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Report No: PAD3267

INTERNATIONAL DEVELOPMENT ASSOCIATION

PROJECT APPRAISAL DOCUMENT
ON
A PROPOSED GRANT
IN THE AMOUNT OF SDR 177.3 MILLION
(US$246.0 MILLION EQUIVALENT)

A PROPOSED CREDIT
IN THE AMOUNT OF SDR 177.3 MILLION
(US$246.0 MILLION EQUIVALENT)

TO THE

DEMOCRATIC REPUBLIC OF CONGO

FOR THE

MULTISECTORAL NUTRITION AND HEALTH PROJECT

May 13, 2019

Health, Nutrition and Population Global Practice
Africa Region

CURRENCY EQUIVALENTS

(Exchange Rate Effective March 31, 2019)

Currency Unit =	Congolese Franc (CDF)
CDF 1,645.01 =	US$1
US$1 =	SDR 0.72
SDR 1 =	US$1.39

FISCAL YEAR
January 1 - December 31

Regional Vice President:	Hafez M. H. Ghanem
Country Director:	Jean Christophe Carret
Senior Global Practice Director:	Timothy Grant Evans
Practice Manager:	Trina S. Haque
Task Team Leaders:	Jakub Jan Kakietek, Hadia Nazem Samaha

ABBREVIATIONS AND ACRONYMS

ADRA	Adventist Development and Relief Agency
AFS	Annual Financial Statements
ANC	Ante-natal Care
ASA	Advisory Services and Analytics
AU	African Union
BWMP	Biomedical Waste Management Plan
CAC	Community Animation Cell *(Cellule d 'Animation Communautaire)*
CAPSA	Centers for Adaptation and Improved Seed Multiplication *(Centre d'Adaptation et de Production des Semences Améliorées)*
CERC	Contingent Emergency Response Component
CIAT	International Center for Tropical Agriculture
CNP-SS	National Steering Committee *(Comité National de Planification – Secteur Santé)*
CODeSa	Community Health Development Committee *(Comité de Développement de Santé)*
CPF	Country Partnership Framework
CPP-SS	Provincial Steering Committee *(Comité Provincial de Planification – Secteur Santé)*
DA	Designated Account
DFID	United Kingdom Department for International Development
DHIS2	District Health Information System 2
DHS	Demographic and Health Survey
DPS	Provincial Health Directorates
DRC	Democratic Republic of Congo
ECD	Early Childhood Development
ESCP	Environmental and Social Commitment Plan
ESF	Environmental and Social Framework
ESMF	Environmental and Social Management Framework
ESS	Environmental and Social Standard
EUP	Public Utility Entity *(Entité d'Utilité Publique)*
FAO	Food and Agriculture Organization of the United Nations
FCV	Fragility, Conflict, and Violence
FM	Financial Management
FP	Family Planning
FY	Fiscal Year
GBV	Gender-based Violence
GDP	Gross Domestic Product
GEMS	Geo-enabling Monitoring and Support
GFF	Global Financing Facility in Support of Every Woman and Every Child
GIS	Geographic Information System
GNI	Gross National Income
GOST	Geospatial Operations Support Team
GRM	Grievance Redress Mechanism
HCI	Human Capital Index
HCP	Human Capital Project
HD	Human Development
HMIS	Health Management Information System

HNP	Health, Nutrition, and Population
HZ	Health Zones
IBM	Iterative Beneficiary Monitoring
ICT	Information and Communication Technology
IDA	International Development Association
IITA	International Institute of Tropical Agriculture
IMCI	Integrated Management of Childhood Illness
INERA	National Institute for Agricultural Studies and Research *(Institut National des Etudes et de la Recherche Agricole)*
IPC	Inter-personal Communication
IPF	Investment Project Financing
IPPF	Indigenous Peoples Planning Framework
IPTp	Intermittent Preventive Treatment for Malaria
IT	Chief Nurse *(Infermière Titulaire)*
IYCF	Infant and Young Child Feeding
LARC	Long-acting Reversible Contraceptive
LiST	Lives Saved Tool
LMP	Labor Management Procedures
M&E	Monitoring and Evaluation
MDGs	Millennium Development Goals
MICS	Multi-indicator Cluster Survey
MII	Method Information Index
MoH	Ministry of Health
MoSA	Ministry of Social Affairs
NAC	National Community Nutrition Platform *(Nutrition a Assise Communataire)*
NGOs	Non-governmental Organizations
NSA	Non-state Actors
ORS	Oral Rehydration Salts
PAC	Post-abortion Care
PACA	Partnership for Aflatoxin Control in Africa
PBF	Performance-based Financing
PDO	Project Development Objective
PCT	Project Coordination Team
PDSS	Health System Strengthening Project *(Projet de Développement du Système de Santé)*
PFM	Public Financial Management
PIP	Productive Inclusion Project
PIU	Project Implementation Unit
PMP	Pest Management Plan
PNDS	National Health Development Plan *(Plan National du Développement de la Sante)*
PNIA	National Agriculture Investment Program *(Programme National d'Investissements Agricoles)*
PoN	Power of Nutrition
PPA	Project Preparation Advance
PPC	Project Preparation Committee
PPSD	Project Procurement Strategy for Development

PRONANUT	National Nutrition Policy
PVS	Participatory Varietal Selection
RAP	Resettlement Action Plan
RBF	Results-based Financing
ReCos	Community Relays *(Relais Communitaire)*
RF	Results Framework
RMNCAH-N	Reproductive, Maternal, Neonatal, Child and Adolescent Health and Nutrition
RPF	Resettlement Policy Framework
SABER	Systems Approach for Better Education Results
SAM	Severe Acute Malnutrition
SBC	Social and Behavior Change
SCD	Systematic Country Diagnostics
SDR	Special Drawing Rights
SENASEM	National Seed Service
SEP	Stakeholder Engagement Plan
SGBV	Sexual and Gender-based Violence
SMART	Standardized Monitoring and Assessment of Relief and Transitions
SNV	National Agriculture Extension Service *(Service Nationale de Vulgarization)*
SoP	Series of Projects
SP	Social Protection
SUN	Scaling-up Nutrition
TA	Technical Assistance
ToR	Terms of Reference
ToT	Training of Trainers
TPM	Third Party Monitoring
UHC	Universal Health Coverage
UN	United Nations
UNFPA	United Nations Fund for Population
UNICEF	United Nations International Children's Emergency Fund
USAID	United States Agency for International Development
WA	Women's Associations
WASH	Water, Sanitation and Hygiene
WB	World Bank
WBG	World Bank Group
WHO	World Health Organization

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DATASHEET

BASIC INFORMATION

Country(ies)	Project Name
Congo, Democratic Republic of	DRC Multisectoral Nutrition and Health Project

Project ID	Financing Instrument	Environmental and Social Risk Classification
P168756	Investment Project Financing	Moderate

Financing & Implementation Modalities

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

Expected Approval Date	Expected Closing Date
28-May-2019	04-Jul-2024

Bank/IFC Collaboration

No

Proposed Development Objective(s)

The development objective of this project is to increase the utilization of nutrition-specific and nutrition-sensitive interventions targeting children 0-23 months of age and pregnant and lactating women in the project regions and to respond to an eligible crisis or emergency.

Components

Component Name	Cost (US$, millions)
Improving the Delivery of Community Interventions and Social and Behavioral Change	177.80
Improving Service Supply and Strategic Purchasing	247.00
Convergence Demonstration Project	47.00
Capacity Strengthening and Project Management	30.20
CERC	0.00

Organizations

Borrower:	Democratic Republic of the Congo
Implementing Agency:	National Nutrition Program (PRONANUT)

PROJECT FINANCING DATA (US$, Millions)

SUMMARY

Total Project Cost	502.00
Total Financing	502.00
of which IBRD/IDA	492.00
Financing Gap	0.00

DETAILS

World Bank Group Financing

International Development Association (IDA)	492.00
IDA Credit	246.00
IDA Grant	246.00

Non-World Bank Group Financing

Trust Funds	10.00
Global Financing Facility	10.00

IDA Resources (in US$, Millions)

	Credit Amount	Grant Amount	Guarantee Amount	Total Amount
National PBA	246.00	246.00	0.00	492.00
Total	**246.00**	**246.00**	**0.00**	**492.00**

Expected Disbursements (in US$, Millions)

WB Fiscal Year	2019	2020	2021	2022	2023	2024	2025
Annual	0.00	65.03	107.17	129.70	104.69	89.30	6.11
Cumulative	0.00	65.03	172.21	301.91	406.60	495.89	502.00

INSTITUTIONAL DATA

Practice Area (Lead)

Health, Nutrition & Population

Contributing Practice Areas

Agriculture, Education, Governance, Social Protection & Labor

Climate Change and Disaster Screening

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

Gender Tag

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

SYSTEMATIC OPERATIONS RISK-RATING TOOL (SORT)

Risk Category	Rating
1. Political and Governance	High

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

COMPLIANCE

Policy

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

[ ] Yes [✓] No

Does the project require any waivers of Bank policies?

[ ] Yes [✓] No

Environmental and Social Standards Relevance Given its Context at the Time of Appraisal

E & S Standards	Relevance
Assessment and Management of Environmental and Social Risks and Impacts	Relevant
Stakeholder Engagement and Information Disclosure	Relevant
Labor and Working Conditions	Relevant
Resource Efficiency and Pollution Prevention and Management	Relevant
Community Health and Safety	Relevant
Land Acquisition, Restrictions on Land Use and Involuntary Resettlement	Relevant
Biodiversity Conservation and Sustainable Management of Living Natural Resources	Relevant
Indigenous Peoples/Sub-Saharan African Historically Underserved Traditional Local Communities	Relevant
Cultural Heritage	Not Currently Relevant
Financial Intermediaries	Not Currently Relevant

NOTE: For further information regarding the World Bank's due diligence assessment of the Project's potential environmental and social risks and impacts, please refer to the Project's Appraisal Environmental and Social Review Summary (ESRS).

Legal Covenants

Sections and Description

Schedule 2, Section I.A.5(d.): Not later than three (3) months after the Effective Date, the Recipient shall cause the PCT to recruit and thereafter retain the following additional staff, (i) a Project Manager/Focal Point; (ii) an Accountant: (iii) a Procurement Specialist: (iv) an FM Specialist; (v) an Environmental Specialist; (vi) a Social Specialist; and (vii) an M&E Specialist.

