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Report No: ICR00006613

IMPLEMENTATION COMPLETION AND RESULTS REPORT
IDA 6230, IDA D3040, TF07042

ON A CREDIT

IN THE AMOUNT OF SDR15.6 MILLION
(US$22.50 MILLION EQUIVALENT)

AND A GRANT

IN THE AMOUNT OF SDR15.6 MILLION

(US$22.50 MILLION EQUIVALENT)

AND A GRANT FROM THE MULTI-DONOR TRUST FUND FOR THE GLOBAL FINANCING FACILITY

IN THE AMOUNT OF US$10.0 MILLION

TO THE

REPUBLIC OF GUINEA

FOR
Guinea Health Service and Capacity Strengthening Project
December 24, 2024

Health, Nutrition & Population
Western And Central Africa

CURRENCY EQUIVALENTS

(Exchange Rate Effective November 30, 2024)

Currency Unit =	Guinea Franc (GF)
GF8,619=	US$1
US$1.31=	SDR 1

FISCAL YEAR
July 1 - June 30

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ABBREVIATIONS AND ACRONYMS

ADM	Accountability and Decision-Making
BCR	Benefit-Cost Ratio
CBA	Cost-Benefit Analysis
CHW	Community Health Worker
COVID-19	Coronavirus Disease 2019
CPF	Country Partnership Framework
CRI	Corporate Results Indicator
CRVS	Civil Registration and Vital Statistics
CVA	Contractualization and Verification Agency
DALY	Disability-Adjusted Life Year
DHD	District Health Directorate
DHIS2	District Health Information Software 2
DHS	Demographic and Health Survey
EVD	Ebola Virus Disease
FCV	Fragility, Conflict, and Violence
FGM	Female Genital Mutilation
FM	Financial Management
GFF	Global Financing Facility
GBV	Gender-Based Violence
HRH	Human Resource for Health
HNP	Health, Nutrition, and Population
ICR	Implementation Completion and Results Report
IDA	International Development Agency
ISR	Implementation Status and Results Report
IRI	Intermediate Results Indicator
IRR	Internal Rate of Return
M&E	Monitoring and Evaluation
MOHPH	Ministry of Health and Public Hygiene
MTR	Mid-Term Review
NGO	Non-Governmental Organization
NPV	Net Present Value
NHDP	National Health Development Plan
OP/BP	Operational Policy/Bank Procedure
PAD	Project Appraisal Document
PCU	Project Coordination Unit

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PDO	Project Development Objective
RBF	Results-Based Financing
RHD	Regional Health Directorate
RMNCH	Reproductive, Maternal, Neonatal, and Child Health
TOC	Theory of Change
TTL	Task Team Leader
UNICEF	United Nations Children's Fund
USR	Unified Social Registry
WHO	World Health Organization

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DATA SHEET

BASIC DATA

Product Information

Operation ID P163140	Operation Name Guinea Health Service and Capacity Strengthening Project
Product Investment Project Financing (IPF)	Operation Short Name Guinea Health Project
Operation Status Closed	Approval Fiscal Year 2018
Original EA Category Partial Assessment (B) (Approval package - 25 Apr 2018)	Current EA Category Partial Assessment (B) (Restructuring Data Sheet - 08 May 2023)

CLIENTS

Borrower/Recipient Ministry of Economy and Finance	Implementing Agency Ministry of Public Health and Hygiene

DEVELOPMENT OBJECTIVE

Original Development Objective (Approved as part of Approval Package on 25-Apr-2018)

Improve the utilization of reproductive, maternal, neonatal and child health services in target regions

FINANCING

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RESTRUCTURING AND/OR ADDITIONAL FINANCING

Date(s)	Type	Amount Disbursed (US$M)	Key Revisions
28-Jul-2021	Portal	24.20	• Components • Reallocations
08-May-2023	Portal	39.16	• Components • Results • Loan Closing Date Extension • Reallocations • Implementation Schedule

KEY DATES

Key Events	Planned Date	Actual Date
Concept Review	28-Jun-2017	28-Jun-2017
Decision Review	19-Jan-2018	19-Jan-2018
Authorize Negotiations	02-Mar-2018	05-Mar-2018
Approval	25-Apr-2018	25-Apr-2018
Signing	02-May-2018	27-Jun-2018
Effectiveness	22-Aug-2018	24-Dec-2018
ICR/NCO	29-Dec-2024	--
Restructuring Sequence.01	Not Applicable	28-Jul-2021
Restructuring Sequence.02	Not Applicable	08-May-2023
Mid-Term Review No. 01	18-Apr-2022	11-Apr-2022
Operation Closing/Cancellation	30-Jun-2024	30-Jun-2024

RATINGS SUMMARY

Outcome	Bank Performance	M&E Quality
Highly Satisfactory	Satisfactory	Substantial

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ISR RATINGS

No.	Date ISR Archived	DO Rating	IP Rating	Actual Disbursements (US$M)
01	27-Sep-2018	Satisfactory	Satisfactory	0.00
02	11-Dec-2018	Satisfactory	Satisfactory	0.00
03	07-Jun-2019	Moderately Satisfactory	Moderately Satisfactory	1.90
04	19-Dec-2019	Moderately Satisfactory	Moderately Satisfactory	2.53
05	19-Jun-2020	Moderately Satisfactory	Moderately Satisfactory	10.46
06	20-Jan-2021	Moderately Satisfactory	Moderately Satisfactory	20.82
07	21-Sep-2021	Moderately Satisfactory	Moderately Satisfactory	24.94
08	25-Mar-2022	Satisfactory	Moderately Satisfactory	26.79
09	16-Jun-2022	Satisfactory	Satisfactory	31.52
10	20-Dec-2022	Satisfactory	Satisfactory	36.65
11	21-Jun-2023	Satisfactory	Satisfactory	43.26
12	27-Nov-2023	Satisfactory	Moderately Satisfactory	49.74
13	20-May-2024	Highly Satisfactory	Satisfactory	51.88

SECTORS AND THEMES

Sectors

Major Sector	Sector	%	Adaptation Co-benefits (%)	Mitigation Co-benefits (%)
FY17 - Health	FY17 - Health	42	0	3
	FY17 - Public Administration - Health	49	0	0
FY17 - Social Protection	FY17 - Social Protection	9	0	0

Themes

Major Theme	Theme (Level 2)	Theme (Level 3)	%
	FY17 - Climate change	FY17 - Mitigation	1

FY17 - Environment and Natural Resource Management	FY17 - Energy	FY17 - Access to Energy	6
FY17 - Human Development and Gender	FY17 - Gender		29
	FY17 - Health Systems and Policies	FY17 - Health Finance	49
		FY17 - Health Service Delivery	100
		FY17 - Health System Strengthening	100
FY17 - Social Development and Protection	FY17 - Social Protection	FY17 - Social Safety Nets	13

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ADM STAFF

Role	At Approval	At ICR
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I. PROJECT CONTEXT AND DEVELOPMENT OBJECTIVES

A. CONTEXT AT APPRAISAL

Context

1. Guinea was among the poorest countries in the world (ranked 182 out of 188 countries on the Human Development Index in 2014), with about half of its population living in poverty. Political instability, insecurity, and governance challenges had limited its potential for growth and shared prosperity. Guinea also suffered from inadequate infrastructure and services for poor households, low agricultural productivity, and low human capital.

2. Health outcomes were among the lowest globally. In 2017, life expectancy was 59 years, the under-five mortality rate was 108 per 1,000 live births, and the maternal mortality ratio was 572 per 100,000 live births.[1] Additionally, in 2016, the total fertility rate was 4.8 children per woman and 37 percent of women aged 20-24 years had given birth at least once before the age of 18.[2] Furthermore, in 2016, 8 percent and 15 percent of children suffered from moderate acute malnutrition and severe stunting, respectively, nationwide.[2]

3. These outcomes were due to low utilization of reproductive, maternal, neonatal, and child health (RMNCH) services. For example, nationwide, only 35 percent of women aged 15-49 and 33 percent of children under five who experienced an illness used health services in 2012.[3] Moreover, only 8 percent of women aged 15-49 used modern contraception, 51 percent of pregnant women attended four or more antenatal visits, 57 percent of women delivered in health facilities, and 10 percent of women and 19 percent of newborns received postnatal care within a day of birth in 2016.[2] Additionally, only 26 percent of children aged 12-23 months received all recommended vaccines in 2016 and 41 percent of children aged 6-59 months received vitamin A every six months in 2012.[2,4]

4. Determinants of the low utilization of RMNCH services on the supply side included:

a. **Weak decentralized decision-making authority.** Regional Health Directorates (RHDs), District Health Directorates (DHDs), and health facilities were granted autonomy only theoretically. Therefore, their ability to locally recruit, deploy, supervise, and provide continuous training to health workers was severely limited. In some regions, including the project's target regions, Kankan and Kindia, no health facility benefitted from supportive supervision.

b. **Inadequate and inefficient financing.** Except during the Ebola Virus Disease (EVD) epidemic, the health sector received a maximum of three percent of the national budget, and the Ministry of Health and Public Hygiene (MOHPH) executed only half of its budget. Moreover, public health spending supported centralized bureaucracy and salaries, leaving little for priority health programs. As a result, the few available free health service programs were ineffective. Efforts to introduce mandatory health insurance for public employees had yet to become operational. A national agency was set up in 2014 to establish universal health coverage, but it was not fully functional.

c. **Dysfunctions within the health system.** Community health services were not functional due to a lack of (i) operationalization of the community health strategy, (ii) community health workers (CHWs), (iii) community relays, and (iv) funding (only development partners financed community health). Additionally, health facilities in the target regions lacked essential elements for proper operation, functioning at an average capacity of only 45 percent. This

[1] World Bank Group. World Development Indicators. https://databank.worldbank.org/source/world-development-indicators.
[2] Republic of Guinea. Ministry of Planning and International Cooperation National Institute of Statistics. Multiple Indicator Cluster Survey. 2016.
[3] Republic of Guinea. Ministry of Planning and Economic Development. National Institute of Statistics. 2012 Lightweight Poverty Assessment Survey.
[4] Republic of Guinea. National Institute for Statistics. Demographic and Health Surveys (DHS) 2012.

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was due to factors such as the availability of essential amenities, equipment, drugs, standard precautions for infection control, and diagnostic capacity.[5] Operational capacities of health facilities in urban areas were higher than those in rural areas.[5] For instance, only one percent of health facilities in rural areas, compared to 22 percent in urban areas, had all the key diagnostic capacity indicators such as hemoglobin testing, malaria diagnostics, and pregnancy testing.

d. **Limited and inequitable distribution of human resources for health (HRHs) and lack of incentives for quality improvement.** HRHs (physicians, nurses, midwives, and technical health agents) were concentrated in Conakry. HRHs in the target regions left their posts vacant while still receiving salaries, and many remained unemployed.[6,7,8] This is in part because HRHs deployed to these regions were recruited from the capital. Additionally, HRH absenteeism, which could be two to three days per month, disrupted service delivery.[9]Furthermore, Guinea had only 0.20 physicians, nurses, and midwives per 1,000 people, far below the standard of 4.5 per 1,000 people required for adequate essential health service coverage.[1,10] Yet, the country had not recruited HRHs in 10 years. Moreover, many of the HRHs were volunteers, undermining the stability and quality of care.

e. **The impact of the EVD epidemic.** The EVD epidemic had disrupted the health system and worsened poverty. The number of physicians per 1,000 people dropped from 0.163 in 2014 to 0.082 in 2016, while the number of nurses and midwives per 1,000 people fell from 0.56 to 0.12 during the same period.[11] Due to the highly infectious and deadly nature of EVD, the population was hesitant to seek health care, resulting in preventable deaths from conditions that could have been treated through essential health services. There was a strong fear of the health system because the community perceived health personnel and humanitarians as conducting human experimentation and health facilities as places associated with a high risk of death.

5. Determinants of the low utilization of RMNCH services on the demand side included:

a. **Financial barriers.** Out-of-pocket expenditures accounted for 65 percent of health expenditures in 2017, in a country where nearly half of the population lived in poverty (55 percent in 2012).[3,12] Moreover, 35 percent of individuals who reported a health issue but did not require hospitalization chose not to seek care due to financial constraints.[3] This was due to the ineffectiveness of the few existing free health care programs.

b. **Geographical barriers.** More than 11 percent of individuals who reported a health issue but did not require hospitalization chose not to seek care because of the distance from their home to the nearest health facility.[3] This percentage was higher in rural areas (16 percent) compared to urban areas (1 percent).

c. **Lack of community awareness.** Among individuals who reported a health problem that did not lead to hospitalization, 26 percent self-medicated and 29 percent did not seek care because they believed it was unnecessary.[3]

[5] Republic of Guinea. National Institute for Statistics. Service Availability and Readiness Assessment (SARA) 2017.
[6] République de Guinée et Union Européenne. Rapport de mission. Élaboration d'un diagnostic des ressources humaines dans une perspective de gestion décentralisées. Octobre-novembre 2015.
[7] Institut de médecine tropicale d'Anvers, Belgique, et Centre de formation et de recherche en santé rurale de Maferinyah/Ministère de la Santé, Guinée. Analyse situationnelle du personnel de santé et des établissements de formation pour le renforcement du système de santé afin de guider la coopération au développement entre la Belgique et la Guinée. Rapport de Recherche. Version 1.4 du 21 mai 2017.
[8] Jansen C, Codjia L, Cometto G, et al. Realizing universal health coverage for maternal health services in the Republic of Guinea: the use of workforce projections to design health labor market interventions. Risk Management and Healthcare Policy. 219-232. 2014.
[9] Witter S, Herbst CH, Smitz M, et al. How to attract and retain health workers in rural areas of a fragile state: Findings from a labour market survey in Guinea. Plos One. 16(12), e0245569. 2021. (data collected from December 2017 to January 2018)
[10] World Health Organization (WHO). Health workforce requirements for universal health coverage and the sustainable development goals. 2016. https://iris.who.int/bitstream/handle/10665/250330/9789241511407-eng.pdf?sequence=1&isAllowed=y.
[11] World Bank Group. World Development Indicators. https://databank.worldbank.org/source/world-development-indicators.
[12] WHO. Global Health Expenditure Database. https://apps.who.int/nha/database/Select/Indicators/en.

