ	Post	02/2019	02/2019

	power source for the MOH					
3	**Consulting Services**	**1.11**				
3.1	Consultancy for independent verification prior to payment of Heath Centers (package delivery, performance, bonus etc.)	0.25	QCBS	Prior	02/2019	06/2019
	Consultancy for Impact studies regarding the FBR program	0.23	QCBS	Prior	15/05/20 19	15/06/20 19
3.3	NGOs selection for the communication Campaign meanly on GBV thematic (5)	0.34	QBS	Prior	11/2019	03/2019
	Consultancy for the external audit of the project	0.04	QCBS	Prior	06/2019	03/2020
3.4	Consultancy for various technical assistance of the MOH at the central level (3 international short terms experts & 3 national short terms experts)	0.07	SCI	Post	02/2019	From 03/2019 various
3.6	Technical Specialists and Personal recruitment for the creation of the first GBV centers (02 psychologists and 10 agents)	0.18	SCI	Post	10/2019	12/2019
Total Budget PP (works, goods, non-consulting and consulting services)		**5.88**				
	Operating Cost (Salary, Internet, Communication, Workshops, various spending cost etc.)	**0.53**				
Total Budget (PP+ Operating Cost)		**6.41**				

Acronyms

RFQ: Request for Quotations
RFP: Request for Proposals
QBS Quality Based Selection
QCBS: Quality and Cost Based Selection
DS: Direct Selection
SCI: Selection of Individual Consultants