Sections and Description

Schedule 2, Section I.G.2.: The Recipient shall, not later than 3 months after the Effective Date, recruit, under terms of reference satisfactory to the Association, and in accordance with the terms of the PIM, an External Verification Agency to conduct independent annual verifications of: (a) the Package of BPNS delivered under Part 1 of the Project; and (b) the performance of implementing agencies (including Health Administration Directorates and Services) under the Performance Frameworks of Part 2 of the Project.

Sections and Description
Schedule 2 Section I.A.4.a:The Recipient shall, not later than three (3) months after the Effective Date, formalize, and at all times during Project implementation maintain, the Project Technical Committee ("PTC") with composition and mandate acceptable to the Association.
Sections and Description
Schedule 2 Section I.J.1:The Recipient shall, not later than three (3) months after the Effective Date acquire, install and customize the management accounting software required to generate the financial reports of the Project.
Sections and Description
Schedule 2 Section I.J.2: The Recipient shall, not later than three (3) months after the Effective Date recruit an internal auditor under terms of reference acceptable to the Association.
Sections and Description
Schedule 2 Section I.J.3: The Recipient shall, not later than three (3) months after the Effective Date recruit an independent external auditor under terms of reference acceptable to the Association.
Sections and Description
Schedule 2 Section I.J.4: The Recipient shall, not later than three (3) months after the Effective Date ensure that all procurement staff are trained on the World Bank's new Procurement Framework.
Sections and Description
Schedule 2, Section I.C.2: The Recipient shall furnish to the Association, not later than November 30 of each year, the annual work plans and budgets approved by the National Steering Committee for the Association's review and approval; except for the annual work plan and budget for the Project for the first year of Project implementation, which shall be furnished no later than one (1) month after the Effective Date.

Conditions

Type	Description
Effectiveness	The Recipient has adopted a project implementation manual (PIM) in form and substance satisfactory to the Association.
Disbursement	Notwithstanding the provisions of Part A above, no withdrawal shall be made: (b)under Category 4 unless and until the following conditions have been met: (i) the Service Agreement has been executed with the Service Provider in form and substance satisfactory to the Association; and (ii) an Accredited Payment Agency has been recruited by the Service Provider.
Disbursement	Notwithstanding the provisions of Part A above, no withdrawal shall be made: (c) under Category 5 unless the following conditions have been met: (i) the Recipient has determined

	that an Eligible Crisis or Emergency has occurred, has furnished to the Association a request to include such activities in the Project in order to respond to said Eligible Crisis or Emergency, and the Association has agreed with such determination, accepted said request and notified the Recipient thereof; (ii) the Recipient has adequate staff and resources for the purposes of said activities;(iii) the Recipient has adopted the EROM in form, substance and manner acceptable to the Association; and (iv) the Recipient has developed and adopted an emergency action plan in form and substance acceptable to the Association.
Type Effectiveness	Description The Condition of Effectiveness for the GFF Grant is that all conditions for the effectiveness of the Financing Agreement, except for the effectiveness of GFF Grant Agreement, have been met.
Type Disbursement	Description For the GFF Grant, notwithstanding the provisions of Part A of this Section no withdrawal shall be made for payments made prior to the Signature Date of the GFF Grant Agreement.

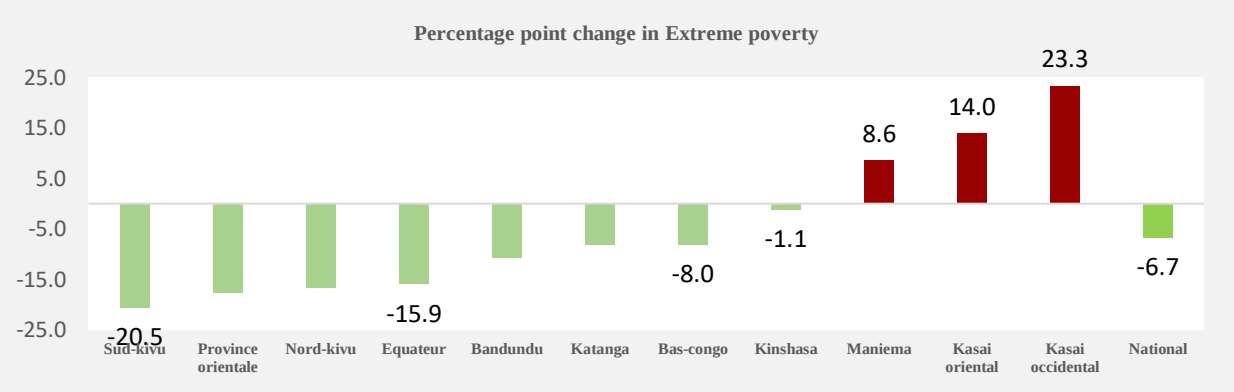
I. STRATEGIC CONTEXT

A. Country Context

1. Despite its tremendous wealth in natural resources and its potential for economic development, the Democratic Republic of Congo (DRC) is one of the poorest countries in the world. The per capita gross domestic product (GDP) in 2017 was US$432, almost a quarter of the Sub-Saharan Africa average (US$1,467). Between 2005 and 2012, the percentage of people living in poverty in DRC declined from 69.3 percent to 64 percent. At the same time, however, due to high population growth, the number of poor increased by 7 million (DRC Systematic Country Diagnostic (SCD); World Bank, 2018)[1].

2. Although poverty is currently decreasing, it remains widespread and was estimated at 73.3 percent in 2017. In fact, DRC contributes the second largest number of extreme poor in Sub-Saharan Africa after Nigeria; 14 percent of all people living in extreme poverty in Sub-Saharan Africa live in DRC (DRC SCD 2018). The pace of poverty reduction is significantly slower than that experienced in other countries in the region (DRC Jobs Diagnostic; World Bank 2016) and large swaths of the population remain trapped in extreme poverty with little hope that their living conditions will improve in the near future (World Bank, 2018). Furthermore, despite the decrease in the national poverty rate, in some regions poverty has increased substantially (see Figure 1). The country's poverty is not only monetary, but it includes a sense of economic instability, insecurity, and inability to cope with uncertainty (World Bank, 2013).

Figure 1: Percentage Point Change in Extreme Poverty in DRC, by Province



Source: Jobs Diagnostics, 2016.

3. Employment opportunities as well as prospects to increase productivity and earnings are limited. Jobs tend to be informal, often for subsistence and with low value added per worker. Rural workers, particularly youth, end up underemployed and find migration to urban areas enticing (World Bank, 2018). Urban areas have been unable to accommodate the growing number of workers—particularly women—into slowly expanding wage jobs and urban dwellers represent an estimated 83 percent of the unemployed. Rapid population increase, insufficient macroeconomic growth, and unbalanced sectoral development have combined to push a great many working-age people into the informal sector, which accounted for 81.5 percent of employment in 2015.

4. One key factor hampering the development of high-quality formal employment and constraining the inclusiveness of economic growth more broadly is the low level of human capital (DRC SCD 2018). DRC ranked

[1] Report No.112733-ZR.

176 among 188 countries on the 2016 Human Development Index and 146 among 157 countries on the 2018 Human Capital Index (HCI). DRC's HCI value of 0.37 indicates that a child born today in the country will achieve only 37 percent of her productive potential. DRC has not reached any of its Millennium Development Goals (MDG) (DRC SCD 2018). The gross enrollment ratio for primary education improved from 93 percent in 2005 to 107 percent in 2014, but retention and achievement of learning outcomes remain challenging and there are an estimated 7 million children out of school.

5. Prospects for a demographic dividend can only be strengthened if the demographic transition is accelerated, and investments in human capital development are put in place. On the latter, investments in health and education remain very low. For example, health expenditure in DRC is 10 percent of the Sub-Saharan Africa average (DRC SCD 2018). With respect to the demographic transition (see Key Health Indicators in Table 1 below), life expectancy at birth was estimated to be 59.6 years in 2015 (six years higher than in 2005). Moreover, the under-5 mortality rate of 104 per 1,000 live births in 2014 (down from 155 in 2007) was higher than the Sub-Saharan Africa average of 78.3 per 1,000. Decline in under-5 mortality is an important precursor of fertility decline, which is a necessary prerequisite for a demographic transition, after which a demographic dividend may be possible. The maternal mortality ratio increased from 543 per 100,000 live births in 2007 to 846 per 100,000 live births in 2014 and at least in part mirrors the increase in the total fertility rate during the same time period from 6.1 to 6.6. High fertility in DRC is driven by high adolescent childbearing as 27 percent of girls 15-19 years old have already either given birth or are pregnant – a figure that increases to one-third of all *rural* girls of the same age. Adolescent fertility is associated with school dropout, higher risk of death and disability as a result of pregnancy and childbirth, poor birth outcomes, and ultimately, stunting. The median time between births is 30.4 months for all women, and only 25.5 months among adolescents (age 15-19 years). Delaying age of first birth and increasing birth spacing will have population-level temporal and quantum shifts in fertility that will serve to slow population growth, which will have downstream effects for both household and national human capital accumulation through a number of related health, nutrition, and socioeconomic pathways.

Table 1: Key Health Indicators

Indicator	Value
Demographic and health indicators	
Neonatal mortality rate (deaths per 1,000 births)	28[2]
Infant mortality rate (deaths per 1,000 births)	58[2]
Child mortality rate (deaths per 1,000 births)	104[2]
Maternal mortality ratio (deaths per 100,000 live births)	846[2]
Life expectancy at birth (years)	59.6[1]
Total fertility rate (children per woman)	6.6[2]
Adolescent fertility rate (births per 1,000 women 15-19 years of age)	138[2]
Stunting prevalence in children 0-5 years of age	42.6%[2]
Health system characteristics	
Total health expenditure per capita (current US$)	US$19.70[1]
Domestic general government health expenditure as % of current health expenditure	16.5%[1]
Physicians per 1,000 people	0.091[1]

Health service utilization	
Pregnant women attending 4 ANC visits (ANC)	48.0%[2]
Deliveries assisted by qualified personnel	80.1%[2]
Deliveries in a health facility	79.9%[2]
Pregnant women receiving antenatal iron supplementation	58.9%[2]
Children 12-23 months of age with complete vaccination	22%-45%[2]
Newborns receiving post-natal care	9.7%[2]

Source: [1]World Development Indicators; [2]DRC Demographic and Health Survey (DHS) 2013-2014.