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6. Some of these determinants, especially the lack of recruitment and training of civil HRHs, their inequitable distribution, and the absence of water infrastructure, are typical of fragile contexts where basic needs take priority. The Project Appraisal Document (PAD) highlighted that although Guinea was not on the World Bank's harmonized list of fragile situations, it was classified as an "exceptional FCV [fragility, conflict, and violence] regime" under the 2018 International Development Association. This is because of increasing risks of FCV (stemming from lack of confidence in state institutions) and the government's commitment to addressing these challenges.[13]

7. The National Health Development Plan (NHDP) 2015-2024 addressed the aforementioned needs of the health sector.[14] The NHDP identified three priority issues for the health sector: (i) high maternal, neonatal, and child mortality rates; (ii) high prevalence of communicable, epidemic-prone (e.g., EVD, meningitis, cholera, and measles), and non-communicable diseases; and (iii) poor health system performance, characterized by limited access to quality essential health services, underfunding by the government, inadequate and poorly distributed health care workforce, lack of quality medicines and medical supplies, insufficient real-time health data for decision-making, and weak organization and management of health services. To address these issues, the NHDP focused on three strategic areas for policy interventions: (i) strengthening the prevention and management of diseases and emergencies; (ii) promoting the health of mothers, children, adolescents, and the elderly; and (iii) strengthening the national health system.

8. The health objectives of the Country Partnership Framework (CPF) 2018-2023 were developed in alignment with the NHDP and the Project Development Objective (PDO) was fully consistent with both the NHDP and CPF. The CPF included two health objectives: (i) Objective 2: Decentralization of service delivery, including health and education, and better engagement of citizens and (ii) Objective 5: Improved health and social protection, especially in rural areas. Furthermore, the financial gaps in achieving RMNCH objectives outlined in the NHDP were most significant in the Kankan and Kindia regions, which accounted for one-fourth of the population and were characterized by poverty and poor health outcomes. Kindia and Kankan ranked second and third in their contribution to national poverty, respectively.[3] Consequently, the project targeted these critical regions to strengthen RMNCH service delivery and utilization at the district level and below, based on the minimum package of services defined in the NHDP, thereby contributing to both the NHDP and CPF. Considering the fragility of the country, the project aimed to strengthen the health system and address critical and urgent gaps and capacity constraints.

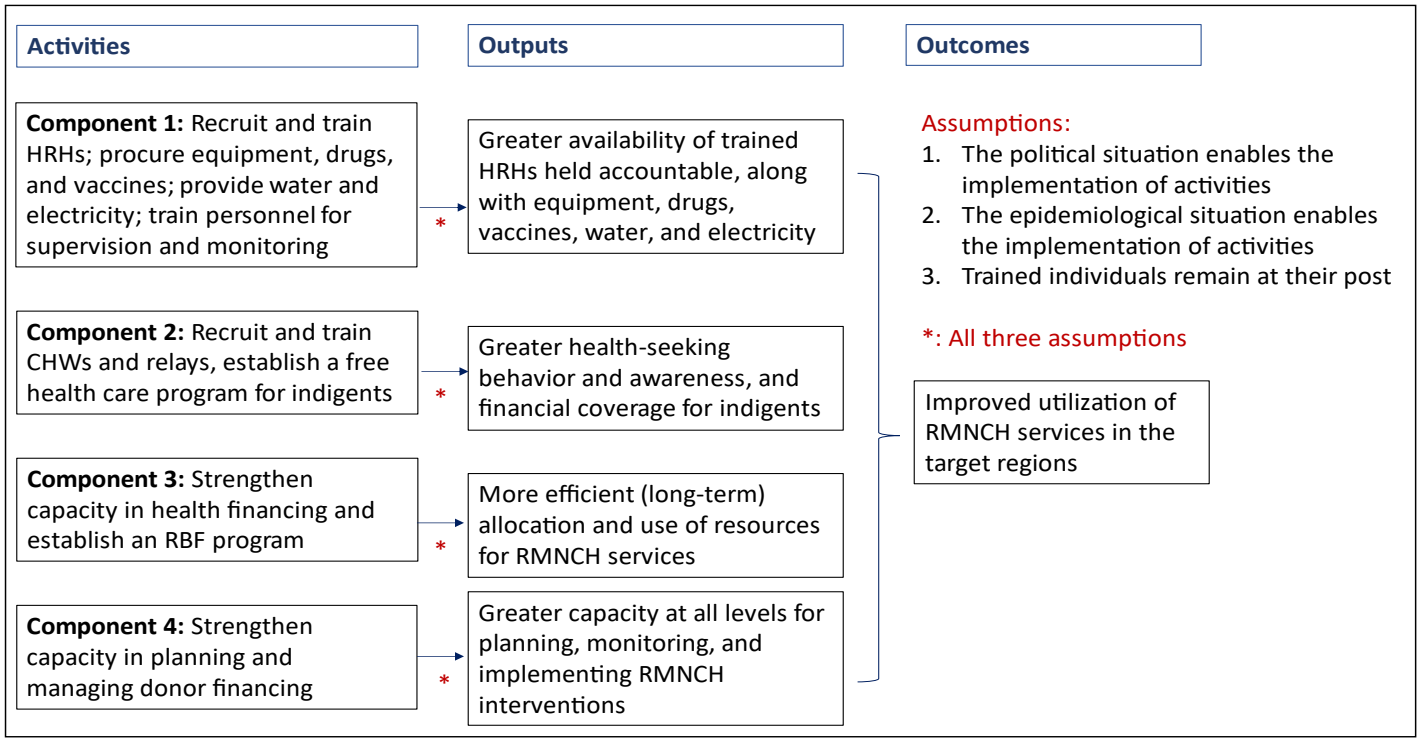
Theory of Change (Results Chain)

9. The Theory of Change (TOC), as detailed in the PAD, is illustrated in Figure 1. The key assumptions were added by the authors of the Implementation Completion and Results Report (ICR). The TOC outlines activities needed to address supply- and demand-side barriers to RMNCH service utilization, previously described, while accounting for the country's fragility.

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[13] World Bank. IDA 2018. Special Theme: Fragility, Conflict, and Violence. IDA Resource Mobilization Department (DFiRM) May 31, 2016. https://worldbankgroup.sharepoint.com/sites/WBFinance/Knowledge%20Base/IDA%2018_2%20Fragility%20Conflict%20and%20Violence%20Special%20Theme.pdf.
[14] Republic of Guinea. MOHPH. Plan National de Développement Sanitaire (PNDS) 2015-2024. https://portail.sante.gov.gn/wp-content/uploads/2022/08/Plan_National-de-D%C3%A9veloppement-Sanitaire-2015-2024-Ao%C3%BBt-2015.pdf.

Figure 1. Project's TOC



RBF: results-based financing

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PDO

10. The PDO stated in the PAD was identical to that in the Financing Agreement: To improve the utilization of RMNCH services in target regions.

Key Expected Outcomes and Outcome Indicators

11. The following five PDO indicators were measured in absolute numbers: (i) Deliveries assisted by trained health personnel, (ii) Pregnant women who received four antenatal care visits, (iii) Children (0-11 months) fully vaccinated, (iv) Children (6-11 months) receiving vitamin A supplementation every six months, and (v) Women who have received modern contraception.

Components

12. The project was financed by an International Development Agency (IDA) credit (US$22.50 million), an IDA grant (US$22.50 million), and a Multi-Donor Global Financing Facility (GFF) grant (US$10.00 million), totaling US$55.00 million at signing and US$52.13 million at closing due to exchange rate fluctuations. The amount disbursed was US$52.13 million (IDA-US$42.27 million, GFF-US$9.86). The amount absorbed was US$52.07 million, representing 99.90 percent of the total. As of the time of the writing of the ICR, the remaining amount had not been reimbursed. No borrower financing was planned or provided. Costs per component and subcomponent changed throughout the project, as explained in section I.B.

13. The project comprised four complementary components, described below.

14. Component 1: Strengthen supply of basic RMNCH services in target regions (estimated: IDA-US$12.00 million, GFF-US$5.00 million; absorbed: IDA-US$18.36 million, GFF-US$7.71 million). This component aimed to support the delivery of a basic RMNCH service package at the district level and below and empower decentralized authorities to implement services and strengthen their financing, supervision, and monitoring capacities. This was to be achieved by (i) increasing availability of medicines, commodities, and access to water and electricity in health facilities; (ii) strengthening district-level capacity to recruit and improve the competencies of HRHs; and (iii) strengthening the capacity of DHDs to supervise and monitor RMNCH service delivery.

15. Component 2: Strengthen the demand for basic RMNCH services in target regions (estimated: IDA-US$11.00 million, GFF-US$2.00 million; absorbed: IDA-US$6.80 million, GFF-US$1.33 million). This component aimed to reduce financial barriers for poor people to access services and engage CHWs in demand-generation activities. This was to be achieved by (i) implementing an innovative fee financing scheme to reduce out-of-pocket expenses for indigents and (ii) supporting DHDs in recruiting, training, supervising, and mentoring CHWs for outreach and basic RMNCH service delivery. A more detailed description of the free care program for indigents is provided in Annex 6.

16. Component 3: Strengthen the MOHPH's financing capacity to guide sector reform and long-term transformation (estimated: IDA-US$20.00 million, GFF-US$2.00 million; absorbed: IDA-US$13.44 million; GFF-US$00.29 million). This component aimed to support the government in developing and implementing comprehensive medium- and long-term strategies for health financing and broader service delivery reforms. This was to be achieved by (i) implementing an RBF program in four districts and (ii) building capacity and generating evidence to foster policy dialogue and develop a vision for more comprehensive health financing and service delivery reforms. A more detailed description of the RBF program is provided in Annex 6.

17. Component 4: Strengthen project management, implementation, and donor coordination capacity (estimated: IDA-US$2.00 million, GFF-US$1.00 million; absorbed: IDA-US$3.61 million, GFF-US$0.53 million). This component aimed to (i) finance the recurring costs of the Project Coordination Unit (PCU) and related monitoring and evaluation (M&E) activities and (ii) support the integration of the PCU into a broader donor coordination unit led by the MOHPH.

B. SIGNIFICANT CHANGES DURING IMPLEMENTATION

Revised PDO and Outcome Targets

18. The PDO was not revised.

Revised Indicators

19. In April 2023, the end targets for all PDO indicators were increased (Table 1). The initial end targets were set low due to the impact of the EVD epidemic, including the loss of numerous HRHs, and the fragile state of the country (see rationale for changes below). Changes to intermediate results indicators (IRIs) involved renaming two IRIs, adjusting baselines and end targets for one IRI following renaming, and increasing the end targets for five IRIs and the corporate results indicator (CRI) along with its three sub-indicators, as detailed in Annex 7.

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Table 1. Increases in end targets for the PDO indicators

PDO Indicator (absolute number)	Baseline (2017)	Initial end target (by June 23, 2023)	New end target as of April 27, 2023[a] (by June 30, 2024)
Deliveries attended by trained health personnel	66,544	94,320	595,318
Pregnant women who received four antenatal care visits	77,951	141,479	602,192
Children (0-11 months) fully vaccinated	94,640	136,239	608,026
Children (6-11 months) receiving vitamin A supplementation every six months	11,407	70,740	96,534
Women who have received modern contraception	52,812	117,899	558,629

[a]Date of restructuring effectiveness (countersignature of the notification letters).

Revised Components

20. The components were revised twice as described in Table 2 below. The changes involved (i) cost reallocations across components, (ii) a decrease in the geographical scope of the free care program for indigents, and (iii) the inclusion of activities related to the fourth National Population and Housing Census. The Census activities supported included (i) capacity-building of the staff of the National Institute for Statistics, (ii) payment for fees and transportation costs for field staff during the census mapping and enumeration phases, and (iii) the recruitment of a financial management (FM) specialist to ensure the quality assurance of the FM of the census.

Table 2. Changes to the project's components and associated costs

Components	Changes during the 1st and 2nd level 2 restructurings on July 21, 2021 and April 27, 2023, respectively[a]	Amount (US$ million)		
		Initial	After first restructuring	After second restructuring
Component 1: Strengthen supply of basic RMNCH services in target regions	• 1st restructuring: Increase in the costs of Subcomponent 1.1	**17.00**	**28.00 (+11.00)**	**28.00**
Subcomponent 1.1: Increase availability of drugs, commodities, and access to water and electricity		6.00	17.00 (+11.00)	17.00
Subcomponent 1.2: Strengthen district-level capacity to recruit and improve the competencies of health workers		4.00	4.00	4.00
Subcomponent 1.3: Strengthen the DHD's capacity to supervise and monitor RMNCH service delivery		7.00	7.00	7.00
Component 2: Strengthen the demand for basic RMNCH services in target regions	• 1st restructuring: Decrease in the costs of the two subcomponents • 2nd restructuring: Narrowing of the geographical scope of the	**13.00**	**9.00 (-4.00)**	**8.15 (-0.85)**
Subcomponent 2.1: Implement an innovative district-level fee-financing scheme to mitigate out-of-pocket expenses for indigents		8.00	5.00 (-3.00)	1.90 (-3.10)

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Subcomponent 2.2: Support the DHD recruitment, training, supervision, and mentoring of CHWs for outreach and basic RMNCH service delivery	free care program for indigents (Subcomponent 2.1) from ten to four districts and expansion of the activities of Subcomponent 2.2. This induced a reallocation of funds to reflect the new costs estimates of the activities	5.00	4.00 (-1.00)	6.25 (+2.25)
Component 3: Strengthen the MOHPH's health financing capacity to guide sector reform and long-term transformation	• 1st restructuring: Decrease in the costs of the two subcomponents • 2nd restructuring: ○ Decrease in the costs of Subcomponent 3.1. ○ Inclusion of activities related to the fourth National Population and Housing Census in Subcomponent 3.2, which increased the costs of this subcomponent	**22.00**	**15.00 (-7.00)**	**14.60 (-0.40)**
Subcomponent 3.1: Enhance the quality and quantity of RMNCH services for recipients in selected districts		17.00	11.00 (-6.00)	5.00 (-6.00)
Subcomponent 3.2: Strengthen the capacity of the MOHPH in health financing and development of long-term reform strategies		5.00	4.00 (-1.00)	9.60 (+5.60)
Component 4: Strengthening project management, implementation, and donor coordination capacity	• 2nd restructuring: Increase in costs	**3.00**	**3.00**	**4.25 (+1.25)**
Total		**55.00**	**55.00**	**55.00**

[a]Dates of restructuring effectiveness (countersignature of the notification letters).

Other Changes

21. During the second level 2 restructuring, the closing date was extended from June 27, 2023 to June 30, 2024, the deadline for withdrawal applications was extended to October 30, 2024, and a reallocation between disbursement categories was implemented.