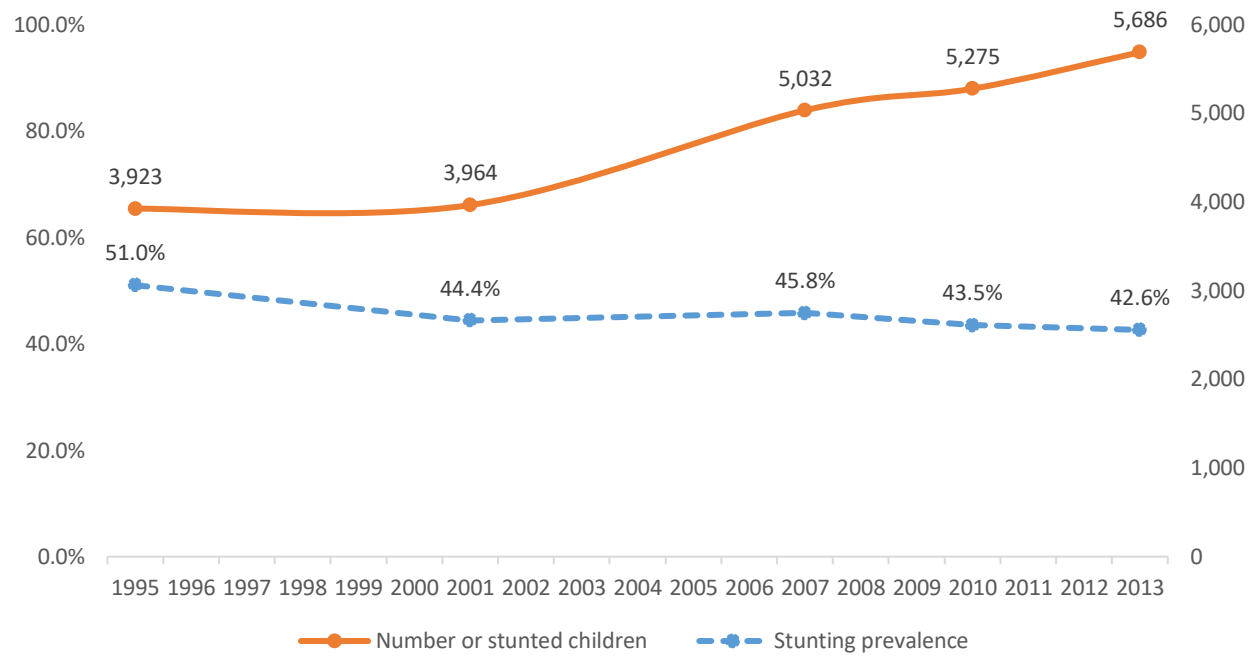
B. Sectoral and Institutional Context

6. Child malnutrition, an underlying cause of up to 45 percent of under-5 deaths, has emerged as one of the key markers of poverty and vulnerability as well as a major challenge in ensuring optimal accumulation of human capital in the country. Global evidence demonstrates that stunting, a manifestation of chronic malnutrition, is associated not only with increased risk of illness and death, but also with poor cognitive development, lower educational attainment, lower productivity, wages, and income in adulthood. Stunting costs countries in Africa and Asia between 4 and 11 percent of GDP annually.

7. In DRC, the negative impact of stunting on educational attainment seems to be particularly relevant. About 20 percent of the children entering primary school drop out before they reach second grade (DRC School Census, 2013). While to date there is no systematic analysis of the factors driving this high dropout rate, stunting, which hampers children's ability to keep up with the curriculum, is hypothesized to be one of the reasons behind this very high dropout rate.

8. In DRC, the prevalence of stunting remains alarmingly high. According to the most recent data, about 42.6 percent or about 5.6 million children under the age of 5 are stunted (DRC DHS 2014). In fact, DRC has the third largest population of stunted children in Sub-Saharan Africa (after Nigeria and Ethiopia). While the prevalence of stunting has been declining on the African continent over the past decades, in the DRC it has remained stagnant (44.4 percent in 2001, 45.8 percent in 2007, 43.5 percent in 2010, and 42.6 percent in 2013), with an annual average decline rate of 0.15 percentage points (see Figure 2 below). Moreover, due to high fertility and population growth, the number of stunted children in DRC in 2014 was about 45 percent (1.7 million) higher than in 1995.

Figure 2: Stunting Prevalence and the Number of Stunted Children in DRC, 1995-2014



Source: World Development Indicators 2019.

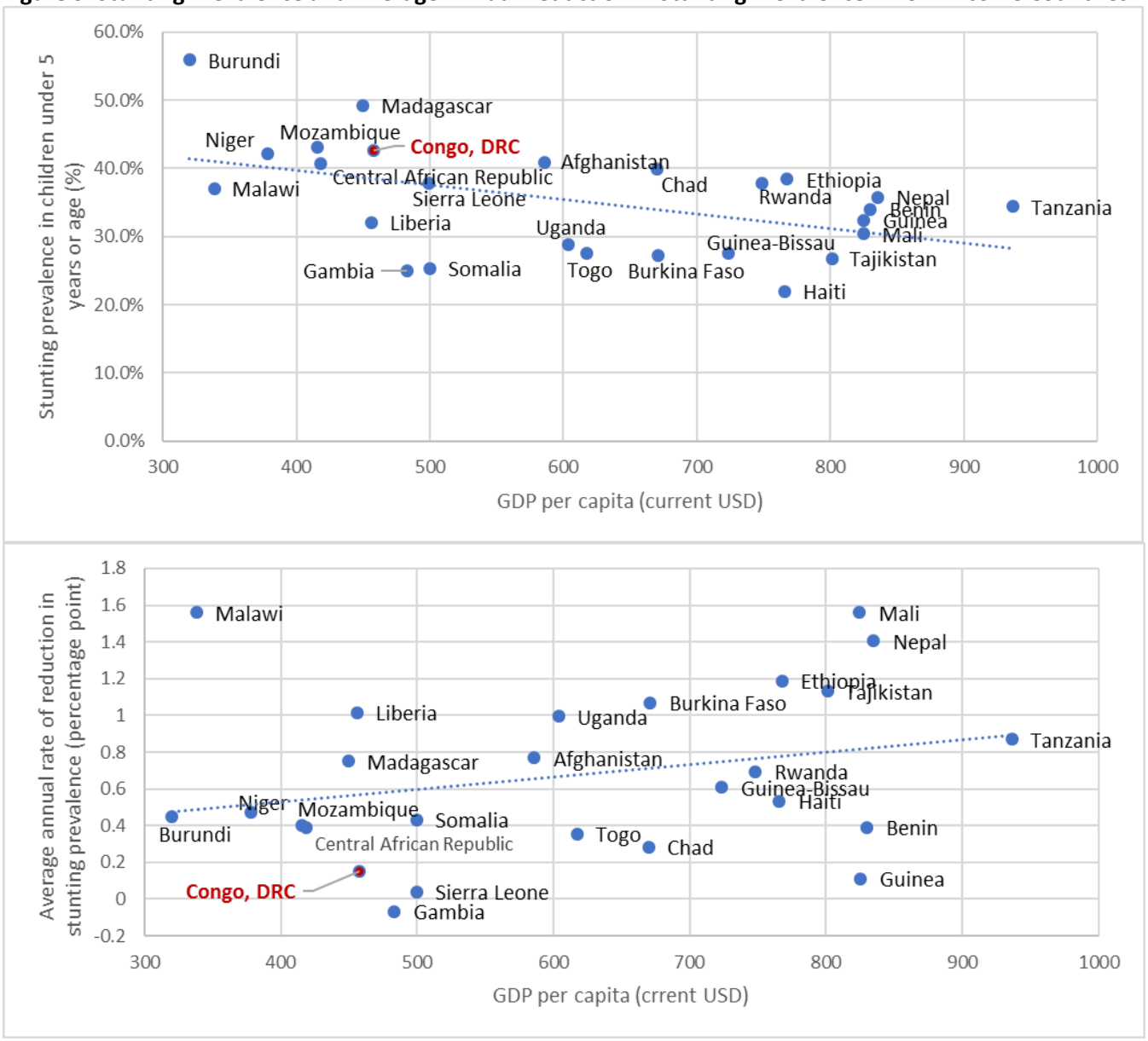
9. Stunting presents a challenge in virtually all regions of the country. In 21 out of the 26 provinces of DRC, stunting prevalence in children 0-59 months of age exceeds 40 percent, which is the World Health Organization's "very high public health significance" threshold. In Nord-Kivu, Sud-Kivu, Tanganyika, Lomami, Sankuru, and Kasai, more than half of all children under the age of 5 are stunted.[2]

10. Cross-country comparisons show that chronic malnutrition is affecting DRC more than other countries with similar income levels. Only three low-income countries have a stunting prevalence higher than that in DRC --Burundi, Madagascar, and Mozambique (see Figure 3, Panel 1). In a number of countries with very similar per capita GDP, stunting prevalence is substantially lower (Central African Republic, Malawi, Liberia, Sierra Leone, Uganda). The pace of stunting reduction is slower in DRC than what would be expected based on its income level. In virtually all low-income countries, stunting prevalence has been declining faster than in the DRC (see Figure 3, Panel 2). This includes other fragility, conflict and violence-affected (FCV) countries such as Somalia, the Central African Republic, and Afghanistan.

11. The comparisons with other low-income countries presented above suggests that substantial reductions in stunting prevalence in DRC can be achieved if chronic malnutrition is prioritized at the policy and programmatic level.

[2] In addition to stunting, the prevalence of other dimensions of malnutrition remains alarmingly high. Nearly 8 percent of all children under the age of 5 suffer from acute malnutrition (DHS 2013) and 60 percent suffer from anemia. The prevalence of anemia is higher (76 percent) in younger children (6-8 months of age), which suggest inadequate accumulation of iron before birth. This is related to the high prevalence of anemia among women of reproductive age and pregnant women which reaches 38 percent and 43 percent, respectively (DHS 2013).

Figure 3: Stunting Prevalence and Average Annual Reduction in Stunting Prevalence in Low-Income Countries



Source: World Development Indicators 2019

Determinants of Chronic Malnutrition in the DRC:

12. Child stunting is a result of inadequate food intake (both in terms of quantity and quality), of repeated and untreated infections, such as diarrhea, acute respiratory illness, or malaria, and of poor birth outcomes, when children are born pre-term or small for gestational age. These in turn result from inadequate access to key maternal and child health services, inappropriate feeding practices, low availability and low diversity of foods, low incomes, poor health and nutrition status of mothers and, more generally, low level of maternal education and low status of women in households and communities.

13. ***Inappropriate feeding behaviors and practices:*** Child feeding practices in DRC remain suboptimal and need to be substantially improved. While the overall breastfeeding rate is high - about 98 percent of children 0-23 consume some breastmilk, only 48 percent of children 0-6 months of age are exclusively breastfed and only 52 percent of newborns are fed breastmilk within the first hours after birth. Early initiation of breastfeeding is critical, because it ensures that the child consumes colostrum, which is very rich not only in nutrients, but also in antibodies and is a crucial early boost for the newborn's immune system. It also enhances uterus contraction and is fundamental in the socioemotional bonding between child and mother (newborn babies can be left on the stomach of the mother and instinctively find their way to the mother's breast and latch on for feeding). Data from DRC shows that children who were breastfed within the first hour after birth had about 20 percent lower odds of being stunted than children who were not (Kismul et al. 2018).[3] The most recent DHS data shows that only about 8.4 percent of children 6-23 months of age have a minimum acceptable diet based on the World Health Organization (WHO)/United Nations International Children's Emergency Fund (UNICEF) infant and young child feeding (IYCF) standards; only 20 percent have adequate food diversity and only 35 percent have adequate meal frequency. Only 11 percent of children in the poorest households consumed foods with adequate food diversity, compared to 37 percent in the richest households. However, it needs to be emphasized that the quality of diet is not simply a matter of income. Even in the richest household (top income quintile), only about 14 percent of children have the minimum acceptable diet.

14. ***Low availability and utilization of maternal and child health services:*** The prevalence of treatable childhood illnesses is high, and the utilization of preventive and curative services for pregnant women and for children is very low. Fewer than half (48 percent) of all women in DRC receive the required four ANC visits, only 17 percent have the first visit in the first trimester of pregnancy, and only about 59 percent of women receive any micronutrient supplementation during pregnancy. More than half (52 percent) of women do not receive any post-partum care. The level of utilization of routine health services for children is even lower: 90.3 percent of newborns do not receive any post-natal care; only 22-45 percent (based on vaccination card and mothers' reports, respectively) of children 12-23 months of age have complete vaccination; only 39 percent of children with diarrhea are treated with oral rehydration salts (ORS), and only 2.4 percent receive therapeutic zinc supplements. Underdeveloped health infrastructure, low quality of services offered, and financial barriers are among the key determinants of low utilization of health services (see below). Low utilization of services contributes to high prevalence and incidence of childhood illnesses, which in turn increases the risk of stunting. Analysis of DHS data shows that children 0-23 months of age whose mothers had four or more ANC visits had 30 percent lower odds of being stunted, and children who attended the required post-natal care visits had 53 percent lower odds of being stunted than children who did not.[4]

15. ***Suboptimal birth outcomes:*** Poor birth outcomes put newborns on suboptimal growth trajectories at the onset of their lives, and children who are born prematurely and who are born small for gestational age are likely to remain stunted throughout childhood. In DRC, 7.1 percent of children are born with low birth weight, with a substantially higher proportion in some geographic regions (for example, Sud Kivu – 11 percent) and among children born to young mothers (10.6 percent). Adolescent pregnancy and short intervals between births are the two key factors that increase the risk of negative birth outcomes and stunting. Recent analyses show that children who were born less than 24 months after a sibling had 40 percent higher odds of being

[3] The document focuses on early initiation because the literature shows that, in DRC, early initiation rather than exclusive breastfeeding is associated with the risk of stunting (Kismul et al. 2018). However, it needs to be noted that breastfeeding promotion interventions need to include early initiation, exclusive breastfeeding for the first 6 months, and complementary breastfeeding up to the age of 23 months.

[4] Reanalysis of the DHS data by the project team.

stunted than children born more than 24 months after a sibling, and children of teenage mothers had 30 percent higher odds of being stunted than children of mothers who were 20-34 years old (Kismul et al. 2018). In DRC, about 13 percent of women aged 15-19 years of age have already given birth, while 42.6 percent of them have a birth interval of less than 24 months. Moreover, the contraceptive prevalence rate for modern methods is only 8 percent overall, and even lower, at 5 percent, for girls age 15-19 years. This is further compounded by the level of unmet need for family planning (FP) which has increased from 26.2 percent to 30.8 percent between 2007 and 2014 (DHS 2013-2014) among adolescents and was 27.7 percent for all women in 2014.

16. ***Low purchasing power:*** According to the Ministry of Agriculture, the average daily consumption in DRC is 1836 kcal, substantially less than the minimum daily requirement of 2500 kcal (FAO, 2009). Most of the energy comes from staples, and the consumption of other types of food, in particular animal-source proteins which are critical for the optimal growth of children, is very limited (Ministry of Agriculture 2009). Low income and purchasing power are the key factor limiting access to food. Nearly 70 percent of households in the lowest income quintile live in chronic food insecurity. This is particularly the case for urban and peri-urban households for whom food comes mainly from market purchases. Because of greater reliance on imported foods and higher price volatility, urban and peri-urban households pay a higher price per calorie consumed. Consequently, chronic food insecurity is more prevalent in urban and peri-urban areas than in rural areas (Adoho et al. 2018). Low income also creates barriers to the use of health and other essential services. Lack of money is the most common barrier to accessing health care - 68.6 percent of women report not having enough money to afford health services (DHS 2013-2014). Consequently, children from the lowest wealth quintile have almost 3 times higher odds of being stunted than children from the top wealth quintile (Kismul et al. 2018).

17. ***Unavailability of high nutritional quality foods:*** Access to adequate quality and quantity of foods is also constrained by very limited agricultural productivity - one of the lowest in Sub-Saharan Africa (Adoho et al. 2018). Low productivity results from, among other factors, a wide-spread use of traditional agricultural techniques and lack of access to modern high-yield inputs. Only 5 percent of food producing households use improved seeds and only 4 percent use fertilizers (Adoho et al. 2018). Among food-insecure households, the use of improved seeds and fertilizers is even lower – 0.9 percent and 0.8 percent, respectively (ibid.). For cassava, the most widely grown and consumed staple, it is estimated that the current production reaches only about 14-18 percent of the potential yield. Insufficient quality and quantity of the food produced in DRC increases reliance on food imports, resulting in high food prices, food price volatility and increasing food insecurity for urban and peri-urban households (see above). It also constitutes a major challenge for rural households, for whom a greater proportion of the food consumed comes from self-production.

Interventions aimed at reducing stunting

18. An extensive body of evidence shows that stunting burden can be reduced using a set of interventions that act on the key determinants of malnutrition described above.

19. Inappropriate feeding behaviors and practices can be improved through IYCF counseling delivered at the community level and through health facilities (see Bhutta et al. 2013 for a review). The impact of IYCF interventions on child stunting can be increased through **social and behavior change campaigns** using multiple channels ranging from community mobilization through national media campaigns (as demonstrated by the recent experiences of the Alive and Thrive initiative in Ethiopia, Bangladesh, and Vietnam. (See for example Kim et al. 2016; Nguyen et al. 2017; Rawat et al. 2017). A **package of interventions delivered through the health system and targeting pregnant and lactating women and children under the age of 5** is also very effective in improving health and nutrition status of children and reducing the risk of stunting. This package

includes **ANC and micronutrient supplementation for pregnant women, post-natal care for women and children, micronutrient supplementation and deworming for children, immunization, and integrated management of childhood illnesses.** (For a review, see the 2013 Lancet series on maternal and child nutrition; for a summary, see Shekar, Kakietek, Dayton, Eberwien, and Walters 2017). The key determinants of suboptimal birth outcomes which increase the risk of stunting can be improved by **peri-conceptual micronutrient supplementation** and by **promotion and provision of FP and modern contraceptive methods**.

20. **Cash transfers** have been shown to increase household purchasing power and improve household food consumption. Several studies from Sub-Saharan Africa show that cash transfer programs are effective in improving not only food security but also dietary diversity (Case 2004; Handa, Seidenfeld, Tembo, Prencipe, and Peterman 2013; Miller and Tsoka 2008; OPM 2013; Berhane et al. 2015; OPM 2014; OPM 2015; Soares and Teixeira 2010). There is also evidence that they improve access to health services for pregnant women, mothers, and children (Adato and Bassett 2009). The evidence suggests that the effects are greater for younger children 0-23 months of age (Leroy, Ruel, and Verhofstadr 2009; Bhutta et al. 2008); for larger transfers, about 20 percent of the baseline household expenditure, (Davis and Handa 2015); when transfers are targeted at high-risk/high nutrition deficiency burden populations (Bassett 2008; Leroy, Ruel, and Verhofstadr 2009); and, critically, when they are provided in contexts where adequate supply of health and nutrition services exists (for example, Manley et al. 2012).

21. Evidence reviews show that nutrition-sensitive interventions in agriculture can be effective in increasing the availability and consumption of high-nutrition quality foods, especially when combined with complementary behavior change interventions. Strong evidence shows that **biofortification** can improve micronutrient intake, reduce micronutrient deficiency, and reduce the incidence of diarrhea - one of the key risk factors of stunting (Bouis and Saltzman 2017; Hotz et al. 2012; Jones and de Brauw 2015). Evidence on increased dietary diversity/intake of nutritious foods also exists for interventions aimed at improving **homestead food production,** mostly for households that live in remote areas, and especially when combined with behavior change communication (Ruel et al., 2018). Studies show that increasing dietary diversity reduces the risk of stunting and improves growth after growth faltering (Busert et al. 2016).

National policy response

22. Efforts to implement multisectoral actions including those described above and to build a comprehensive nutrition policy agenda in DRC have been under way since the early 2000s. Recognizing the impact of malnutrition on human development and economic growth, the country's government identified the fight against malnutrition and, more broadly, the investments in the early years, as priorities in the national strategy for poverty reduction and economic development.

23. In 2000, the Government adopted a national nutrition policy and created the National Nutrition Program (PRONANUT) within the Ministry of Health (MoH). In the early 2000s both the policy and the program focused on nutrition-specific curative interventions for acute malnutrition. In 2010, a nutrition component was included in the National Health Development Plan for 2011-2015. The plan focused on reaching the MDGs and was developed in the context of the 5-Year National Development Plan 2011-2015. In 2013, DRC adopted the second National Nutrition Policy. The policy set up ambitious goals including reducing stunting prevalence in children 0-23 months of age by 50 percent by 2023. Unlike the 2000 version, the 2013 iteration extended beyond the health sector, recognizing that addressing maternal and child malnutrition required a concerted multi-sectoral approach. In the same year, the country joined the global Scaling-up Nutrition (SUN) Movement. The prime minister became the president of the national SUN platform, and the Minister of Health became its first vice-president. In 2017, DRC adopted a National Multisectoral Strategic Nutrition Plan that operationalized the

Nutrition Policy. PRONANUT, which serves as the SUN platform's executive secretariat, is mandated to oversee and coordinate the implementation of the Plan.