Rationale for Changes and Their Implication on the Original TOC

First Restructuring

22. The objective of the first restructuring was to address an US$11 million overrun under Subcomponent 1.1. The activities of this subcomponent were more expensive than originally estimated during project appraisal due to several factors. These factors include increases in supply chain disruptions caused by the Coronavirus Disease 2019 (COVID-19) pandemic, the need to comply with the World Bank's climate-related standards for equipment, and a higher-than-expected number of health facilities requiring equipment (water infrastructure for example, see paragraph 24). Funds were reallocated without changing the total project amount, as savings were already made under other subcomponents that had experienced delays and because of one adjustment. More specifically, the US$11 million came from:

a. Subcomponent 2.1: US$3 million. Delays in identifying indigents and producing vouchers reduced the

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implementation period of related activities from the planned four years to two and a half years. Additionally, fewer indigents were identified than initially estimated – 162,729 instead of 175,115 (the target was 150,000 but program costs were calculated conservatively based on the total estimated indigent population of 175,115 in the target regions).

b. Subcomponent 2.2: US$1 million. Due to delays in project effectiveness and training, salary payments for 585 community relays and 261 CHWs started in September 2020 instead of one year after the project's effectiveness (within three months of contract signing).

c. Subcomponent 3.1: US$6 million. The launch of the RBF program was delayed until February 2021, primarily due to setbacks in the appointment of government officials. These appointments, necessary for signing contracts and establishing the RBF national coordination unit, were delayed by civil unrest and the 2020 presidential election. As a result, payments for the RBF program national coordination unit, contractualization and verification agencies (CVAs), and subsidies were postponed.

d. Subcomponent 3.1: US$1 million. The plan to create an Economic Unit within the MOHPH and recruit an agency to train its staff and develop key documents was not realized. By April 2021, the government had yet to establish the unit, and the funds were reallocated for other purposes.

Second Restructuring

23. The objective of the second restructuring was to (i) expand the project's scope in light of its achievements, (ii) address issues with the free care program for indigents, (iii) adjust costs across components, and (iv) respond to the government's request to include activities that support the fourth National Population and Housing Census. The project's closing date was extended by one year to allow sufficient time to complete ongoing activities, in light of the new targets, and the newly added Census activities. Changes to withdrawal applications and reallocation of disbursement categories were made to align with the extended closing date. The rationale for the main changes is detailed below:

a. **Increase in scope.** At the time of restructuring, the end target for all PDO indicators and nine out of 12 IRIs (75 percent), including the indicator for free care program for indigents, had been achieved or surpassed. The baseline figures for project indicators reflected the post-EVD health system disruption (see section I.A), and the initial end targets were very conservative due to political and epidemiological risks. However, the project quickly improved health outcomes in the target regions. Except for the free care program for indigents, all end targets were adjusted to account for additional beneficiaries the project could reach by the extended closing date.

b. **Adjustments to the free care program for indigents.** Several issues related to this program, detailed in section III, were noted during the mid-term review (MTR) mission, including the production of non-compliant invoices by some health facilities (37 percent of invoices) or the lack of sufficient supporting documentation. Limiting the free care program for indigents to the four districts covered by the RBF program was therefore deemed appropriate to improve implementation, including fiduciary and accountability aspects. Indeed, there was already a culture of performance in these districts due to the RBF program's audit and sanction mechanisms at the community health, health facility, and district levels with regards to the management of registries and invoices. Although the program was restricted to these districts from the third quarter of 2022, the changes were formalized during the restructuring. Consequently, the corresponding indicator was formally adjusted during the restructuring.

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c. **Adjustments to costs.**

i. Subcomponent 2.1: -US$3.10 million. Savings were realized due to delays in implementing the free care program for indigents, caused by the 2021 coup and the lack of recruitment of non-governmental organizations (NGOs) to verify services provided to indigents. Cost reductions were based on actual disbursements and projected costs for the remaining implementation period, with most savings reallocated to Subcomponent 2.2.

ii. Subcomponent 2.2: +US$2.25 million. Additional funds were required to cover health workforce salaries and their activities, given the project's extended closing date.

iii. Subcomponent 3.1: -US$6 million. Savings remained after accounting for actual and projected disbursements. Following its launch in early 2021, the RBF program was also impacted by the 2021 coup, further reducing expenditures. Most savings were reallocated to Subcomponent 3.2.

iv. Subcomponent 3.2: +US$5.6 million. The government requested an additional US$5.6 million to address a financing gap for the Census.

v. Component 4: +US$1.25 million. Remaining savings from other components were allocated to Component 4 to cover the PCU's operating costs, including salaries and supervision activities, for the remaining implementation period.

24. The second restructuring was also an opportunity to revise IRIs related to water access and health workers to better capture project activities. Firstly, the indicator "Proportion of health centers with access to water" was renamed "Proportion of health centers with access to water supply powered by solar energy" to indicate that the project installed solar-powered water supplies, not just regular boreholes. A baseline assessment conducted during the project's preparation revealed that 86 out of 121 health facilities in the target regions had access to water, leaving 35 health centers without it. The project aimed to provide water to 23 of these health centers, bringing the total number of centers with water access to 109. The baseline and end target were therefore set at 71 percent (86 centers) and 90 percent (109 centers), respectively. However, in 2019, an MOHPH mission found that 81 centers lacked access to water or had non-functional systems, including the original 23. Thus, it was decided that the project would provide water to these 81 centers, resetting the baseline to 0 percent and the end target to 100 percent. Secondly, the indicator "Number of health facility health workers trained in RMNCH competencies" was renamed "Number of health facility health workers recruited and trained in RMNCH competencies" to reflect the project's role in both recruiting health workers and covering their salaries.[15]

25. Section III provides additional details on implementation issues that led to both restructurings.

26. The changes addressed the country's needs, mitigated the negative impacts of various factors (see section III), and ensured the project was impactful and efficient. These changes supported the PDO without affecting the TOC.

[15] In the Implementation Status and Results Report (ISR) nº 10, the task team also corrected the values for the CRI "People who have received essential HNP services" and its three sub-indicators to comply with the requirement that corporate indicator baselines should be set to 0. Thus, the baselines were set to 0 and the other values were adjusted accordingly. These changes did not require formal restructuring, but were later recorded in the second restructuring paper. Moreover, during the second restructuring, other modifications were made to the CRI and its sub-indicators to accommodate the revisions made to the non-CRIs used for their calculation.

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II. OUTCOME

A. RELEVANCE OF PDO

Assessment of Relevance of PDO and Rating: High

27. At appraisal, the project was highly relevant, given the health sector challenges and health outcomes outlined in section I.A. The PDO was aligned with the NHDP 2015-2024, which focused on improving the health of mothers, children, and adolescents, among others. The project targeted regions with significant financial gaps in achieving the NHDP's RMNCH objectives and focused on the minimum package of services defined in the NHDP. NHDP indicators included the neonatal mortality rate, under-five mortality rate, stunting prevalence (which can be addressed through vitamin A supplementation), and maternal mortality ratio. Health-related indicators of the CPF included "Proportion of frontline health facilities with increased financing for operational expenses", "Increased rate of satisfaction with governmental basic services (health, basic education, and justice)", "Share of children fully vaccinated", and "Share of deliveries assisted by trained health personnel." The PDO was also aligned with the CPF 2018-2023, which aimed to decentralize service delivery, including health and education, improve citizen engagement (under Objective 2), and improve health and social protection, especially in rural areas (under Objective 5). Indicators under Objective 2 included the "Proportion of frontline health facilities with increased financing for operational expenses" and "Increased rate of satisfaction with governmental basic services (health, basic education, and justice)"; and indicators under Objective 5 included the "Share of children fully vaccinated" and "Share of deliveries assisted by trained health personnel." Interventions to be carried out included strengthening district level capacity to train, deploy, and supervise health workers; strengthening local financing for pharmaceuticals and supplies, including contraceptive supplies and other requirements for maternal health; and improving accountability systems and available data for monitoring and planning efforts.

28. At project closing, the NHDP 2015-2024 and CPF 2018-2023 were still in effect and the PDO had not changed, remaining fully aligned with both frameworks and therefore highly relevant. The project continued to target two of the critical regions identified in the NHDP and provided financing for health facility operational expenses. It also supported an RBF program to increase funding and autonomy for health facilities, in line with the NHDP and the CPF objectives. All PDO indicators were directly linked to the NHDP and CPF objectives, with two (deliveries assisted by trained health personnel and children fully vaccinated) overlapping with CPF indicators.

29. At closing, the project also aligned with the Guinea Interim Reference Program 2022-2025, which is consistent with the NHDP. Universal access to health services is central to the fourth Pillar of the Interim Reference Program, "social action, employment, and employability." The two key indicators for this pillar are maternal mortality ratio and under-five mortality rate. The pillar comprised eight health-related activities: (i) improving access to quality medications, vaccines, blood, infrastructure, equipment, and other health care technologies; (ii) developing high-quality human resources; (iii) developing the health information system and health research; (iv) ensuring adequate financing of the sector for universal access to health care; (v) promoting maternal, child, adolescent, and elderly health; (vi) strengthening disease prevention, management, and emergency health response; (vii) enhancing health care provision and services, especially at the prefectural and community levels; and (viii) strengthening leadership and health care governance. These activities mirror those of the project (see section I.A) and align with the project's TOC. They are reflected in all PDO indicators and IRIs.

30. In June 2021, the Performance and Learning Review led to changes in the CPF, but these did not affect the high relevance of the project, which remained strongly aligned with the CPF.

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a. Objective 2 of the CPF was slightly reworded from "Decentralization of service delivery, including health and education, and better engagement of citizens" to "Strengthened social sector systems through decentralization of service delivery." Nevertheless, the project's objective – to improve decision-making and financial autonomy at the decentralized level for increased utilization of RMNCH services – remained consistent with the new wording. The indicators for this objective were also adjusted due to data availability issues. "Proportion of frontline health facilities with increased financing for operational expenses" was replaced with "Local Governments' National Local Development Fund investment budget execution rate." The old and new indicators addressed the same development challenge: promoting financial autonomy at the decentralized level. Additionally, "Increased rate of satisfaction with the government's provision of basic services (health, basic education, and justice)" was replaced by "Reported risks of conflict addressed by early warning and response system." According to the CPF, in the health sector, this indicator was linked to the RBF program, which was a central part of the project until its closure. Moreover, the change made to this indicator did not impact the link between the PDO (increased RMNCH services at the regional level) and Objective 2 (decentralization of health services).

b. The project contributed to fighting the COVID-19 pandemic (a priority for the government) by providing personal protective equipment to health workers, helping prevent infections, and ensuring the continuity of essential health services. This was important, given the experience with the EVD epidemic, during which many health workers abandoned their posts for fear of infection. Moreover, a study conducted in Conakry highlighted the pandemic's negative impact on RMNCH services, including declines in first antenatal visits, tetanus vaccination coverage among pregnant women, vaccination coverage of children under five years, artemisinin-based combination therapy for children under five with fever, and distribution of long-lasting insecticide-treated nets.[16] Stakeholders interviewed for the study also reported increased shortages of technical, diagnostic, and therapeutic resources during the pandemic. Consequently, the PDO remained aligned with efforts to combat the pandemic, and no changes were deemed necessary.

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B. ACHIEVEMENT OF PDO (EFFICACY)

Assessment of Achievement of Each Objective/Outcome: High

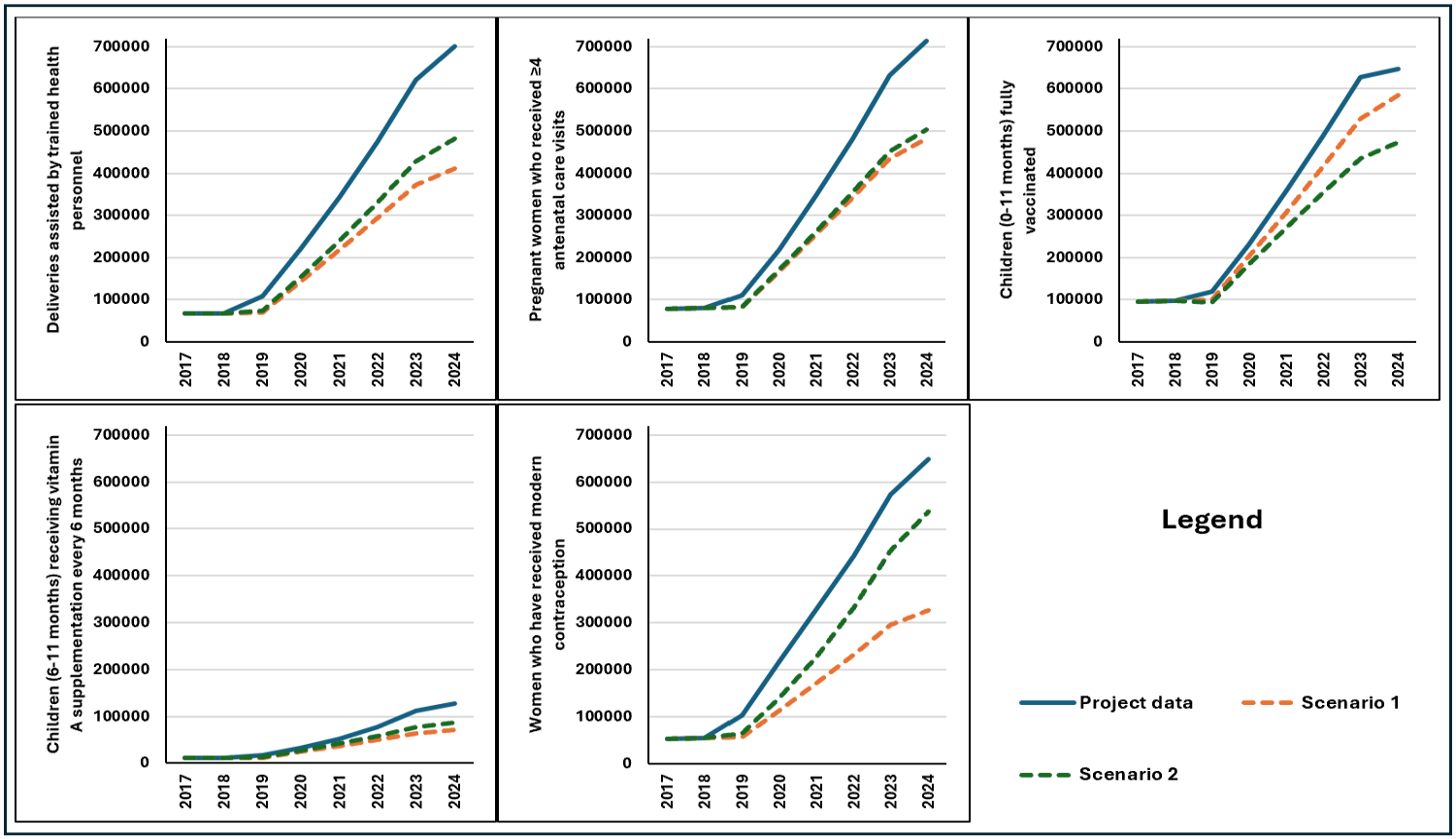
31. The project had one PDO – to improve the utilization of RMNCH services in target regions – and it was highly successful in achieving this objective. The project was implemented in Kankan and Kindia, regions chosen for their high poverty levels, poor health outcomes, and significant financial gaps in achieving the RMNCH objectives in the NHDP. These two regions accounted for one-fourth of the population. As discussed in section IV, a robust M&E system was established to inform the results framework, with primary data collected to ensure completeness and accuracy, and PDO indicators adequately measuring the utilization of RMNCH services. As shown in figure 1, the values of all PDO indicators steadily increased throughout the project after its effectiveness in December 2018. As of June 30, 2024, all PDO indicators had exceeded their revised (increased) end targets. The achievement rates were as follows (see Annex 1 for details):

a. Number of deliveries assisted by trained health personnel: 120%
b. Number of pregnant women who received four antenatal care visits: 121%
c. Number of children (0-11 months) fully vaccinated: 118%
d. Number of children (6-11 months) receiving vitamin A supplementation every six months: 136%
e. Number of women who received modern contraception: 118%.