The NAC model:

24. In 2002, the Government developed a policy and a set of operational documents for the national community nutrition platform (*Nutrition a Assis Communautaire,*NAC), anchored in local governance structures and using Community Relays (R*elais Communautaires,* ReCos), a cadre of community nutrition agents who provide a basic package of nutrition services targeting pregnant and lactating women and children under the age of 5. They also work as an interface between the community and public service providers (see Box 1 below). The NAC guidelines were updated in 2017. To date, however, the strategy has only been rolled out on a small scale (covering only 36 out of 516 [6.7 percent] health zones (HZ) in DRC), largely driven by donors through short-term programs. The experience to date indicates the viability of NAC as an effective service delivery modality at the community level. At the same time, however, the multitude of actors involved, and the very limited coverage of the interventions point to an urgent need to scale the model up.

Box 1: Community Nutrition in DRC: *The* NAC Model

Recognizing the importance of the community in addressing the challenge of malnutrition, the Government of DRC, through the National Nutrition Program (PRONANUT) adopted a model for the delivery of NAC. The model consists of the following elements:

Relais Communautaires (ReCos): ReCos are community volunteers who provide a basic package of community nutrition and health services: (a) promotion of good nutrition and hygiene behaviors including infant and young child feeding and FP through household visits and group sessions in the community; (b) provision of basic commodities (delivery kits; child health kits [zinc, ORS, micronutrient powers, and paracetamol]; condoms and oral contraceptives); and (c) referral to health services and other relevant services.

Community organizations: ReCos are selected by and are part of the key community governance structures, including the CAC and the community health development committee (*Comité de développement de santé* [CoDeSa]). Through CAC and CoDeSa, the ReCos are accountable to their communities.

Health System: ReCos are supported by the formal health sector. Their work is supervised by the chief nurse IT within the health zone where they work. The IT is responsible for training and supportive supervision of the ReCo and for managing and reporting to the HMIS the data collected by the ReCos on services they provide.

NGOs: Recognizing capacity constraints within the health system in DRC, the NAC Guide stipulates that in the initial phase of its scale-up, the NAC model should be supported by nongovernment organizations (NGOs). More specifically, NGOs should support the communities and the CAC in identifying the ReCo, and the health system in training, supervising, and monitoring their work.

Nutrition in key sectoral documents:

25. Nutrition is included in some of the key health sector documents and initiatives, including the 2016 National Health Development Plan (*Plan National du Développement de la Sante,* PNDS*).* In 2015, DRC joined the Global Financing Facility in support of Every Women and Every Child (GFF). The GFF Trust Fund acts as a catalyst for financing, with countries using modest GFF Trust Fund grants to significantly increase their domestic resources alongside the World Bank's financing, aligned external financing, and private sector resources. Each

relatively small external investment is multiplied by countries' own commitments – generating a large return on investment, contributing to lives saved and to the accumulation of human capital. The Government of DRC put in place a national GFF platform that brought together the key government health stakeholders, line ministries, civil society representatives, and development partners. The platform led the development of the country's reproductive, maternal, neonatal, child, and adolescent health and nutrition investment case within the context of the interventions laid out in the PNDS. The investment case has identified 12 priorities with a goal of reducing maternal mortality and child mortality over a period of five years in 14 priority provinces.[5] Improving the coverage and quality of nutrition interventions is included as Priority 3 of the investment case and stunting reduction is among its key strategic results. The MoH has identified performance-based financing (PBF) as the key strategy to ensure the achievement of universal health coverage (UHC) in DRC. Both PNDS and the Investment case emphasize its role, and the ministry is committed to ensuring that all new investments in health in DRC include PBF elements at the primary health care level.

26. Several policy documents govern the agriculture sector, but they are not well coordinated and do not address nutrition in a direct manner. The 2013 National Agriculture Investment Program *(Programme National d'Investissements Agricoles,* PNIA), which has a total estimated cost of US$5.7 billion over seven years, rests on five pillars: (i) fostering value chains and agribusiness; (ii) achieving food security; (iii) enhancing research, extension, and training; (iv) improving sector governance, gender participation, and institutional capacity; and (v) adapting to climate change. In 2014 the Government launched the Agro-Industrial Action Plan to boost agribusiness and industry. A national policy for food security and nutrition is currently under development. In addition, the Government of DRC, in partnership with HarvestPlus, has been developing locally biofortified crops, including vitamin A-fortified cassava and maize and iron-fortified beans, but no roll-out of those crops has been undertaken to date. In practice, ownership of nutrition-sensitive agriculture policies at the provincial level, and even occasionally at the central level, is low. There is weak coordination and harmonization across the different policies and implementing agencies, and human, technical, and financial capacity to implement agricultural policies is poor.

27. The 2011 Standards and Guidance for Integrated Interventions for Maternal, Newborn and Child Health in DRC (*Normes et lignes directrices sur les interventions intégrées pour la santé maternelle, du nouveau-né et des enfants en République Démocratique du Congo*) and the Integrated Early Childhood Development Policy (*Politique Nationale sur le Développement Intégré du Jeune*) adopted by nine ministries in 2012 demonstrates that the country understands the importance of investing in support services that provide children with a good start in life involving nurturing, care, and a safe environment during their early years (see Table 2 below). However, despite government efforts in promoting early childhood development (ECD), evidence gathered in the World Bank's ECD Systems Approach for Better Education Results (SABER) tool for ECD, suggests that the policy environment remains limited, with low inter-institution coordination and few programs with sustained financing.

Key bottlenecks constraining the scale up of key nutrition specific and nutrition sensitive interventions:

28. Despite the commitment and positive development at the policy level, three general systemic bottlenecks constrain the scale up of the evidence-based actions aimed at reducing the burden of stunting in DRC. These three bottlenecks include: (i) absence of a coordinated response and a severely underdeveloped service delivery platform at the community level; (ii) low availability and quality of public services in health and

[5] Tanganyika, Haut-Lomami, Sankuru, Maniema, Lomami, Tshuapa, Kongo Central, Sud-Kivu, Kasaï, Kasaï-Central, Lualaba, Mongala, Sud-Ubangi, and Kwango.

other nutrition-sensitive sectors; and (iii) weak governance and limited management capacity of state actors at the local, provincial, and central levels.

Table 2: Coverage of Selected High-Impact Nutrition-Specific and Nutrition-Sensitive Interventions in DRC

Indicator	Value
Iron supplementation in pregnancy	
Any iron supplementation	59.9%
90 days supplementation	5.0%
Intermittent Preventive Treatment of malaria in pregnancy (IPTp)	14.3%
Vitamin A supplementation for children 6-59mo	70.4%
Micronutrient supplementation for children 0-59mo	15.7%
ORS+zinc	2.4%
Deworming	60.6%
Vitamin A supplementation for pregnant women	27.0%
Intermittent iron/folic acid supplementation for women 15-49yo	0.0%
Pregnant women attending 4 ANC	48.0%
Percentage of children 12-23mo with complete vaccination	22%-45%[a]
Percentage of infants receiving post-natal care	9.7%
Percentage of women with met demand for modern FP services	16.3%

Sources: DRC DHS 2013-2014; No data are available regarding the coverage of IYCF, severe acute malnutrition (SAM) treatment, nutrition-sensitive cash transfers, biofortification, and homestead food production intervention.
Notes: [a] based on vaccination cards and mothers' self-reports, respectively.

29. ***(1) Absence of a coordinated response at the community level:*** While key policies and guidelines regarding community-level service provision and mobilization have been developed, to date the NAC model has only been rolled out on a small scale, largely by external donor programs, and in an uncoordinated fashion, often inconsistent with the national guidelines. A recent mapping exercise led by PRONANUT has identified nearly 60 organizations in different sectors that provide support for nutrition activities at the community level. Among those, 16 organizations provide different infant and young child-feeding counseling services, and as many as 58 provide interventions related to hygiene promotion and water, sanitation, and hygiene (WASH). Despite the multitude of actors, the coverage of the essential nutrition interventions on the ground remains very limited. For example, only 5 out of 34 *zones de santé* in Sud Kivu and 5 out of 19 *zones de santé* in Kasai Oriental are covered with IYCF interventions. The coverage is even weaker for iron and folic acid supplementation, therapeutic zinc, management of SAM, or inputs for FP. Furthermore, the geographic coverage of the interventions often does not correspond with the disease burden. For example, the highest coverage of zinc and oral rehydration solution (zinc+ORS) for the treatment of diarrhea is in Maniema – a province with one of the lowest diarrhea incidence levels in DRC. This highly fragmented landscape demonstrates that in addition to the absence of services at the community level, coordination across different actors remains a significant challenge.

30. ***(2) Low availability and quality of health, FP, and other nutrition-sensitive services:*** DRC has 0.09 physicians per 1,000 inhabitants – three times fewer than the Sub-Saharan Africa average (0.3) and well below the WHO recommendation of 1 per 1,000. In many regions of the country, health facilities and medical equipment have been looted and destroyed. For example, in the Kasai region, according to the emergency response plan prepared by the MoH (2017), of the 1,077 health facilities 29 percent were destroyed or looted during the recent crisis; 32 percent experienced increased demand for care due to influx of internally-displaced persons, and 13 percent were abandoned by health staff who fled fearing for

their safety. In 2016, according to a survey conducted for the DRC Health System Strengthening project (P147555), only 20 percent of health facilities had all six tracer drugs, only 30 percent of health facilities surveyed offered FP services, and the average health facility had only 4 of the 6 essential FP commodities. Service availability and quality is also low in other key nutrition-sensitive sectors. Despite high levels of vulnerability and the existence of large groups with specific special needs, DRC has no national social protection (SP) system to provide targeted support to the poorest and most vulnerable (DRC SCD 2018). A World Bank-supported safety net assessment conducted in 2014—the first ever in the country—estimated the total funding for safety nets at about 0.7 percent of GDP, below the average of lower-income countries in Africa. Small scale, partner-financed social safety-net programs have received very limited funding, lack a national social registry, and have high delivery costs. Consequently, their delivery is fragmented, and varies widely in terms of coverage, generosity, and performance.

31. ***(3) Weak governance and management capacity:*** Program management capacity at the central, provincial, and local levels in DRC remains weak. While very engaged at the central level, PRONANUT is understaffed (compared with other vertical programs, such as HIV or malaria) with low levels of technical and managerial skills among key personnel. Recently, with the support from the Minister of Health, PRONANUT has intensified its engagement as a coordinator of the national multisectoral efforts to address malnutrition in the DRC. However, the program needs strengthening both in terms of resources and management expertise. At the provincial level, provincial health directorates (DPS) do not have capacity to perform their oversight, management, and supervisory functions due to a lack resources (for example, lack of basic information technology equipment, cars, and fuel budgets). Furthermore, while each DPS has a nutrition officer/coordinator, the coordinators lack managerial and technical skills to effectively coordinate activities. Similarly, the capacity at the local levels (*zones des santé aires, de santé*) is constrained by insufficient skills and resources.

32. In sum, reducing the prevalence of stunting in DRC will require a focused, multisectoral effort to: (a) improve infant and child feeding behaviors and practices; (b) increase utilization and quality of essential maternal and child health and nutrition services; (c) improve the availability and diversity of foods; (d) increase the purchasing power of the most vulnerable households; and (e) address the challenges of reproductive health among adolescent girls and the issues of early motherhood (see Box 2). This effort needs to focus on overcoming three major systemic bottlenecks, including: (i) the absence of a coordinated response and platform at the community level; (ii) the low availability and quality of public services in health and other key nutrition-sensitive sectors; and (iii) the weak governance and management capacity of state actors at the local, provincial, and central levels. The proposed project will address the key

Box 2: The Proposed Project and the Human Capital Index

The proposed project will contribute directly to the improvement of human capital in DRC in a way consistent with the HCP, and even in the short term, will impact all dimensions of the Human Capital Index. More specifically the project will:

- Contribute to reducing the prevalence of stunting
- Contribute to reducing under-5 mortality
- Contribute to increasing life expectancy (by reducing maternal mortality through maternal health interventions and FP)
- Contribute to Improving quality-adjusted years of schooling by reducing dropout rates due to poor cognitive development at entry into primary school and by improving performance and attainment by reducing the prevalence of anemia among school-aged children

determinants of stunting listed above and will remove the key bottlenecks by: (a) strengthening and scaling-up the multisectoral community-level service delivery and mobilization platform – the NAC; (b) improving the supply (quality and quantity) of essential nutrition-specific interventions and selected evidence-based nutrition-sensitive actions in agriculture, SP, and education by investing in essential infrastructure and inputs and scaling up strategic purchasing schemes; and (c) building and maintaining nutrition governance capacity at the central, provincial, and local levels, through innovative Technical Assistance (TA) mechanisms to incentivize performance and the use of data for program management.

C. Relevance to Higher Level Objectives

33. The renewed commitment of the Government to the fight against malnutrition expressed in the 2013 National Nutrition Policy and the 2015 National Multisectoral Nutrition Strategy, combined with World Bank's global engagement in support of investing in human capital in its client countries through the Human Capital Project (HCP) and the Investing in the Early Years initiative, creates a perfect opportunity for a World Bank investment in stunting prevention in DRC.

34. The proposed project is aligned with the government's priority of building a comprehensive nutrition agenda. As noted above, recognizing the impact of malnutrition on human development and economic growth, DRC identified the fight against malnutrition, and more broadly, the need for investments in the early years, as priorities in the national strategy for poverty reduction and economic development. The project will directly contribute to the implementation of the 2015 National Multisectoral Strategic Plan and to the achievement of the objectives of the 2013 National Nutrition Policy. It will also help achieve Priority 3 of DRC's Reproductive Maternal Neonatal Child and Adolescent Health and Nutrition investment case.

35. The project will contribute to the newly launched World Bank's Africa Human Capital Plan, whose goal is to help governments in the region create an environment in which children enter school well-nourished and ready to learn and realize their full human and productive potential. It is also aligned with the newly published DRC SCD. The SCD identifies building human capital as one of the five priority areas where policy actions could provide quick wins and build cumulative and virtuous cycles to sustain inclusive growth and foster resilience and shared prosperity over the next decade. Within this priority area, the SCD recommends focusing on many elements central to the proposed project including: (a) laying the foundation for future productivity through improved nutrition; (b) increasing access to good-quality health services to build human capital; (c) establishing preconditions for an eventual demographic dividend; and (d) building a safety-net system to consolidate the benefits of investments in human development and foster household resilience. Actions aimed at strengthening the capacity of state actors to effectively plan, manage, and supervise national programs will also help strengthen governance and build stronger and more inclusive institutions (SDC Priority Area 2). A new Country Partnership Framework for 2020-2024 is under development to be delivered in FY20, which will take into consideration the findings of the SCD[6].

[6] The World Bank's current Country Assistance Strategy (CAS) for the DRC (Report Number 66158) ended in June 2017, subject to review. Its review concluded its objectives are still aligned with DRC's development goals, with 10 of 14 expected outcomes likely to be achieved.

36. Finally, the proposed project is also closely aligned with the World Bank's strategy on Africa, which calls for improvement in human capital and access to basic services. The priorities for this strategy include investing in early years, reducing stunting (see Box 3 below), as well as strengthening of reproductive, maternal and child health (RMCH) quality and coverage to support the demographic transition.

Box 3: Benefits of Reducing Stunting in DRC

- Economy: Increased economic productivity; increased GDP
- Health: Reduced morbidity and mortality; reduced health expenditures
- Education: Increased retention; reduced drop-out rates; increased educational attainment
- Agriculture: Increased labor productivity
- Social Protection: Reduced poverty incidence; reduced social safety net expenditures

II. PROJECT DESCRIPTION

A. Project Development Objective

PDO Statement

37. The development objective of this project is to increase the utilization of nutrition-specific and nutrition-sensitive interventions targeting children 0-23 months of age and pregnant and lactating women in the project regions and to respond to an eligible crisis or emergency.

PDO Level Indicators

38. The PDO-level indicators will focus on measuring short-term changes that can be attributed to the project:

- Number of people who received essential health, nutrition and population services (aggregated by number of women and by number of children aged 0-23 months)
- Number of children who have received post-natal consultations
- Number of women who have received post-partum FP services
- Number of pregnant women who have received iron and folic acid supplementation
- Number of beneficiaries who have received household food production kits
- Number of beneficiaries who have received cash transfers

39. Most data will be collected using routine health and nutrition management information systems. A multi-indicator cluster survey (MICS) is currently being finalized in DRC and will be used to provide baseline data on indicators related to meal frequency and food diversity. Periodic surveys will be undertaken with project financing (see below) and will provide midline and endline information for those indicators. The complete set of project results is presented in the results framework.

Long-term vision – a Series of Projects:

40. Reducing stunting in DRC will require a long-term engagement that exceeds the usual 5-year time horizon of a single World Bank operation for two reasons. First, interventions aimed at reducing the risk of stunting need to be delivered over three years (from conception through the second birthday) to reduce the most severe impact on physical and cognitive development, and over six years (from conception through the fifth birthday), to fully mitigate the risk of stunting on child development, morbidity, and survival. Second, in the low-capacity context of DRC, building institutional capacity and sustainable delivery platforms and coordination mechanisms across the key sectors will require time. For these reasons, this project is envisioned as the first in a series of 2-3 projects spanning the next 12 years. The overall development objective for the series of projects (SoP) will be to contribute to the reduction of stunting in children 0-23 months of age in DRC.

41. The first project will scale up the NAC model in four high-malnutrition-burden provinces. It will also improve the supply of key nutrition-specific services as well as FP services delivered through the health sector and pilot a limited set of nutrition-sensitive interventions in agriculture, SP, and education. The

objective of this phase is to demonstrate the effectiveness of the NAC platform and its complementary services as the national model to address child malnutrition. For this project, non-governmental actors (for example, NGOs and United Nations (UN) agencies), will be contracted by the government to directly support project implementation, while also developing capacity and skills transfer to prepare the appropriate government agencies to take over the implementation of subsequent projects.

42. The second project will expand the NAC platform to new provinces. It will also establish and test mechanisms for mobilizing and pooling financing for the platform from sources other than the World Bank. To complement international development assistance (IDA), the second project will seek cofinancing from innovative sources of financing, such as the Power of Nutrition (PoN) and other donors. A multi-donor trust fund to support the expansion of the community platform may be established. The nutrition-sensitive interventions that were proven to be effective under the first project will be expanded (either under the second project or under complementary investments in other sectors) and additional ones will be tested and piloted. For the second project, the direct involvement of nonstate actors in the implementation will be decreasing and they will begin transitioning to providing TA to support government agencies to take over implementation.

43. The third project will scale-up the NAC platform to new provinces. It will also formalize the resource mobilization and pooling mechanisms so that IDA will contribute to the platform but not necessarily constitute the principal source of financing for the platform. The plan is that its implementation will be carried out by the appropriate government agencies and that nonstate actors will only provide targeted TA.

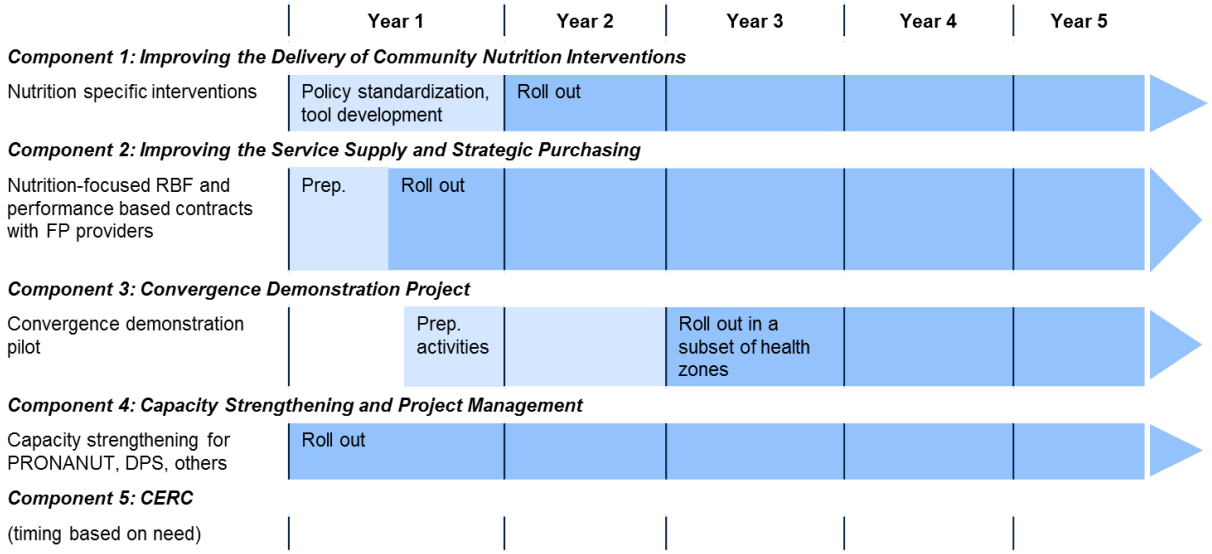
B. Project Components

44. This proposed project will address the key determinants of child stunting in the targeted provinces by focused, evidence-based, nutrition-specific interventions and complementary multisectoral actions in SP, agriculture, and education. It will support the Government in establishing and scaling-up the NAC - a community health and nutrition platform to deliver an essential package of services, support community mobilization, and strengthen the demand for nutrition-specific and nutrition-sensitive services. It will also strengthen the supply of evidence-based public services. A coordinated and synergistic approach to stunting reduction will be operationalized through: (a) vertical coordination between the community and service providers through a system of formal and informal referral and counter-referral mechanisms and follow-up procedures; and (b) horizontal coordination across different sectors through cotargeting (different interventions targeting the same individuals) and colocation (different interventions located in the same communities) with a complementary package of services in health, social safety nets, agriculture, and education.