[16] Republic of Guinea and World Bank Group. (2021). Factors of discontinuity of essential reproductive, maternal, neonatal, child and adolescent health, and nutritional services due to COVID-19 in Guinea.

32. In simulations modeling scenarios where the project was not implemented, the values of the PDO indicators were lower than those observed with the project in place. In the first scenario, a 2.77 percent population growth was applied to the 2017 baselines (estimated through health facility data). This scenario is overly optimistic and highly improbable, assuming sufficient annual financing to sustain pre-project outcomes despite population growth and the rising health needs. Moreover, as mentioned below, the community health strategy was financed only by development partners, which hinders demand generation activities. The scenario also fails to account for disruptions by the COVID-19 pandemic and the coup, which resulted in health facility bank accounts being frozen. Notably, the COVID-19 pandemic's significant impact on Conakry (a region with lower poverty and higher per capital health expenditures), as noted in the relevance section, suggests that, without the project, RMNCH service utilization in Kankan and Kindia would have been severely disrupted. In the second scenario, the average trend in RMNCH service utilization, derived from the 2012 DHS, 2016 MICS, and 2018 DHS (and the 2021 Malaria Indicator Survey for antenatal care visits) was applied to the 2017 baselines. This scenario is also overly optimistic and highly improbable as it does not account for growing health needs, the limited government financing, the COVID-19 pandemic, or the coup. Moreover, it assumes financial support from development partners was evenly distributed across the country, including Kankan and Kindia, when in reality, these regions received financing far below their needs, despite their high poverty levels.

Figure 1. Evolution of the PDO indicators



Cumulative numbers
Scenario 1: Application of a 2.77 percent population growth to the 2017 baselines (estimated trough health facility data)
Scenario 2: Application of the average tendency in utilization of RMNCH services between the results of the 2012 DHS, 2016 MICS, and 2018 DHS (and the 2021 Malaria Indicator Survey for antenatal care visits) to the 2017 baselines (estimated trough health facility data)

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33. Other simulations were limited by a lack of reliable data on PDO indicators or comparable metrics across regions during the project. The most recent surveys available were the 2018 DHS and the 2021 Malaria Indicator Survey. The 2018 DHS was produced before the project was implemented. Moreover, the 2021 Malaria Indicator Survey only partially overlaps with the project period, as not all key activities had been launched, and it provides relevant data only on antenatal care visits. Additionally, the national health information system (the District Health Information Software 2 [DHIS2]) was not a reliable source of data for the comparison, as highlighted in the M&E section. The project supported the health information system at the central level and in Kankan and Kindia only. Therefore, using DHIS2 data for other regions would have produced inaccurate estimates.

34. Data on the RBF program corroborate the increased utilization of RMNCH services. From 2021 to 2023, RMNCH services covered by the RBF program were provided a total of 1,795,925 times, including 199,910 instances in hospitals and 1,596,015 in other health facilities. Table 3 presents key RBF indicators aligned with the PDO indicators. For example, the number of deliveries performed in a health facility by a qualified heath personnel and monitored using a partograph rose from 10,320 in 2021 to 12,317 in 2022, and 27,876 in 2023 in the four districts where the RBF program was implemented. Similarly, the number of pregnant women who attended at least four prenatal visits, including the final visit during the last month of pregnancy, increased from 12,583 in 2021 to 14,168 in 2022, and 117,428 in 2023. All indicators demonstrated consistent growth during the 2021-2023 implementation period of the RBF program.

Table 3. Key RBF indicators linked to the PDO indicators

RBF indicators	2021	2022	2023	Total
Number of deliveries performed in a health facility by qualified health personnel and monitored using a partograph	10,329	12,317	27,876	50,522
Number of pregnant women who attended at least four prenatal visits, including the last one during the final month of pregnancy	12,583	14,168	117,428	144,179
Number of children aged 0–11 months fully vaccinated before their first birthday during the period	14,790	14,738	26,274	55,802
Number of children under 5 years old who received vitamin A supplementation during the period	7,455	19,553	29,201	56,209
Number of new users of modern short- and long-acting contraceptive methods	6,446	13,47	19,315	39,231
Number of pregnant women who received at least one prescription of Sulfadoxine-Pyrimethamine for intermittent preventive treatment of malaria during the period	20,971	29,493	59,673	110,137

35. The perspectives of the direct and indirect beneficiaries also highlight the project's efficacy.[17,18] A nurse reported that before the project, "water and electricity were major concerns, making it very difficult to work under good conditions. Nursing staff had to fetch water from miles away." A physician added, "We didn't have enough money to buy water, and we had to wait for hours at the supply point because it was too crowded." Another physician emphasized how the lack of medicines, water, and electricity "was an ordeal, not only for the patients, but also for the health center." The nurse further explained that "midwives used flashlights to illuminate the room during deliveries. When a woman arrived in the middle of the night to give birth, our attention was divided. How could we properly care for a mother and baby with so little light and insufficient water? It was often complicated to save lives under such circumstances. We didn't have enough water to keep our workplace clean or to care for the mother and baby after delivery." Following the project's implementation, a physician, who also served as the head of the health post, reported "it is a real relief to see our activities

[17] Fonds des Nations Unies pour l'enfance (United Nations Children's Fund ; UNICEF). "Les femmes viennent accoucher sans craintes, même la nuit " M'Balou, sage-femme. Grâce au soutien de la Banque Mondiale à travers l'UNICEF, le centre de santé de Karifamoria à maintenant accès à l'eau potable et à l'électricité. 09 février 2023. https://www.unicef.org/guinea/recits/les-femmes-viennent-accoucher-sans-craintes-m%C3%AAme-la-nuit-mbalou-sage-femme.
[18] World Bank Group. Free medical care protects vulnerable families in Guinea. November 20, 2024. https://www.worldbank.org/en/news/feature/2024/11/20/free-medical-care-protects-vulnerable-families-in-guinea.

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improving and to work in better conditions for the well-being of newborns, mothers, and patients. Health standards have really improved. These changes have restored the community's confidence in returning to the health center for treatment and re-motivated our nursing staff." A district hospital director added, "thanks to this project, our practices, methods, and techniques have evolved. The culture of performance and results is now reflected in the attitude of health staff and patient satisfaction, thanks to RBF." Lastly, a direct beneficiary reported that "with my health care card, I no longer pay for care, and my children are monitored regularly. The medical staff is welcoming and warm."

36. The increase in RMNCH service utilization was directly attributable to various investments and activities implemented under the project. These outcomes were tracked through 12 IRIs, 11 of which met or exceeded their targets (see Annex 1). The only exception was the IRI measuring the "Number of health centers under RBF receiving due payments for their results on time."

a. **The project provided necessary commodities, equipment, and human resources.** It installed solar-powered water supply systems in 81 health facilities, provided electricity to 61 health facilities, and delivered essential equipment, including diagnostic tools, furniture, and 10 medical ambulances for referrals (including obstetrical emergencies). The project also supplied medicines, consumables, and vaccines to all 126 health facilities in the target regions. It recruited 399 HRHs (15 physicians, 102 nurses, 100 midwives, and 182 technical health agents) and one statistician. The HRHs underwent further training on specific topics, including reproductive health, nutrition, integrated management of childhood illnesses, primary health care, and essential medicines management. Moreover, 232 CHWs and 2,351 relays were hired, trained, and equipped with motorcycles and other tools. Initially, the plan was to recruit and train 585 community relays (then referred to as CHWs) while expecting other partners to fill additional needs, in alignment with WHO standards. However, following an update to the government's community health strategy, the project recruited the required number of CHWs and relays. These personnel sensitized the population about the use of RMNCH services and offered basic (preventive) RMNCH services. As of June 30, 2024, all health facilities had access to water and electricity, only five percent of facilities experienced stock-outs of tracer medicines exceeding 30 percent, which is lower than the end target of 25 percent, all health facilities offered integrated management of childhood illnesses, and all hired HRHs, CHWs, and community relays were at their post.

b. **The project enhanced the quality of care through supportive supervision, the RBF program, and the entry of health facility data into the DHIS2 for M&E and decision-making.** It provided 170 off-road motorcycles to health facilities (126) and statisticians (44), as well as 12 4x4 vehicles to DHDs and RHDs to reinforce health activity monitoring. The project also improved health information systems, including developing standards and procedures for the DHIS2, migrating historical data to a new server, and aligning RBF indicators with the national health information system. By the end of the project, all health facilities had received at least one supportive supervision session per trimester and submitted their data on time. RBF activities were implemented despite several challenges (see section III), but the indicator remained at zero because payments were delayed. This program helped increase service quality through (i) the development of business plans for better management of health facilities and generation of funds; (ii) better medical records keeping; (iii) constructions and rehabilitations (including medicine storage rooms, parking for cars and motorcycles, and conference rooms); (iv) cleaner health facilities; (v) better patient reception; (vi) increased humanized care with the establishment of individual rooms in some facilities; (vii) installation of air conditioning in some facilities; (viii) the purchase of office furniture; and (ix) proper diagnostics and prescription practices. RBF verification results from 2021 and 2023 showed significant improvements in quality scores: from 50.35 to 74.40 percent for health centers (for care), 60.30 to 82.47 percent for DHDs (for supervision), and 44.45 to 82.30 percent for RHDs (for supervision).

c. **The project addressed financial barriers to RMNCH services by making free health services accessible through the investments previously described and by establishing a program for indigents.** First, by financing the inputs needed

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to deliver the basic package of RMNCH services, as defined in the NDHP, the project ensured that the free health service programs of the government were indeed free of charge for all women of reproductive age and children under five years. The free health service programs of the government included prenatal care and delivery services, such as cesarean sections, and free care for severe malaria cases.[19] Second, as a complementary measure, for services not included in the programs, the project implemented the free care program for indigents by providing vouchers to the most destitute women of reproductive age and children under five years old, enabling them to access health services for free (see annex 7 for more details on the program). In total, 162,729 indigents received vouchers, exceeding the initial target of 150,000. From April 2021 to June 2022, all 162,729 beneficiaries could use their vouchers. From July 2022 (after the MTR) to September 2023, because of the high risk of fraud (submission of falsified invoices by health facilities), 77,774 vouchers were still effective. These were the ones in the four districts covered by the RBF program. Vouchers were only used (i) when individuals required health services and (ii) for services not covered by the free health service programs, which were now free. In total, based on the number of validated invoices, the vouchers were used 11,882 times. Services included consultations, prescriptions for medicines, small surgeries, complementary testing, and hospitalization. Thus, the free care program for indigents also contributed to eliminating financial barriers to health services.

37. The project's efficacy is also evident in the resilience of health facilities in the target regions during the COVID-19 pandemic and the 2021 coup. As mentioned earlier, the COVID-19 pandemic should have disrupted health services. Nonetheless, the consistent improvement in the PDO indicators demonstrates that project interventions enabled health facilities to continue providing RMNCH services through investments in infrastructure and the provision of personal protective equipment for health workers. Moreover, after the coup, authorities froze the bank accounts of public entities, including health facilities, until mid-March 2023. Despite this, the project's investments and the subsidies provided through the RBF program enabled health facilities in the target regions to continue operations during this period. Therefore, the project served as an important source of continuity in service delivery.

38. The project has been instrumental in making the aforementioned improvements singularly. Few partners operated in the target regions, and their financial contributions were significantly smaller. Additionally, other partners focused on narrow aspects of RMNCH services, typically addressing needs in one or two subdistricts over time frames. In contrast, the project took a comprehensive approach, addressing systematic gaps in the health system and implementing sustained interventions.

Justification of Overall Efficacy Rating

39. The end targets for the five PDO indicators were surpassed and 11 (92 percent) out of the 12 IRIs were either achieved or surpassed. The project played a key role in these achievements, including supporting service provision and increasing overall quality of services through the RBF program. It also acted as a critical buffer for maintaining service access for a year and a half following the coup. Without the project's interventions, service delivery would not have been possible. The project also contributed to the fight against the COVID-19 pandemic.

[19] Republic of Guinea. Health financing strategy towards universal health coverage in Guinea. Conakry: Republic of Guinea. 2014.

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C. EFFICIENCY

Assessment of Efficiency and Rating: Substantial

Cost-benefit analysis (CBA) – Rating: High

40. During the project's appraisal, a CBA based on gained productive life-years showed that the project would be a sound investment. This CBA estimated a positive net present value (NPV) of US$51.01 million, indicating that the project's benefits would outweigh its costs. The benefit-cost ratio (BCR) was projected to be 2.01, meaning that for every $1 invested, a return of $2.01 was expected. No internal rate of return (IRR) was calculated.

41. At project closing, another CBA, based on the number of averted disability-adjusted life years (DALYs), showed that investments effectively generated results (see Annex 4 for more details). The NPV was US$152.71 million with a BCR of 3.46, indicating that each US$1 invested through the project yielded an economic return of US$3.46. The IRR was 304 percent, which is substantially higher than the cost of capital in Guinea (3.33 percent). The differences between the two CBAs can be attributed to the PDO indicator values exceeding initial targets by two to seven times, notwithstanding the methodological differences (see the synthesis of the methods of the two CBAs conducted during project appraisal in Annex 4).