45. During the first year, the project will focus on supporting the standardization of policy and guidelines for community-level service delivery of nutrition-specific interventions and on preparing delivery mechanisms and systems (see Figure 4). It will also launch a series of activities to strengthen the capacity of state actors. Starting in year two, it will roll out the NAC approach at the community level in the targeted provinces. In year 3, the project will start implementing a convergence demonstration pilot of a set of complementary nutrition-sensitive interventions in agriculture, SP, and education (see below for details). The focus of the demonstration pilots will be to determine the value added of the multisectoral convergence, and if the pilot results are positive, to identify the best and most efficient way of delivering

multisectoral services at scale in the subsequent projects within this SoP or as part of World Bank investments in the respective sectors. A detailed description of the project components is included in Annex 2.

Figure 4: Phasing of the Proposed Project



Component 1. Improving the Delivery of Community Interventions and Social and Behavioral Change (US$177.8 million equivalent: US$170.0 million from IDA; US$7.8 million from the Global Financing Facility (GFF) in Support of Every Woman and Every Child)

46. The long-term programmatic objective of this component will be to support the Government in implementing the NAC approach - a standardized community-level delivery platform and package of services whose scale-up could be financed by the Government and development partners (including the future phases of this SoP) either individually or through pooled financing mechanisms (for example, a multidonor community health and nutrition trust fund).

Subcomponent 1.1: Improving the Delivery of Community Nutrition Interventions (US$170.0 million from IDA)

47. The proposed project will finance the scale-up of the NAC model in the project areas. The project will provide financing for the PRONANUT to set up contracts through the project coordination team (PCT) within the MoH responsible for project implementation (PCT; see the implementation arrangement section below) with NGOs to support the identification, engagement, training, supervision, and monitoring of ReCos, and to provide them with the necessary equipment and job aids. The contracts with the NGOs will be performance-based and the payments will depend on, among other factors, the number of ReCos recruited and trained, the number of supervision meetings convened, and the number of supportive supervision visits carried out. The NGOs will be encouraged to propose innovative methods of supervision that are cost effective in the challenging field settings where the ReCos are deployed (for example, Geographic Information Systems (GIS) tagging of home visits). As part of their engagement, the NGOs will develop skills transfer plans; it is envisioned that in later phases of the SoP, the identification, training, and supervision responsibilities will be transferred to the appropriate health system agencies.

48. Consistent with the government's community health strategy, the project will finance incentives for ReCos. The project will consider and test incentives targeting the communities, more specifically the Community Animation Cell (*Cellule d 'Animation Communautaire,* CAC) in the form of support for income-generating activities. Those incentives will be provided through the contracted NGOs. Alternative modalities of delivering incentives may also be tested.

Subcomponent 1.2 Social and Behavioral Change (US$7.8 million from the GFF)

49. Social and behavior change (SBC) will be a critical subcomponent of this project, as it will underpin and support most of the main interventions. A comprehensive SBC strategy with broad consensus among a range of stakeholders, including the Government, other key donors, development partners, and the implementers, will be necessary to tackle the intractable impediments to behavior change to advance the multisectoral actions needed to improve stunting. SBC will be needed at every level of the system from national mass media campaigns; to provincial and health zonal levels with more local language messaging; to facility- and school-based counseling; and down to the community and household levels with inter-personal communication (IPC).

50. The content, modalities, and specific messages of the SBC strategy will be informed through formative research on nutrition and FP that will be executed during the lead-up to effectiveness. The formative research will seek to determine (a) a limited set of key messages that should be promoted; (b) the potential to implement integrated SBC as the same target groups are implicated in the project for nutrition, FP, agriculture, and SP; and (c) innovative modalities, technologies, and platforms to conduct SBC. This formative research will also provide the basis for the IPC materials for the ReCos in nutrition and FP. The formative research around nutrition and FP will be competitively bid out using the Project Preparation Advance (PPA). A competitively procured consortium of partners will be tasked with implementation of integrated SBC with respect to nutrition, FP, agriculture, SP, and related messaging. During implementation, the SBC subcomponent of the project will host embedded implementation research to enable rapid identification of bottlenecks and to roll out impediments, as well as to achieve quick wins that can be scaled-up. Above all, the SBC strategy seeks to be creative, targeted, and evidence-based to effect sustained behavior change across the population.

Component 2. Improving Service Supply and Strategic Purchasing (US$247.0 million equivalent from IDA)

Subcomponent 2.1: Performance-based Financing of Health Services (US$185.0 million from IDA)

51. Increasing the demand for nutrition and health services through community-level actions will be ineffective if the supply of those services is insufficient. As noted in the preceding section, the supply of essential maternal and child nutrition and health services in DRC remains grossly inadequate. To address this critical bottleneck, this subcomponent will focus on improving the supply (quantity and quality) of key nutrition-specific and nutrition-sensitive interventions delivered through primary health care facilities. More specifically, it will finance the expansion of the existing strategic purchasing scheme and PBF in health facilities under the Health System Strengthening Project (*Projet de Developpement du Systeme de Sante,* PDSS, P147555) into the proposed project regions. PBF has been identified in the National Health Development Plan as the key government strategy to achieve universal health coverage. Under this project, PBF will provide health facilities with financial incentives in the form of discretionary spending based on the quantity and quality of their service output.

52. The project will expand the current PBF program in terms of scale and scope. In terms of scale, PBF will be expanded to the HZs in the four provinces that are not currently covered by the PDSS program, in parallel and in coordination with activities under Component 1. (See Box 4 below concerning successes in expanding maternal and child health services through the PDSS project). In terms of scope, the PBF incentive scheme will emphasize key nutrition-specific and nutrition-sensitive services. PBF incentives will target the following services for pregnant and lactating women, children 0-5 years, and adolescent girls: ANC (including iron/folic acid supplementation and IPTp for malaria during pregnancy; IYCF counseling for pregnant women; growth monitoring and nutrition counseling for children during routine child health visits (consultations *prescolaire*), FP; management of acute malnutrition; and integrated management of child illnesses. In addition to providing financial incentives, the project will also finance key inputs and equipment (for example solar refrigerators). The project will finance the procurement of FP commodities for health facilities in the target provinces to reduce the incidence of stockouts. Family planning will also be strengthened by putting special emphasis on improving the quality of post-partum services for all women, especially among adolescent girls, through the use of clinical vignettes and by measuring patient-reported quality of counseling through interviews of FP clients.[7] In cholera endemic areas the project may also finance inputs for setting up cholera treatment points in primary health facilities. This subcomponent will complement the Health System Strengthening Project (P147555) and use its existing implementation arrangements (For details see Annex 1).

53. Under this project, PBF will be expanded in Sud Kivu, Kassai Central, and Kassai. PBF is currently implemented through PDSS in all HZs in Kwilu and no expansion in that province will be necessary.

Subcomponent 2.2: Performance-based Contracts with Nonstate Providers of Family Planning (US$62.0 million equivalent from IDA)

54. Given that only 34 percent of women using contraception receive services from public providers (DHS 2013-2014), it is important to consider responding to the needs of women and couples who may not want or be able to go to a public facility by providing other options closer to the household. This may be particularly the case for adolescent girls who may perceive greater stigma about using contraception, and who may feel more confidential and safer with a nonpublic provider. Countries that have successfully increased modern contraceptive use at scale have done so by increasing access to a range of methods and providers. In an effort to expand choice of FP providers, the project will facilitate access to FP counseling and methods through nonstate actors, such as NGO. who will provide a full range of reproductive health services and will ensure a confidential, quality service offered through a fixed or mobile site (see Implementation Arrangements section for related details). Moreover, the NGOs may also provide post-abortion care (PAC) services if the MoH is willing to include it in their terms of reference (ToR). These NGOs will be different from those overseeing the ReCos and will, in fact, be precluded from applying for both contracts (ReCo support and FP service delivery).

Component 3: Convergence Demonstration Project (US$47.0 million equivalent from IDA)

[7] A 10-question measurement tool is being validated in a number of countries, including DRC, to be able to measure and track the quality of FP services as reported by the client. It is envisioned that this system can be piloted in this new project and factored into the quality payment calculation.

55. This component is intended to demonstrate the added value of multisectoral convergence to improve nutrition outcomes. To do this, in a subset of the HZs targeted by Components 1 and 2, the project will finance complementary activities in SP (targeted cash transfers), agriculture (biofortification and targeted distribution of household food production kits), and education (micronutrient supplementation in schools). The actions selected for the pilot have been successfully implemented and have shown effectiveness in improving nutrition outcomes, although at a small scale and never in a coordinated fashion. The convergence demonstration project will utilize the existing and tested delivery mechanisms and partners to support the implementation at a larger scale and through a coordinated approach. Once the added value of the convergence approach is demonstrated, specific interventions (for example cash transfers, biofortification, and so forth), could be expanded in a coordinated fashion through sector-specific World Bank investments and through broader initiatives and programs. For example, nutrition-sensitive cash transfers could be scaled up through future social safety-net programs, biofortification could be expanded through future agriculture investments, and so forth.

56. The demonstration project will provide **unconditional cash transfers to pregnant women and mothers of children 0-23 months of age to improve access to adequate quantity and quality of foods**. Targeted cash transfers are a strategy recommended in the most recent DRC SCD (2018) to improve social safety nets. Malnourished pregnant women and mothers of children suffering from severe acute malnutrition will receive a basic transfer. Cash will be distributed at regular intervals at health facilities to create incentives and an opportunity for the women and children who receive cash to also use health services at the same time.[8] Transfers will be unconditional. The appropriate targeting mechanisms and frequency of transfers will be determined during the first year of project implementation based on the experiences from DRC and other countries, putting emphasis on coordination and consistency with other World Bank SP operations in DRC, most notably the Productive Inclusion Project (PIP). The project will finance the transfers, cover the costs of identifying and hiring the national and local implementation agencies, supervising the transfers by the Ministry of Social Affairs (MoSA), and developing the beneficiary registry.