42. The benefits of the project extend beyond the CBA results. Not all benefits could be captured. For example, DALYs averted for polio and type B influenza, attributable to the project, were not included in the analysis due to lack of data. Similarly, the PDO indicator "Number of women who have received modern contraception" was excluded because it could not be converted into DALYs, despite 648,852 women receiving modern contraception over the project cycle. Moreover, the economic impact of vitamin A was not fully captured. Children with vitamin A deficiency have 1.43 to 1.64 times the odds of stunting of those without the deficiency.[20] Every 10-percentage point decrease in the prevalence of childhood stunting results in a 3.5 percent increase in adult productivity.[21] Lastly, the number of beneficiaries is underestimated as the number of people who would have benefited from RMNCH services without the project is based only on a 2.77 percent population growth (scenario 1 mentioned in the efficacy section), which is overly optimistic as explained above.

Operational and administrative efficiency – Rating: Substantial

43. Overall, the project was implemented efficiently. It disbursed nearly 100 percent of its budget and achieved its intended results, providing essential funding for RMNCH services that would have otherwise been unavailable. The project scope was also expanded to include new Census interventions, critical for the government since the previous census (conducted in 2014) produced questionable results (see section IV.A on M&E). As a result, the project was extended by one year. This also helped address challenges posed by the COVID-19 pandemic and the 2021 coup, which triggered Operational Policy/Bank Procedure (OP/BP) 7.30 (see section III). Some implementation delays were also caused by i) an eight-month gap between project approval and effectiveness and (ii) a one-and-half-year delay between the expected and actual delivery of essential medicines, vaccines, and equipment to health facilities caused by the supplier. Notably, Component 3 (Strengthen project management, implementation, and donor coordination capacity) accounted for 6.5 percent of the total project costs. The resources allocated to the PCU, whose operational costs were covered under Component 3, were lower than the maximum recommended percentage of the total project cost.

[20] Ssentongo P, Ba DM, Ssentongo AE, et al. (2020). Association of vitamin A deficiency with early childhood stunting in Uganda: A population-based cross-sectional study. PloS One.15(5), e0233615.
[21] The World Bank Group. The Human Capital Index 2020 Update: Human Capital in the Time of COVID-19. Washington DC: World Bank Group; 2020.

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44. Based on the high rate of return on investments and overall substantial implementation efficiency, the project's efficiency is rated as Substantial.

D. Justification OF OVERALL OUTCOME RATING

45. Relevance and efficacy are rated as High, and efficiency is rated as Substantial. Therefore, the project's outcome is considered to be Highly Satisfactory.

E. OTHER OUTCOMES AND IMPACTS

Gender

46. Gender disparities were not assessed during the preparatory and implementation phases of the project. Nonetheless, HRHs, CHWs, and community relays were trained on gender-based violence (GBV) and female genital mutilation (FGM). Following WHO recommendations, community relays were tasked with promoting anti-GBV and anti-FGM behaviors in households and during sensitization campaigns. The relays also recorded all cases of GBV and FGM and transmitted the data to the district and central authorities (none of which were project-related). Furthermore, the GBV specialist from the PCU strengthened the GBV- and FGM-related capacity of the focal point and senior midwife in each district hospital within the target regions.

Institutional Strengthening

47. Institutional strengthening was part of the TOC and was included in Components 3 and 4. The project contributed to the long-term development of the country by:

a. strengthening the capacity of key actors at both the central and decentralized levels in areas such as health financing planning and budgeting, RBF, RMNCH, community health, health information systems, civil registration and vital statistics (CRVS), and M&E. This was accomplished by (i) hiring international and national consultants for close support; (ii) evaluating the RMNCH Strategic Plan 2016-2020, which informed the development of the 2020-2024 plan; (iii) revising key documents, such as the RBF manual, verification tools, and long-term roadmap, as well as the community health strategy; and (iv) organizing study tours;
b. supporting the generation of crucial data by (i) producing national health accounts for 2020 and 2021 and some work on the 2021 and 2022 accounts; (ii) assisting with preparatory work for the Sixth DHS in 2024, and (iii) conducting studies on the national pricing of health services;
c. supporting the launch of the new DHIS2 platform for health data transmission and management; and
d. financing and reviewing a strengths, weaknesses, opportunities, and threats assessment for integrating the PCU into the MOHPH's newly established PCU, which oversees all health projects financed by development partners. Based on the results of the assessment, it was decided to strengthen the capacity of the staff of this new PCU on specific areas before proceeding with the integration.

48. In terms of CRVS, the project helped establish accurate nationwide administrative boundaries and contributed to the enactment of two important laws. These boundaries will enable the country to assign a code to each prefecture, commune, and district in order to (i) facilitate the digitalization of CRVS records; (ii) assign addresses, a prerequisite for introducing personal identification numbers; and (iii) establish a national population registry. The project also assisted in drafting law L019 on the identification of natural persons and law L020 on the civil status system, both passed on October 25, 2023. These laws ensure legal security for Guinean citizens, protect their personal data, and provide the government

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with reliable, constantly updated data for public policy. These laws also lay the groundwork for creating a national register of natural persons and the allocation of personal identification numbers.

49. The project supported the Social Development and Indigence Fund in setting up the Unified Social Registry (USR), an electronic database. This support included (i) acquiring and installing three physical and four virtual servers; (ii) providing technical assistance for the USR's IT system; (iii) transferring the indigent targeting database for the Labé, Faranah, Kankan, and Kindia regions to the USR; (iv) implementing the USR portal; and (v) conducting training sessions for USR personnel.

Mobilizing Private Sector Financing

Not applicable.

Poverty Reduction and Shared Prosperity

50. Although there was no formal evaluation of the project's impact on poverty, it likely contributed to poverty alleviation. The project made the free health service programs effective and provided free access to all RMNCH health services for some indigents. In 2018-2019, approximately 10 percent of people in Kankan and 12 percent in Kindia spent over 10 percent of their total consumption expenditure on health, which is considered catastrophic.[22] The project invested in essential medicines, which constitute 75 percent of out-of-pocket health expenditures in Guinea. It is estimated that subsidizing medications could potentially prevent 73 percent of impoverishing health expenditures in Guinea.

Other Outcomes and Impacts

51. The project improved medical waste management. It supported the development and implementation of medical waste management plans in the target regions. Nonetheless, implementing these plans was challenging due to the lack of coordination and accountability among medical waste management stakeholders in Guinea and their insufficient capacity. Before the project, health structures burned waste openly or mixed it with household waste, posing social and environmental risks to waste workers and the public. To mitigate these risks, the project purchased and installed 78 modern waste incinerators in health facilities, following environmental audits. Although additional follow-up, such as maintenance training and establishing clear oversight roles for incinerator management, is needed, this initiative marks a significant contribution to modernizing the health system in Guinea.

III. KEY FACTORS THAT AFFECTED IMPLEMENTATION AND OUTCOME

A. KEY FACTORS DURING PREPARATION

52. Simple design: **The project's design was informed by a health project implemented in Labé and Faranah (P147758) with the same PDO and implemented from 2016 to 2020.** This experience helped the task team design a simple project with a robust TOC, essential and complementary components addressing long-term sector financial challenges, and appropriate indicators. More importantly, the project prioritized the local recruitment of HRHs to ensure their retention at their posts. This was one of the project's main success factors, as no services could have been delivered without sufficient health care staff, which was severely lacking prior to the project.

[22] Porgo TV, Magazi I, & Djallo EA. Prevalence of Catastrophic and Impoverishing Health Expenditures and Potential Protection against Financial Risks through Subsidies in Guinea. 2023. https://documents.worldbank.org/curated/en/099615403092324466/pdf/IDU097afb21b0970104d330b3150d3880f9cde32.pdf.

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53. Readiness for implementation: **The same PCU that had managed the Labé and Faranah project (P147758) and three other World Bank-financed health projects (P152359, P154807, and P158579) was involved in this project, capitalizing on its knowledge of World Bank procedures.** Moreover, the PCU's offices in Kankan and Kindia, in addition to the central office, helped improve efficiency by enabling faster implementation and closer supervision of activities, as well as faster identification and response to challenges.

B. KEY FACTORS DURING IMPLEMENTATION

Factors subject to the control of the government and/or implementing entities

54. Commitment and leadership: **The project benefited from the involvement of key actors at the highest levels.** Firstly, the project was monitored by the successive Secretary General of the MOHPH (second-in-command at the MOHPH). Secondly, in line with their mandate, the Ministry of Territorial Administration and Decentralization, through the governors and prefects, supervised health facilities during planned and impromptu visits (sometimes at night), which increased accountability. Their involvement encouraged community participation in health activities. Thirdly, high cadres of the MOHPH (Principal Advisors and the latest Secretary General) were willing to serve as GFF focal points.

55. Human resources, organizational capacity, and M&E:

a. **The PCU's composition and prior experience with World Bank-financed health projects was a key factor in the achievement of the indicators.** The PCU was well staffed and all staff were at their post from the beginning to the end of the project. At the central level, it included a coordinator, an operations specialist, an M&E specialist, an FM specialist, a procurement specialist, an internal auditor, an accountant, and a maternal and child health specialist. At the regional level, it included an operations officer, an accountant, an assistant accountant, and an M&E specialist. The PCU ensured effective coordination between the World Bank and the project's implementing entities, explained World Bank procedures, followed up on activities, and mobilized stakeholders for missions and key meetings. The PCU also provided technical assistance to the implementing entities for developing their terms of reference, strengthening their capacity throughout the project.

b. **Insufficient rigorous monitoring by the PCU and the MOHPH led to several shortcomings that slowed the implementation of activities:** (i) late transmission of terms of reference; (ii) delays in salary payments to HRHs, CHWs, and relays, as the PCU decided to pay them quarterly without informing the World Bank; (iii) delays in processing invoices; and (iv) delayed or lack of implementation of recommendations from World Bank missions. In October 2023, delayed salary payments led to protests and media coverage in the two project regions, posing high reputational risks for the World Bank. The World Bank only became aware of these delays and demonstrations during the October 2023 mission and recommended urgent payment of the arrears and monthly salary payment, as initially planned. These delays adversely affected both the free care program for indigents and the RBF program.
   i. **Free care program for indigents:** Delays in salary payments to HRHs, CHWs, and community relays, along with late processing of invoices, led to reluctance among health workers to provide care to indigents. Moreover, the PCU failed to recruit local NGOs to verify service delivery as initially planned. To address this, the World Bank recommended the establishment of local multipartite committees. Other factors related to the irregular monitoring of the PCU and/or DHDs that impacted this program were the (i) delayed identification of indigents and production of vouchers (which took one year and a half), (ii) lack of lists of indigents in some health facilities, (iii) production of non-compliant invoices by some health facilities, and (iv) insufficient awareness activities among indigents to increase their use of services in the beginning of the program, which led to increased sensitization activities. It should be noted that sensitization activities were also needed to address the

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stigmatizing nature of the term "indigent". Identification was also challenging because of the population's mobility.

ii. **RBF program:** Delays in processing invoices, caused by insufficient supporting documentation from health facilities and the limited capacity within the RBF national coordination unit (despite a series of training sessions), led to delays in paying program subsidies and honoraria for CVAs. To address these challenges, a consultant was recruited to review and improve the RBF national manual and to conduct an institutional evaluation of the RBF national coordination unit to strengthen its capacity.

Factors under the control of the World Bank

56. Adequacy of supervision and reporting: **The World Bank's supervision and reporting were crucial in identifying issues, correcting them, providing technical support to the PCU, and maintaining stakeholder engagement and political dialogue to ensure the success of the project.** The quality of supervision and reporting of the World Bank is deemed satisfactory and is detailed in section IV.C.

Factors outside the control of the government and/or implementing entities

57. Conflict and instability: **Sociopolitical instability hindered project implementation throughout its life cycle.** In the first two years, Guinea experienced political instability in response to proposed constitutional modifications by the president, leading to widespread civil unrest and riots. Furthermore, public administration was halted following the October 2020 presidential elections until government officials were appointed in January 2021. The appointments enabled the signing of key pending contracts, including the establishment of the RBF national coordination unit. In addition, a coup d'état occurred on September 5, 2021, prompting the suspension of all pending payments and withdrawal applications in accordance with World Bank policy on Dealings with De Facto Governments (OP/BP7.30) for four months. On November 4, 2021, a waiver of BP 7.30 was obtained to resume disbursements related to COVID-19 activities. Afterwards, following a formal assessment of OP/BP 7.30, disbursements related to the project resumed in January 2022. These events impacted the free care program for indigents, particularly the printing and distribution of vouchers. Some RBF activities, such as the provision of care, were implemented but not paid on time, while other RBF activities, like certain verification tasks, were not performed and therefore not paid. After disbursements resumed, verification activities were slow to recover. Over the project's lifecycle, the government changed four times, and the MOHPH was headed by three different ministers, with frequent turnover among MOHPH Directors. These frequent changes necessitated a perpetual recommencement of political dialogue and advocacy to address urgent issues and advance the universal health coverage agenda.

58. Natural disaster: **The COVID-19 pandemic hit Guinea in March 2020 and caused several disruptions.** Due to restrictions on movement and health measures, the implementation of proximity activities by CHWs and community relays, particularly for the free care program for indigents, was suspended. Nevertheless, these restrictions began to ease by the end of 2021, which enabled the resumption of these activities. The pandemic also disrupted training, supervision, and strategic meetings, though virtual meetings were held when possible. World Bank physical support was unavailable from March 2020 to April 2022, and supply chain costs increased due to the pandemic. Overall, the disruptions caused by the COVID-19 pandemic did not affect the utilization of health services in the target regions.

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IV. M&E, COMPLIANCE ISSUES, BANK PERFORMANCE, AND RISK TO DEVELOPMENT OUTCOME

A. QUALITY OF M&E

M&E Design

59. The PDO was well-formulated, the TOC clear, and the indicators adequate to monitor progress toward the PDO. The PAD clearly stated how project progress would be monitored and evaluated, including specific provisions for data collection and verification (particularly for activities such as the free care program for indigents and the RBF program), and the frequency of data reporting. The PAD also detailed plans to strengthen the project's M&E, including strengthening the health information and CRVS systems, equipping health facilities, and training staff for timely data collection and reporting. The PDO indicators reflected midterm outcomes and provided direct measures of the use of RMNCH services. Most PDO indicators also indirectly capture the quality of care and trust in the health system, which is critical for encouraging the utilization of health services. For example, the number of women attending four antenatal care visits suggests satisfaction with services and willingness to obtain care, despite associated indirect costs. Similarly, parents are unlikely to fully vaccinate their children or seek vitamin A supplements if they do not trust the health system. Additionally, the PDO indicators on vaccination, vitamin A supplementation, and modern contraception implies improvement in the supply chain and availability of essential commodities. Unlike the previous project, this project established baseline indicators before implementation, based on data collected from health facilities. This helped address issues with data completeness and accuracy transmitted through the health information system. Indeed, the national health information system (through the DHIS2) was not a reliable source of data. For example, a comparison of baseline values collected at health facilities with DHIS2 data for the same regions and year revealed differences ranging from 8 to 86 percent.

60. Although indicators of the use of RMNCH services were expressed in absolute numbers, they were appropriate for measuring PDO achievement. Percentages could not be used due to difficulties in determining accurate denominators. The 2014 census was incomplete because many refused to participate, due to the political situation and the EVD epidemic. As a result, analyses based on the census yielded questionable results, often conflicting with national surveys such as the DHSs and Multiple Indicator Cluster Surveys. For example, using census data as denominators and the data collected from health facilities through the project as numerators, the prevalence of deliveries assisted by trained health personnel was 84 percent in 2018 – much higher than the 55 percent reported in the DHS.[23] Additionally, the proportion of fully vaccinated children was 79 percent in 2020, compared to the 24 percent reported in the 2018 DHS.

M&E Implementation

61. The M&E arrangements were implemented. The PCU entities at the central and regional levels were staffed with M&E specialists who collected data at health facilities to ensure quality and monitor improvements in data entry into the DHIS2. Nonetheless, data collection was temporarily hindered by the COVID-19 pandemic and the application of the OP/BP 7.30. Additionally, the PCU submitted quarterly and annual reports, but often with delays. The task team reviewed these reports to ensure they were of good quality. Adjustments and clarifications to the initial M&E arrangements were also necessary. First, NGOs were not hired to verify service effectiveness as initially planned. Furthermore, technical verification by DHSs was insufficient to detect errors. Therefore, invoices for the free care program for indigents required verification by local committees, the PCU, and the task team. Second, data from the user satisfaction survey, conducted to improve monitoring of health facility activities, were used to assess the IRI related to user satisfaction with RMNCH

[23] Republic of Guinea. National Institute for Statistics. Annuaire Statistique Sanitaire. 2018. https://www.stat-guinee.org/index.php/autres-publications-ssn/113-ministere-de-la-sante.

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services. Third, although the PAD had scheduled the MTR for 2021, key project activities only fully launched that year, and the coup delayed disbursements for four months, as noted in section III. B. Moreover, conducting the MTR in person was preferred, so it was postponed until COVID-19 restrictions were lifted. Therefore, the MTR was only conducted in April 2022. The MTR clarified the meaning of two IRIs misunderstood by the PCU, improving reporting.

M&E Utilization

62. M&E data were regularly examined and used to assess project progress, adjust the results framework for better impact monitoring, and adapt the project to meet the country's needs through recommendations and restructuring (as discussed in previous sections on rationale for changes, section I.B; factors that affected implementation, section III.B; and M&E implementation above). This process involved analyzing the results framework, financial data, and feedback from presentations and discussions with the PCU, implementing entities, and project beneficiaries. Errors in progress reports and systematic discrepancies in the World Bank operations portal (e.g., in the ISRs) were corrected in subsequent ISRs.

63. A drawback in M&E utilization was the delayed adjustment of the end targets for indicators that had already been surpassed. The project quickly enabled the health system in target regions to recover after the devastating EVD epidemic. Of the five PDO indicators, one surpassed its end target in 2019, and three more in 2020. Despite this, the decision to increase the targets was only made following the MTR in April 2022, with the government formally requesting revisions in January 2023. Therefore, the project's ambition could have been recalibrated earlier.

Justification of Overall Rating of Quality of M&E

64. The M&E system was sufficient to assess the achievement of project objectives, though minor weaknesses were noted. The M&E design is rated as High, while its implementation and utilization are rated as Substantial, resulting in an overall rating of Substantial.

B. ENVIRONMENTAL, SOCIAL, AND FIDUCIARY COMPLIANCE

Environmental and social compliance

65. Two main safeguard instruments were prepared: an Environmental and Social Management Framework and medical waste management plans for each region, which included identified weaknesses and mitigation measures. The project was developed when safeguard policies were in effect. Environmentally, the project was assigned category B due to potential increases in health care waste and impacts from water supply construction (involving land excavations). OP/BP 4.01 (Environmental Assessment) and OP/PB 4.11 (Physical Cultural Resources) were triggered. Nonetheless, the project's potential effects were deemed limited, site-specific, and manageable. Socially, no policies were triggered.

66. The safeguard specialists recruited by the PCU had limited capacity. Several shortcomings were noted, including late report submissions, poor report quality (sometimes lacking valid information), delays in addressing phone complaints (especially related to health personnel salaries), failure to implement all mission recommendations, and discrepancies between reported information and on-the-ground observations, including issues with the Grievance Redress Mechanism. To address these issues, the task team provided multiple training sessions, closely monitored activities to ensure compliance with World Bank policies, and developed specific action plans.

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Fiduciary compliance

67. FM and procurement were consistently rated Satisfactory during the project's implementation. The FM arrangements were operational, and the procurement policy framework, procedures, and documents were deemed adequate. The central-level FM specialist, procurement specialist, and accountant had previous experience managing World Bank health projects, and each regional PCU had an accountant. Unaudited interim financial reports and external audit reports were submitted on time and deemed acceptable by the World Bank. The external auditor's opinions on the financial audit reports for 2020, 2021, 2022, and 2023 were unqualified. Only minor corrective actions were required after procurement post reviews. No incidences of fraud, corruption, misuse of funds, or misprocurement were reported. Nonetheless, delays in project implementation were noted, primarily due to the country's fragile context and the impact of the COVID-19 pandemic (see section III and quality of supervision below). While there were moments where a rating of Moderately Satisfactory could have been justified, the Satisfactory ratings reflected the adequacy of FM and procurement arrangements, efficiency, and the absence of misuse of funds and misprocurement. Overall, project implementation progressed well, despite the delays.

C. BANK PERFORMANCE

Quality at Entry

68. The task team conducted due diligence in analyzing economic, financial, technical, FM, procurement, and social and environmental safeguards, although there were some shortcomings. Lessons from previous health projects were incorporated into the project design, and the PDO was realistic. Furthermore, face-to-face consultations and collaboration with the Government and other non-state actors (such as WHO and UNICEF) ensured stakeholder buy-in for a smooth implementation, including M&E components. The use of the same PCU that had managed four previous health projects and the provision of additional training for PCU staff helped mitigate many technical and institutional risks.

Quality of Supervision

69. The project benefited from the expertise and stability of the task team. The project was managed by two task team leaders (TTLs) who held accountability and decision-making responsibility (ADM). The first ADM-TTL, based in Guinea, also managed the health project in Labé and Faranah, making him well-versed in the country's health and political context. His replacement in 2022, who had been the co-TTL since 2020, was familiar with the project and the country's challenges. FM, procurement, and environmental safeguards specialists were based in-country, providing daily assistance to the PCU and implementing entities. The social development specialist provided virtual and in-person assistance. Due to the PCU's weak performance in social and environmental safeguards, an international consultant was hired in March 2023 to support the Conakry office. Targeted training on M&E, FM, and procurement was also provided to the PCU. Furthermore, national consultants with expertise in RMNCH, community health, health information systems, and CRVS, and international consultants with expertise in RMNCH, indigence, health information systems, and RBF were engaged to support the government. Regular adjustments, such as purchasing personal protective equipment to protect health workers and patients from COVID-19 and incorporating National Population and Housing Census activities, were made as the project evolved. Moreover, the task team proactively revised IRIs to better capture project activities (see section I.B).

70. The missions were consistently used to provide technical support to the PCU and project implementation entities, as well as to identify and resolve project implementation issues. Missions occurred at least twice a year and shifted to virtual platforms during COVID-19 restrictions. After restrictions were lifted, the MTR mission was conducted in April 2022. The Practice Manager visited Guinea four times, conducting field trips to target regions, engaging in political

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dialogue, and providing technical guidance. Specific missions focused on fiduciary, social, and environmental safeguards, held both in person and virtually.

71. Issues and progress in resolving them were documented in aide-mémoires, ISRs, and restructuring documents. For example, discrepancies between the quantities of medicines to be delivered to health facilities and those received were noted in the April 2022 mission aide-mémoire. This issue became apparent only when field visits resumed post-COVID-19 restrictions. It was recommended that the PCU, RHDs, UNICEF (the medicines procurement agency), and the Central Pharmacy of Guinea ensure accurate deliveries and impose sanctions for discrepancies. In the event of overstocking or risk of expiry, the PCU and RHDs were advised to redistribute the medicines. Another example is the free care program for indigents, where recommendations were made to set up local multipartite committees to verify care effectiveness and invoice quality (April 2022 and October 2023 aide-mémoires) and to limit the program to districts covered by the RBF program.

Justification of Overall Rating of Bank Performance

72. Quality at entry and quality of supervision are both considered Satisfactory. Therefore, the overall rating of the World Bank's performance is Satisfactory.

D. RISK TO DEVELOPMENT OUTCOME

73. The risk to development outcome is high, but a follow-up project, which includes support for key reforms, is helping to mitigate it. The government has only been able to recruit 42 out of the 400 HRHs recruited and trained by the project (12 in Kindia and 30 in Kankan). Moreover, the government has not been able to sustain key interventions such as the free care program for indigents and the RBF program, due in part to lack of financing. This threatens the sustainability of the PDO, as utilization of health services may decrease due to (i) a shortage of qualified HRHs, CHWs, and community relays needed to drive community engagement and health service demand and (ii) decreased service quality at the facility-level and financial accessibility due to the suspension of the free care and RBF programs. The country continues to face significant budgetary constraints that hinder the sustainability of these interventions. Nonetheless, the Simandou project, which aims to capitalize on Guinea's iron ore deposits, offers a potential opportunity to expand fiscal space for health in the future. In the meantime, to mitigate the immediate risk, the World Bank approved a follow-up project, the Guinea Enhancing Health System Transformation project (P506072), on September 23, 2024. This new initiative will scale up key activities such as recruiting HRHs, CHWs, and relays in seven of the country's eight regions (excluding the capital region) and the free care and RBF programs in four regions. The RBF program will strengthen the autonomy of health facilities, enabling them to raise funds to recruit HRHs and procure equipment as needed. The new project will support key reforms to advance the universal health coverage agenda, focusing on the health workforce, and the supply of essential medicines and equipment. The World Bank will also continue policy dialogue with the government to transition from input-based financing to output-based financing, institutionalizing the RBF program within the broader health financing strategy.

V. LESSONS AND RECOMMENDATIONS

74. Key lessons from the project include the following:

- **Narrowing the catchment area can ensure achievement of the PDO in low-capacity settings.** This project focused on only two regions, which allowed close monitoring of project activities, including the free care and the RBF programs, which were relatively new in the country. This facilitated the identification of issues, such as delays in

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processing and paying invoices for the free care program for indigents and subsidies for the RBF program, and allowed corrective measures to be implemented to ensure that objectives were attained despite setbacks.

- **Focusing on essential health system building blocks, with a combination of supply-side and demand-side interventions, in fragile contexts allows the health system to function.** By addressing urgent needs (such as providing HRHs, essential drugs, and equipment), removing financial barriers to the health facilities, and sensitizing the community on the importance of health services, the project significantly improved RMNCH service utilization in the post-EVD environment.
- **Having a well-staffed, stable, and decentralized PCU can ensure the overall progress of a project.** The central and regional offices of the PCU were well-staffed and remained until the end of the project. Most staff also had prior experience with World Bank-finance projects. Having central and regional offices helped ensure quick coordination of activities between the central and regional levels and effective implementation of activities on the ground through communication of key decisions and technical assistance to implementing entities.
- **Involving local authorities, such as governors and prefects, increases accountability for HRHs, CHWs, and relays, and promotes RMNCH service utilization.** The involvement of the Ministry of Territorial Administration and Decentralization in supervising health facilities during planned and impromptu visits increased accountability and generated demand for health services.
- **Ensuring financial autonomy of health facilities in fragile contexts is essential for the continuity of care.** Despite the political instability, the project enabled health facilities in the target regions to continue providing services, even when their bank accounts were frozen following the coup. Financial resources must therefore be made available at the health facility level for effective operation.
- **RBF is a powerful tool for ensuring health facility autonomy and improving service quality.** RBF subsidies enabled health facilities to increase their revenues and address their needs in real-time (as opposed to waiting for the central level to provide the funds needed), greatly improving their working conditions, as reflected in improved care quality scores.
- **The implementation of a free care program for indigents in a fragile context is challenging and requires adequate preparation and prerequisites.** Despite econometric studies to identify individuals who were below a certain poverty level, their identification on the ground can prove challenging given the stigmatizing nature of the term “indigent” and the population’s mobility. It is therefore important to allocate sufficient time for this step, especially in fragile contexts like Guinea. Verification activities are equally important. As seen in this project, some health facilities either submitted insufficient or falsified documentation. It is therefore important to establish strong and independent mechanisms to verify the quality of care and invoices, as well as the effectiveness of services provided to indigents.

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ANNEX 1. RESULTS FRAMEWORK AND KEY OUTPUTS

A. RESULTS FRAMEWORK

PDO Indicators by Outcomes

Improve the utilization of reproductive, maternal, neonatal and child health services in target regi								
Indicator Name	Baseline		Closing Period (Original)		Closing Period (Current)		Actual Achieved at Completion	
	Result	Month/Year	Result	Month/Year	Result	Month/Year	Result	Month/Year
Number of deliveries assisted by trained health personnel (Number)	66,544.00	Dec/2017	595,318.00	Jun/2024	595,318.00	Jun/2024	701,314.00	Jun/2024
	Comments on achieving targets		120% achieved					
Number of pregnant women who received 4 antenetal care visits (Number)	77,951.00	Dec/2017	602,192.00	Jun/2024	602,192.00	Jun/2024	713,409.00	Jun/2024
	Comments on achieving targets		121% achieved					
Number of children (0-11 months) fully vaccinated (Number)	94,640.00	Dec/2017	608,026.00	Jun/2024	608,026.00	Jun/2024	698,860.00	Jun/2024
	Comments on achieving targets		118% achieved					
Number of children (6-11 months) receiving vitamin A supplementation every 6 months (Number)	11,407.00	Dec/2017	96,534.00	Jun/2024	96,534.00	Jun/2024	127,107.00	Jun/2024
	Comments on achieving targets		136% achieved					
Number of women who have received modern contraception (Number)	52,812.00	Dec/2017	558,629.00	Jun/2024	558,629.00	Jun/2024	648,852.00	Jun/2024
	Comments on achieving targets		118% achieved					

Intermediate Indicators by Components

Strengthen supply of basic RMNCH services in target regions								
Indicator Name	Baseline		Closing Period (Original)		Closing Period (Current)		Actual Achieved at Completion	
	Result	Month/Year	Result	Month/Year	Result	Month/Year	Result	Month/Year
Proportion of health centers with access to water supply powered by solar energy (Percentage)	0	Mar/2023	64.00	Jun/2024	100	Jun/2024	100.00	Jun/2024
	Comments on achieving targets		100% achieved					
Proportion of health centers with more than 30 percent of stock-outs of tracer drugs (Percentage)	100.00	Nov/2017	25.00	Jun/2024	25.00	Jun/2024	5.00	Jun/2024
	Comments on achieving targets		127% achieved					
Proportion of health centers offering integrated management of childhood illnesses (Percentage)	0.00	Nov/2017	100.00	Jun/2024	100.00	Jun/2024	100.00	Jun/2024
	Comments on achieving targets		100% achieved					
Number of health facility health workers recruited and trained in RMNCH competencies (Number)	0.00	Nov/2017	400.00	Jun/2024	400.00	Jun/2024	400.00	Jun/2024
	Comments on achieving targets		100% achieved					
Proportion of health centers who benefited from at least one supportive supervision per trimester (Percentage)	0.00	Nov/2017	100.00	Jun/2024	100.00	Jun/2024	100.00	Jun/2024
	Comments on achieving targets		100% achieved					
Strengthen the demand for basic RMNCH services in target regions								
Indicator Name	Baseline		Closing Period (Original)		Closing Period (Current)		Actual Achieved at Completion	
	Result	Month/Year	Result	Month/Year	Result	Month/Year	Result	Month/Year
Number of women and children who utilized health centers for RMNCH services (Number)	458,412.00	Nov/2017	5,456,603.00	Jun/2024	5,456,603.00	Jun/2024	5,003,090.00	Jun/2024
	Comments on achieving targets		91% achieved					
Number of new indigents covered under exemption mechanisms (identified and provided with card) (Number)	0.00	Nov/2017	77,774.00	Jun/2024	77,774.00	Jun/2024	77,774.00	Jun/2024
	Comments on achieving targets		100% achieved					
Satisfaction of users with basic RMNCH services provided (Percentage)	0.00	Nov/2017	60.00	Jun/2024	60.00	Jun/2024	73.00	Jun/2024
	Comments on achieving targets		122% achieved					

People who have received essential health, nutrition, and population (HNP) services (Number)	0.00	Apr/2018	1,127,287.00	Jun/2024	1,127,287.00	Jun/2024	1,354,690.00	Jun/2024
	Comments on achieving targets		120% achieved					
Number of children immunized (Number)	0.00	Apr/2018	513,386.00	Jun/2024	513,386.00	Jun/2024	604,220.00	Jun/2024
	Comments on achieving targets		118% achieved					
Number of women and children who have received basic nutrition services (Number)	0.00	Apr/2018	85,127.00	Jun/2024	85,127.00	Jun/2024	115,700.00	Jun/2024
	Comments on achieving targets		136% achieved					
Number of deliveries attended by skilled health personnel (Number)	0.00	Apr/2018	528,774.00	Jun/2024	528,774.00	Jun/2024	634,770.00	Jun/2024
	Comments on achieving targets		120% achieved					
Strengthen health financing capacity of the MOH to guide sector reform and long-term transformation								
Indicator Name	Baseline		Closing Period (Original)		Closing Period (Current)		Actual Achieved at Completion	
	Result	Month/Year	Result	Month/Year	Result	Month/Year	Result	Month/Year
Number of health centers under results-based financing mechanisms receiving due payments for their results on time (Number)	0.00	Nov/2017	46.00	Jun/2024	46.00	Jun/2024	0.00	Jun/2024
	Comments on achieving targets		0% achieved					
Number of RBF Contracts Signed between the purchasing Agency and identified RBF facilities (Number)	0.00		46.00		46.00		58.00	
	Comments on achieving targets		126% achieved					
Health Financing Strategy Produced (incorporating evidence from PER and NHA) (Yes/No)	No	Nov/2017	Yes	Jun/2024	Yes	Jun/2024	Yes	Jun/2024
	Comments on achieving targets		100% achieved					
NHA and PER produced (Yes/No)	No		Yes		Yes		Yes	
	Comments on achieving targets		100% achieved					
Strengthen project management, implementation, and donor coordination capacity								
Indicator Name	Baseline		Closing Period (Original)		Closing Period (Current)		Actual Achieved at Completion	

	Result	Month/Year	Result	Month/Year	Result	Month/Year	Result	Month/Year
Proportion of health centers transmitting health data on time (Percentage)	0.00	Nov/2017	100.00	Jun/2024	100.00	Jun/2024	100.00	Jun/2024
	Comments on achieving targets		100% achieved					

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B. KEY OUTPUTS

Objective/Outcome 1: Improve the utilization of RMNCH services in target regions (Kankan and Kindia)	
Outcome Indicators	1. Number of deliveries assisted by trained health personnel 2. Number of pregnant women who received ≥four antenatal care visits 3. Number of children (0-11 months) fully vaccinated 4. Number of children (6-11) receiving vitamin A supplementation every six (6) months 5. Number of women who have received modern contraception
IRIs	1. Proportion of health centers with access to water supply powered by solar energy 2. Proportion of health centers with more than 30 percent of stock-outs of tracer drugs 3. Proportion of health centers offering integrated management of childhood illnesses 4. Number of health facility health workers recruited and trained in RMNCH competencies 5. Proportion of health centers who benefited from at least one supportive supervision per trimester 6. Number of women and children who utilized health centers for RMNCH services 7. Number of new indigents covered under exemption mechanisms (identified and provided with card) 8. Satisfaction of users with basic RMNCH services provided 9. People who have received essential HNP services (Corporate) 10. Number of health centers under RBF mechanisms receiving due payments for their results on time 11. Health Financing Strategy Produced (incorporating evidence from PER and NHA) (Yes/No) 12. Proportion of health centers transmitting health data on time
Key Outputs by Component	**Component 1: Strengthen supply of basic RMNCH services in target regions** 1. 81 solar-powered water supply equipment installed in 81 health facilities 2. Essential equipment, medicines, consumables, and vaccines provided to 126 health facilities 3. 399 HRHs, 232 CHWs, and 2,351 community relays recruited and trained 4. Provision of supervision material (motorcycles, vehicles, etc.) **Component 2: Strengthen the demand for basic RMNCH services in target regions** 1. 6,003,090 women and children utilized health facilities for RMNCH services* 2. 77,774 indigents provided with vouchers to access health services for free 3. 73 percent of users satisfied with the RMNCH services they received 4. Supervision material (motorcycles and vehicles, tools, etc.) provided at the decentralized level

	Component 3: Strengthen health financing capacity of the MOHPH to guide sector reform and long-term transformation 1. 58 health facilities under the RBF program for improved quantity and quality of services 2. Key strategic documents produced (2020 and 2021 national health accounts (and support for the 2021 and 2022 accounts), studies on the pricing of health services) **Component 4: Strengthen project management, implementation, and donor coordination capacity** 1. Health information system strengthened for data transmission by all health facilities for supervision and decision-making

* More women and children are captured under this IRI than by the CRI. For example, women who receive family planning advice and contraceptive, women who receive antenatal care, and women and babies who receive post-natal care.

ANNEX 2. BANK LENDING AND IMPLEMENTATION SUPPORT/SUPERVISION

A. TASK TEAM MEMBERS

Name	Role
Zenab Konkobo Kouanda, Teegwende Valerie Porgo	TTLs
Koulako Camara	Procurement Specialist
Fatoumata Toure	FM Specialist
Marine Retif	Team Member
Lesfran Sam Wanilo Agbahoungba	Team Member
Mamadou Dian Diallo	Team Member
Yao Thibaut Kpegli	Team Member
Murat Cengizlier	Counsel
Issiaka Traore	Team Member
Saliou Dian Diallo	Team Member
Aissatou Tidiane Diallo	Team Member
Adjoua Veronique Ouattara	Social Development Specialist
Freddy Essimbi Onana Essomba	Team Member
Mamady Kobele Keita	Environmental Specialist
Ibrahima Sekou Sow	Team Member
Isidore Sieleunou	Team Member
Jean De Dieu Rusatira Rwema	Team Member
Alpha Mamoudou Bah	Team member
Thierno Hamidou Diallo	Team member
Waleska Magalhaes Pedrosa	Counsel
Mohamed I. Diaw	Team Member
Aloys Zongo	Team Member
Cyriaque Laleye	Team Member
Nathalie S. Munzberg	Safeguards Advisor

B. STAFF TIME & COST

Stage of Project Cycle	Staff Time & Cost	
	No. of Staff Weeks	US$ (including travel and consultant costs)
Preparation		
FY17	15.150	76,524.25
FY18	29.215	240,242.98
FY19	10.785	58,705.18
FY20	0.000	1,558.22
FY21	0.000	28,825.80
Total	55.15	405,856.43
Supervision/ICR		
FY19	10.375	135,219.81
FY20	15.650	191,314.29
FY21	21.905	281,067.87
FY22	34.804	360,565.62
FY23	21.260	238,457.05
FY24	30.306	423,083.57
FY25	10.062	85,041.43
Total	144.36	1,714,749.64

ANNEX 3. PROJECT COST BY COMPONENT

Component	Amount at Approval (US$M)	Actual at Project Closing (US$M)*
Strengthen supply of basic RMNCH services in target regions	26.0	26.07
Strengthen the demand for basic RMNCH services in target regions	8.4	8.13
Strengthen health financing capacity of the MOHPH to guide sector reform and long-term transformation	17.0	13.73
Strengthen project management, implementation, and donor coordination capacity	3.6	4.14

*Amount absorbed

The amount disbursed was US$52.13 million. The amount absorbed was US$52.07 million, representing 99.90 percent of the total. As of the time of the writing of the ICR, the remaining amount had not been reimbursed.

ANNEX 4. EFFICIENCY ANALYSIS

The CBA was conducted using the number of averted DALYs as a health outcome. DALYs for a health condition are the sum of the years of life lost due to premature death and the years lived with a disability due to prevalent cases of the health condition in a population.[24] Thus, DALYs capture both mortality and morbidity in a population and one DALY represents the loss of the equivalent of one year of full health. Only indicators that could be converted into DALYs were considered as benefits. These include three out of the five PDO indicators: (i) the number of deliveries assisted by a trained health personnel, (ii) the number of children (0-11 months) fully vaccinated, and (iii) the number of children (6-11 months) receiving vitamin A supplementation every six months. The number of pregnant women who received four antenatal care visits could be converted into DALYs but was excluded as it overlapped with maternal and neonatal conditions already covered by the number of deliveries assisted.

The costs and benefits of the project were first estimated and then the NPV, BCR, and IRR were calculated. A discount rate of five percent was used to calculate present values for costs and DALYs, as is common practice in CBAs in the health sector and recommended for low- and middle-income countries.[25,26] The discount rate was assumed to be constant throughout the project.

Costs

The total amount absorbed (covering all components of the project) was included. The amount absorbed by the government was US$52.08 million compared to US$52.13 million disbursed. Since the project became effective in December 2018, 2018 was used as the reference year to calculate the costs of the project in present value (from 2019 to 2024).

Benefits

Data on DALYs in Guinea were obtained from WHO's DALY database, based on the selected indicators.[24] Data for 2019 were used, thus 2019 was set as the reference year. Except for 2019, DALYs for each year, from 2020 to 2024, were estimated by discounting DALYs for the previous year. For the number of deliveries assisted by a trained health personnel, DALYs related to maternal conditions as well as DALYs related to neonatal conditions were included. For the number of children (0-11 months) fully vaccinated, DALYs for tuberculosis, measles, tetanus, diphtheria, hepatitis B, yellow fever, and whooping cough were included. These conditions, in addition to polio and type B Influenza, are targeted by the Expanded Program on Immunization in Guinea. Nevertheless, DALYs for polio and type B influenza were not available. It was assumed that vaccines were 100 percent effective. For the number of children (6-11 months) receiving vitamin A supplementation every six months, DALYs for vitamin A deficiency were included.

For each selected indicator, the yearly number of DALYs that were averted was calculated by applying the corresponding yearly DALYs rate to the number of women or children who benefited from health services owing to the project. The number of women or children who benefited from health services owing to the project was obtained by subtracting the number of children who would have benefited from the health services provided under the project, had the project not been implemented, from the number of children who benefited from these health services over the project cycle. A yearly

[24] WHO. The Global Health Observatory. DALYs. https://www.who.int/data/gho/indicator-metadataregistry/imr-details/158.
[25] Haacker M, Hallett TB, Atun R. (2020). On discount rates for economic evaluation in global health. Health Policy and Planning. 35 (1): 107-114.
[26] Attema AE, Brouwer WBF, Claxton K. (2018). Discounting in Economic Evaluations. PharmacoEconomics. 36 (7):745–758.

2.77 percent population growth rate was applied to each year starting from the 2019 baseline.[27] For 2024, a 1/2-year adjustment was made, as the project was implemented until June 30, 2024.

The valuation of DALYs was done using the most current Guinea GNI per capita of US$1,190 (Atlas method, 2022).[28] The total economic gains were calculated by summing yearly averted DALYs, converted to monetary value, across the selected indicators.

Results of the CBA

While the total invested financial resources amounted to US$44.13 million in present value, the benefits totaled US$196.84 million (Table 4). The NPV was US$152.71 million with a BCR of 3.46, indicating that each US$1 invested through the project yielded an economic return of US$3.46. The IRR was 304 percent, which is substantially higher than the cost of capital in Guinea (3.33 percent).

The benefits of the project go beyond the results of the NPV, BCR, and IRR calculated. Not all benefits could be captured. For example, the DALYs averted for polio and type B influenza, attributable to the project, were not included in the CBA due to lack of data. Furthermore, the PDO indicator "Number of women who have received modern contraception" was excluded because it could not be converted into DALYs. Yet, over the life cycle of the project, 648,852 women received modern contraception. Moreover, the economic impact of vitamin A is not fully captured. Yet, children with vitamin A deficiency have between 1.43 and 1.64 times the odds of stunting compared to children without vitamin A deficiency[29] and every 10-percentage point decrease in the prevalence of childhood stunting results in a 3.5 percent increase in adult productivity.[30] Lastly, the number of beneficiaries is underestimated as the number of people who would have benefited from RMNCH services without the project is based only on a 2.77 percent population growth, which is overly optimistic as explained in the efficacy section.

Table 4. Results of the CBA

	Total
Project costs	
Total costs (nominal, US$)	52,079,002
Total costs (present value (2018), US$)	**44,129,389**
Benefits	
Deliveries assisted by a trained health personnel	
Number of women who would have benefited from these services without the project	411,708
Number of women who benefited from these services over the project cycle	701,314
Number of women who benefitted from these services thanks to the project	289,606
Total DALYs averted (present value)	137,235
Economic gains (US$, present value)	163,309,128
Number of children (0-11 months) fully vaccinated	
Number of children who would have been fully immunized without the project*	585,538
Number of children who were fully immunized over the project cycle	698,860

[27] United Nations Population Division. Department of Economics and Social Affairs. Population Dynamics. World population prospects. Population Data. 2020.https://population.un.org/wpp/Download/Standard/Population/.
[28] World Bank Group. World Development Indicators. https://databank.worldbank.org/source/world-development-indicators.
[29] Ssentongo P, Ba DM, Ssentongo AE, et al. (2020). Association of vitamin A deficiency with early childhood stunting in Uganda: A population-based cross-sectional study. PloS One. 15(5), e0233615.
[30] The World Bank Group. The Human Capital Index 2020 Update: Human Capital in the Time of COVID-19. Washington DC: World Bank Group; 2020.

Number of children who were fully immunized thanks to the project	113,322
Total DALYs averted (present value)	28,070
Economic gains (US$, present value)	33,403,343
Number of children (6-11 months) receiving vitamin A supplementation every six months	
Number of children who would have received vitamin A supplementation every 6 months without the project*	70,575
Number of children who received vitamin A supplementation every 6 months over the project cycle	127,107
Number of children who received vitamin A supplementation every 6 months thanks to the project	56,532
Total DALYs averted (present value)	106
Economic gains (US$, present value)	125,993
Total economic gains (US$, present value)	**196,838,465**
NPV (US$, 2018)	**152,709,076**
BCR	**3.46**
IRR	**304%**

*The 2015-2020 population growth rate of 2.77% was applied to the 2017 baseline for subsequent years. For 2024, a 1/2-year adjustment was made, as the project was implemented until June 30, 2024.

Methods of the CBA Conducted During Project Appraisal

The results of this CBA are different from the CBA conducted during project appraisal, which also included all the project costs (covering all components), but was based on productive life years gained due to reduced mortality following the project's interventions. In gained productive life years, life expectancy is taken into account by assigning greater weight to younger populations than older ones. This is because saving the life of an infant yields more productive life years compared to saving the life of an older person. This method was chosen because the project focused on children and young adults.

The assumptions in the CBA conducted during project appraisal were the following:

a. A discount rate of 3 percent, similar to Guinea's 2026 deposit interest rate (3.8 percent), was applied and was assumed to be constant over the project's five years.
b. A population growth rate of 2.5 percent was applied and assumed to be constant over the project's five years.
c. It was estimated that half of the total population in the targeted regions would directly benefit from the project's interventions and that the project will prevent 0.5 percent of deaths per year among these individuals.
d. The average gained productive life-years per person was 20 years.
e. The 2016 gross national income per capita of US$490 was used to value the gained productive life-years and was assumed to be constant for the project's five years.

At project closure, using DALYs already estimated for Guinea by WHO for specific conditions and age groups was deemed more appropriate than relying on assumptions regarding productive life years.

ANNEX 5. BORROWER COMMENTS

The project is part of the government's initiative to improve service quality and make health care more accessible to all Guineans by enhancing health facilities and improving the skills, motivation, and resources of health professionals. Once again, this project demonstrates the commitment of our partners, particularly the World Bank, to supporting the major health reforms initiated by the Republic of Guinea. The project builds on the successful outcomes of the Primary Health Care Improvement Project (PASSP). It serves as both a continuation and consolidation of the strategies envisioned, with its performance evaluated from multiple perspectives. Despite challenges such as the restructuring of the project, the COVID-19 pandemic, and the coup d'état, the project remained aligned with its objectives and expected results. The redefined indicators and targets ensured the project's continuity without compromising the commitment of the involved stakeholders.

Our strategy focused on four key areas to improve the quality and use of health services: (i) strengthening the health workforce, (ii) ensuring the availability of medicines and pharmaceutical supplies, (iii) providing logistical resources, and (iv) involving communities in the implementation of health strategies. We extend our gratitude to all the stakeholders who contributed to these successes: government authorities for their leadership, implementing agencies and operational personnel for their full engagement, World Bank specialists for their technical support, and the entire PCU team.

In terms of sustainability, the rehabilitation and equipping of health facilities, RHDs, and DHDs should have lasting effects. Similarly, tools developed under the RBF framework are expected to endure. However, high staff turnover could lead to a gradual loss of acquired knowledge, necessitating ongoing training. All stakeholders must take ownership of the lessons learned and the recommendations made during project implementation to guide future improvements and maximize the impact of our health care investments.

Given the project's convincing and significant results, the Guinean government is committed to continuing these efforts through the new project aimed at building a high-performing, resilient health care system. This will involve integrating sensitive, tailored approaches.

We are delighted to once again take on the challenge of strengthening the health care system. Our commitment is grounded in collaborative synergy and collective effort.

ANNEX 6. DESCRIPTION OF THE FREE CARE AND RBF PROGRAMS

The free care program for indigents

The free care program for indigents was implemented in the 10 health districts within the project's target regions, Kankan and Kindia. The program builds on lessons from the Productive Social Safety Net Project (P123900) and the Guinea Primary Health Services Improvement Project (P147758), both financed by the World Bank. This program provided coverage of all RMNCH services not already covered under existing free care programs for individuals holding a voucher (project card).

Targets: All women of childbearing age (15-49) and children under five with incomes below 3,068,265 GNF/year, or 8,406 GNF/day (determined using the Proxy Means Test approach).

Identification process: Indigents were identified using two methods, both involving investigators conducting house to house visits:

a) Self-targeting: Heads of households in need or who recognized themselves in descriptions of poverty or extreme poverty asked investigators to be registered.
b) Community-targeting: Community members reported individuals matching poverty or extreme poverty profiles who had not come forward due to lack of information, displacement, or other significant barriers.

The identified individuals were registered in the USR (an electronic database), managed by the Social Development and Indigence Fund under the Ministry for the Promotion of Women, Children, and Vulnerable Persons.

Players involved and their functions: The key players included (i) HRHs, who provided care to beneficiaries and generated related invoices; (ii) community relays, who distributed vouchers and raised local awareness; (iii) NGOs, for community verification of care, but in theory as explained below; (iv) DHDs, who conducted technical verification of care provided to beneficiaries; and (v) the PCU (at the central and regional levels) responsible for controlling and reimbursing invoices of health facilities.

Training given to the players involved: Several types of training were provided during project implementation: (i) training for investigators focused on targeting poor and extremely poor households, (ii) training for community relays, CHWs, and HRHs covered how to provide free care and raise awareness among indigents, and (iii) training for the Social Development and Indigence Fund and DHDs staff on how to implement the project and carry out verification.

Verification mechanisms:

a) **Initial proposal:** Two verification mechanisms were planned prior to payments of invoices:
   i. Community verification of the effectiveness and quality of care by local NGOs (not implemented): This verification implied confirming with households that care billed by health facilities was effective. It was also supposed to help to gather feedback from indigents on the quality of services received (e.g., reception, medicine availability, and staff presence).
   ii. Government technical verification (quality control): This assessed compliance with medical flowcharts/algorithms and verified supporting documents (including quarterly summary of cases treated, invoice control report, and community verification report) submitted by health facilities and local NGOs. In particular, the DHDs documented detailed procedures and services provided by health facilities, medicine invoices certified by vendors, and paraclinical examination reports with certified costs. The DHDs also checked invoices for services from third-party providers and transport cost statements signed by facility heads. The DHDs also verified the eligibility of beneficiaries and the quality of procedures and services, making corrections if necessary. They consulted the service sheets for each indigent patient, ensuring billed amounts aligned with official rates. When prescriptions did not comply with the flowchart,

health facilities were paid only for compliant invoices on a pro-rata basis. Only requests for payment relating to compliant invoices were forwarded to the PCU. In cases where listed beneficiaries reported not receiving care, payments were withheld until a joint investigation by the PCU, MOHPH, and Social Development and Indigence Fund was completed.

b) **Necessary adjustments during project implementation:** Due to the failure to recruit local NGOs for community verification, only technical verification was implemented, though irregularly. During the MTR, the World Bank recommended establishing local committees in health districts to verify the effectiveness and quality of care provide to indigents. A decree was issued to form these committees, which were responsible for verifying adherence to indigent selection criteria and monitoring the quality of care provided to indigents. The committees were composed of representatives from the DHDs, database managers, directors of microprojects, community-based services, secretaries-general of urban communes, and Social Development and Indigence Fund heads of office in each prefecture. Furthermore, the program was limited to the four districts participating in the RBF program in July 2022 to improve implementation, including fiduciary and accountability aspects.

Health facilities reimbursement procedures: Summary statements and supporting documents submitted by DHDs and multiparty committees were reviewed by the PCU's regional offices to verify the eligibility of beneficiaries and the quality and quantity of services provided. The PCU's finance department further analyzed the reimbursement file by consulting (i) the list of beneficiaries; (ii) quarterly summary statements from health facilities, approved by the DHDs; and (iii) individual care sheets. If the invoices were deemed valid and consistent, the PCU's central office transferred the approved amounts to the health facility account.

Impact: The unique and consensual national targeting approach supported by the project was used by the government to expand the process of identifying poor and vulnerable populations to six new administrative regions by the end of 2022-2023.

The RBF program

Following the successful implementation of an RBF program pilot project in the Mamou health district from 2016 to 2018, supported by various development partners, including the World Bank, the MOHPH decided to gradually expand this financing strategy to other districts, with the goal of achieving national coverage.

In 2021, the RBF program was launched in the Kankan and Kindia regions through the project, covering four districts: Dubreka and Telimele in the Kindia region, and Kouroussa and Mandiana in the Kankan region. Together, these districts accounted for approximately one-third of the population in these regions, corresponding to approximately 1.3 million inhabitants. The program's scale remained intentionally limited to facilitate a gradual process of capacity building and continuous learning before broader expansion.

The program aimed to improve both the quantity (use of services) and quality of RMNCH services through a contractual approach.

Players involved and their functions: The players adhered to the RBF principle of separating functions, as outlined in table 5 below.

Table 5. Functions of the key RBF program players

Functions	Implementation structures
Regulation, planning, and quality assurance	MOHPH, through the RHDs and DHDs
Service providers	Community relays and public health facilities
Contractualization, verification, and validation	1. CVAs (for contractualization and quantity verification for RHDs, DHDs, health facilities, and community relays, using local independent associations) 2. RHDs verification and validation committees (for quality verification and validation for DHDs and district hospitals) 3. DHDs verification committees (for quality verification and validation for health centers) 4. RBF national coordination unit (for validation)
Buyer	MOHPH, through the CVAs and RHDs and DHDs verification and validation committees
Payer	PCU
Strengthening the voice of the people	Local independent associations in each community

Training given to the players involved: All actors involved received training to ensure the successful implementation of the RBF strategy, including a study tour to Cameroon in September 2022 for 12 cadres.

Services purchased: The services purchased included those under the minimum packages of services and complementary packages of services offered by health facilities. For regulatory structures (the RHDs and DHDs), the purchased services pertained to the core functions of Guinea's health system. Community health activities were also included.

Types of verification: Payment for indicators was made only after results had been verified. The types of verification included (i) quantity verification; (ii) quality verification, which included verification of administrative and FM; (iii) community verification, coupled with a satisfaction survey; and (iv) cross-checking.

These verifications strengthened the accuracy of data recorded in the DHIS2 and ensured the validity of invoices submitted. Field verifications helped identify and correct any errors in reported data. Payments were made based on validated data, meaning errors were corrected before final approval.

Results entry, printing, and invoice payment: After verification, results were entered into the RBF portal by CVAs and validated by RHDs and DHDs verification and validation committees. Once results were validated, invoices were generated directly from the RBF portal. The RBF national coordination unit then printed these invoices and forwarded them to the PCU for payment.

Subsidies were paid directly into the beneficiaries' bank accounts. The use of these funds was regulated by the guidelines outlined in the national RBF manual.

Audits-Sanctions: Internal and external audits of transferred subsidy management were conducted regularly. In cases of irregularities or fraud, administrative and financial penalties were applied to health facilities in accordance with the procedures in the manual:

- 1st fraud detected = 20% of subsidies withheld;
- 1st repeat offence = 30% of subsidies withheld;
- 2nd recidivism = contract suspension until corrective administrative action, such as replacing the offender(s), was implemented.

Impact:

a) Institutional

The RBF design emphasized the development and strengthening of the local health system. In the implementation zones, regional and district health system stakeholders actively participated in all activities across the major functions of the RBF scheme. This involvement enabled them to take ownership of the program, build their capacities, and transfer their skills, ensuring the program's continuity. These skills are now available to support the extension of the RBF scheme to other regions through the Guinea Enhancing Health System Transformation Project (P506072).

Key tools developed during the program, such as the index tool, business plans, quantity and quality audit tools, community audit tools, and satisfaction surveys, can be seamlessly integrated into broader health system management.

b) Environmental

The implementation of the RBF program positively impacted the environment by improving hygiene, sanitation, and biomedical waste management in health facilities. This has contributed to reducing environmental pollution through measures such as the elimination of plastic waste, proper wastewater management, and the use of incinerators for destroying biomedical waste. Additionally, the program has improved infection prevention and control practices at both individual and collective levels, particularly in treatment areas such as delivery rooms and operating theatres.

ANNEX 7. CHANGES TO THE IRIs

Table 6. Changes to the IRIs

Initial IRI	Changes
Proportion of health centers with access to water	Renamed as Proportion of health centers with access to water supply powered by solar energy; Initial baseline of 71% set at 0; Initial end target of 90% set at 100%
Proportion of health centers offering integrated management of childhood illnesses	End target increased from 90% to 100%
Number of health facility health workers trained in RMNCH competencies	Renamed as Number of health facility health workers recruited and trained in RMNCH competencies
Proportion of health centers that benefited from at least one supportive supervision per trimester	End target increased from 80% to 100%
Number of women and children who utilized health centers for RMNCH services	End target increased from 733,597 to 5,456,603
Number of new indigents covered under exemption mechanisms (identified and provided with card)	End target decreased from 150,000 to 77,774
Proportion of health centers transmitting health data on time	End target increased from 90% to 100%
CRIs	
People who have received essential HNP services	End target increased from 301,299 to 1,127,286
Number of children immunized	End target increased from 136,239 to 513,386
Number of women and children who have received basic nutrition services	End target increased from 70,740 to 85,127
Number of deliveries attended by trained health personnel	End target increased from 94,320 to 528,774