57. To restore the productive capacity of the households of vulnerable women and children and prevent their relapse into food insecurity and malnutrition, **the demonstration project will complement the cash transfers with food production kits** for households with food production capacity. The Project Coordination Team (PCT) will sign a TA agreement with the Food and Agriculture Organization (FAO) of the UN, which has a track record of delivering agricultural inputs and support in project areas. Under the technical direction of the specialized services within the Ministry of Agriculture and the Ministry of Fishers and Livestock, the partner will implement this activity. However, through the joint design of a pilot intervention, and on-the-job training, it will build the capacity of the government (Ministry of Agriculture, Ministry of Fisheries and Livestock) to eventually take over the implementation of this activity. The partner will also provide support for capacity development related to mainstreaming nutrition in the sectoral policies, programs, and projects. The project will first finance the production of the key inputs that will constitute the kits. Through targeting of beneficiaries conducted jointly with the cash transfer activity, vulnerable women will be identified. They will receive training and food production kits that will include items such as small animals (protein kits), nutrient-rich seeds and cuttings (including biofortified varieties), vegetable inputs for home gardens, and farming tools to replicate activities at home. The project will train and work through women's associations and other existing community structures within the communities

[8] The demonstration project may also test distribution of cash through Social Promotion Centers (*Centres de promotion sociale*).

hosting the production units to multiply the seeds, cuttings, and small animals, as well as build the capacity of the National Agricultural Extension Service (*Service National de Vulgarisation,* SNV) to support this production. An assessment study will be conducted to determine actual composition of kits, including whether fisheries can be part of them.

58. To improve micronutrient status for women and young children, **the demonstration pilot will also finance the scale-up of the locally-developed biofortified varieties of key crops**, including vitamin A-enriched maize and cassava, iron-rich beans, and/or orange flesh sweet potatoes. Since 2011, the National Seed Service (SENASEM), and the National Institute for Agricultural Studies and Research (*Institut National des Etudes et de la Recherche Agricole* INERA), with the help of HarvestPlus, the International Institute of Tropical Agriculture (IITA), and the International Center for Tropical Agriculture (CIAT), have been adaptively breeding and testing biofortified varieties of vitamin-A cassava and maize and high iron beans. To expand the utilization of biofortified crops, the project will finance a TA contract between the PCT and HarvestPlus to support INERA and SENASEM. HarvestPlus will work with Ministry of Agriculture and the SNV, INERA, and SENASEM to identify and contract with accredited local partners, including NGOs, farmer associations, and cooperatives working in the target areas, to grow the biofortified crops. Once sufficient quality seeds and vines are available, HarvestPlus will train the Ministry of Agriculture, SNV, other relevant directorates (Studies and Planning [*Direction des Etudes et de la Planification*; *DEP*]), the Ministry of Research and its agencies (for example, INERA, Centers for Adaptation and Improved Seed Multiplication [*Centres d'Appui et de Production de Semences Améliorées, CAPSA]*) and partners to manage the dissemination of biofortified crops to farmers. HarvestPlus will also provide targeted TA to SENASEM, INERA, SNV, DEP, and CAPSA. The TA will also focus on best practices for aflatoxin control for maize, including engagement with the Partnership for Aflatoxin Control in Africa (PACA) at the African Union (AU).

59. In addition to targeting adolescent girls through community-based services, the education system can be used as a platform to reach them. The demonstration project will, therefore, finance **deworming and intermittent micronutrient supplementation for adolescent girls**, and capacity strengthening for teachers to deliver these interventions with the support of the ReCos. The intermittent micronutrient supplementation for adolescent girls will serve as a platform for health and nutrition education sessions. The activity will be supported by performance-based contracts with NGOs (see Component 1). In the areas where the pilot will be implemented. The NGOs contracted to identify and monitor the ReCos and support their supervision will also provide the training for the teachers, procure and deliver commodities, and monitor the distribution.

60. To ensure rapid and efficient implementation, Component 3 will be implemented in two HZs with existing INERA centers and with an established network of partner organizations (for example agrimultipiers and farmers' associations).[9] An additional HZ in the Kassai or the Kassai Central may be included.

Component 4. Capacity Strengthening and Project Management (US$30.2 million equivalent: US$28.0 from IDA; US$2.2 million from GFF)

61. This component will serve two objectives: (i) to build the capacity at the central, regional, and local levels to ensure sustainable strengthening of country systems so that activities financed under

[9] The Kiyaka INERA center in Kwilu and the Mulungu INERA center in Sud Kivu

Components 1, 2, and 3 are implemented successfully; and (ii) to provide the Government and the World Bank with evidence-based analysis on various aspects of service delivery in the nutrition sector which leads to sound recommendations for improvement.

Subcomponent 4.1 Capacity Strengthening (US$16.7 million equivalent from IDA)

62. Under this subcomponent, the project will finance capacity strengthening for PRONANUT and other relevant programs within the MoH and other relevant line ministries to effectively plan, manage, and monitor programs. Capacity strengthening will include investments in basic equipment, information technology infrastructure, and additional personnel, as well as in skills training, coaching, and supervision. The project will finance a contract with one or more entities (for example, a UN agency) that will provide TA and delivery training, coaching, and supervision for national staff, and will develop specific, time-bound skill transfer plans. The TA will also include strengthening of the government's core public sector management systems for human resource management, logistics and supply chain management, financial management (FM), procurement, and integrity arrangements at different levels of the nutrition service-delivery chain, along with providing project-specific fiduciary oversight. This component will also cover strengthening the monitoring capacity of the subnational and national institutions involved in the management and implementation of nutrition activities.

63. The project will also use PBF schemes at the provincial level to provide discretionary financing in exchange for achieving certain performance metrics. The project will expand the Single Contract (*contrat unique* [CU]) which provides incentives to the DPS against the execution of certain agreed elements of their quarterly work plans. The incentives will focus on the joint planning and review of maternal and child health and nutrition activities, for example, payments made against the joint annual nutrition reviews led by the DPS. The contracts will be signed between the DPS and PCT. Their execution will be monitored and verified by the Public Utility Entities (*Entités d'Utilité Publique,* EUP).

Subcomponent 4.2 Disruptive Technologies, Innovation, and Learning (US$8.4 million: US$6.2 million from IDA; US$2.2 million from the GFF)

64. Under this subcomponent, the project will finance a robust learning and innovation agenda. First, the program will include rigorous implementation research and evaluation related to the demonstration project planned under Component 3, including an evaluation of the convergence project. Second, the project will finance learning related to disruptive technologies and to the use of ITC innovations to improve service delivery. Those innovations may include: (a) machine learning to develop a system of risk-based verification to reduce the cost of PBF;[10] (b) development and testing of electronic job aids and decision support tools for facility-based and community-based providers; and (c) novel methods for child anthropometry. This part of the learning agenda will be financed through the GFF grant. Third, the project will support a series of analytical studies to improve the collective understanding of the key challenges in the nutrition governance and prepare for subsequent operations in the SoP. Fourth, this subcomponent

[10] Periodic verification of the reports submitted by health facilities accounts for a substantial proportion of the overall cost of RBF. Risk-based verification is a process in which a computer algorithm is used to analyze the data submitted by health facilities and identify those where the risk of irregularities is the highest. Intensive verification is then focused on those facilities while less frequent verification is used for all other facilities.

will also finance survey data collection necessary to provide midline and endline data for the key indicators included in the project results framework (see below).

Subcomponent 4.3 Project Management (US$5.1 million equivalent from IDA)

65. This component will finance the costs associated with the day-to-day project management, including the costs of running the PCT, and the Project Technical Committee. The PCT already exists and is currently managing the PDSS Project. This unit will be in charge of managing the fiduciary aspects as well as the monitoring and evaluation (M&E) of the proposed operation.

66. The capacity-strengthening activities at the central level will contribute to better management and governance of nutrition programs nationally. The capacity-strengthening activities at the provincial level will be implemented in all four provinces covered by the project. The capacity strengthening at the HZ level will be implemented in all 103 priority HZs.

Component 5: Contingent Emergency Response Component (CERC) – (US$0.00)

67. A no-cost CERC will be included under the proposed project in accordance with World Bank Investment Project Financing (IPF) Policy (paragraphs 12 and 13, for projects in Situations of Urgent Need of Assistance or Capacity Constraints. This will allow for rapid reallocation of project proceeds in the event of a natural or man-made disaster or crisis that has caused, or is likely to imminently cause, a major adverse economic and/or social impact.

C. Project Beneficiaries

68. The key target groups for the project are children 0-23 months and pregnant and lactating women. Children 24-59 months of age will be the secondary target group. To address the issues of fertility and adolescent pregnancy and suboptimal birth outcomes, the project will also target women of reproductive age and adolescent girls (10-19 years of age).

69. Nine priority provinces have been identified as priority provinces for the proposed project based on two criteria, (i) the burden of stunting in children 0-23 months of age; and (ii) the cost-effectiveness of investments in stunting prevention. The priority provinces include: Haut Katanga, Kassai, Kassai Central, Kongo Central, Kwilu, Lualaba, Nord Kivu, Sud Kivu, and Tanganyika. From among the nine provinces four provinces were selected for the proposed project: Kwilu, Kassai Central, Kassai and Sud Kivu based on additional criteria, namely: (a) past experiences with the implementation of the NAC approach; (b) representativeness of the larger macro-regions; and (c) geographic convergence with the broader World Bank portfolio in DRC.

70. Within the four provinces, the project will cover all 103 HZs, and it is estimated that about 80 percent of the population of the provinces will be covered by community, primary health care, nutrition, and FP services. In total, it is projected that about 1.5 million pregnant and lactating women and 2.5 million children 0-23 months will benefit from the project over the five years of the project, with over 200,000 women of reproductive age covered with FP services. Table 3 presents the projected number of beneficiaries reached each year. This projection is done under the conservative assumption that during the first year, the project will focus mostly on preparatory activities, policy development, and capacity

strengthening, and that the service scale-up in that year will be very limited. The projections presented in this table likely underestimate the number of beneficiaries reached.

Table 3: Projected Number of Pregnant Women and Children 0-23 Months of Age Benefiting from the Package of Community Nutrition Services by Year

Beneficiaries	Year 1	Year 2	Year 3	Year 4	Year 5
Children 0-23 months old	0	282,900	565,800	848,800	848,800
Pregnant and lactating women	0	170,300	340,600	510,900	510,900
Women receiving FP services	0	38,100	45,800	54,900	66,000

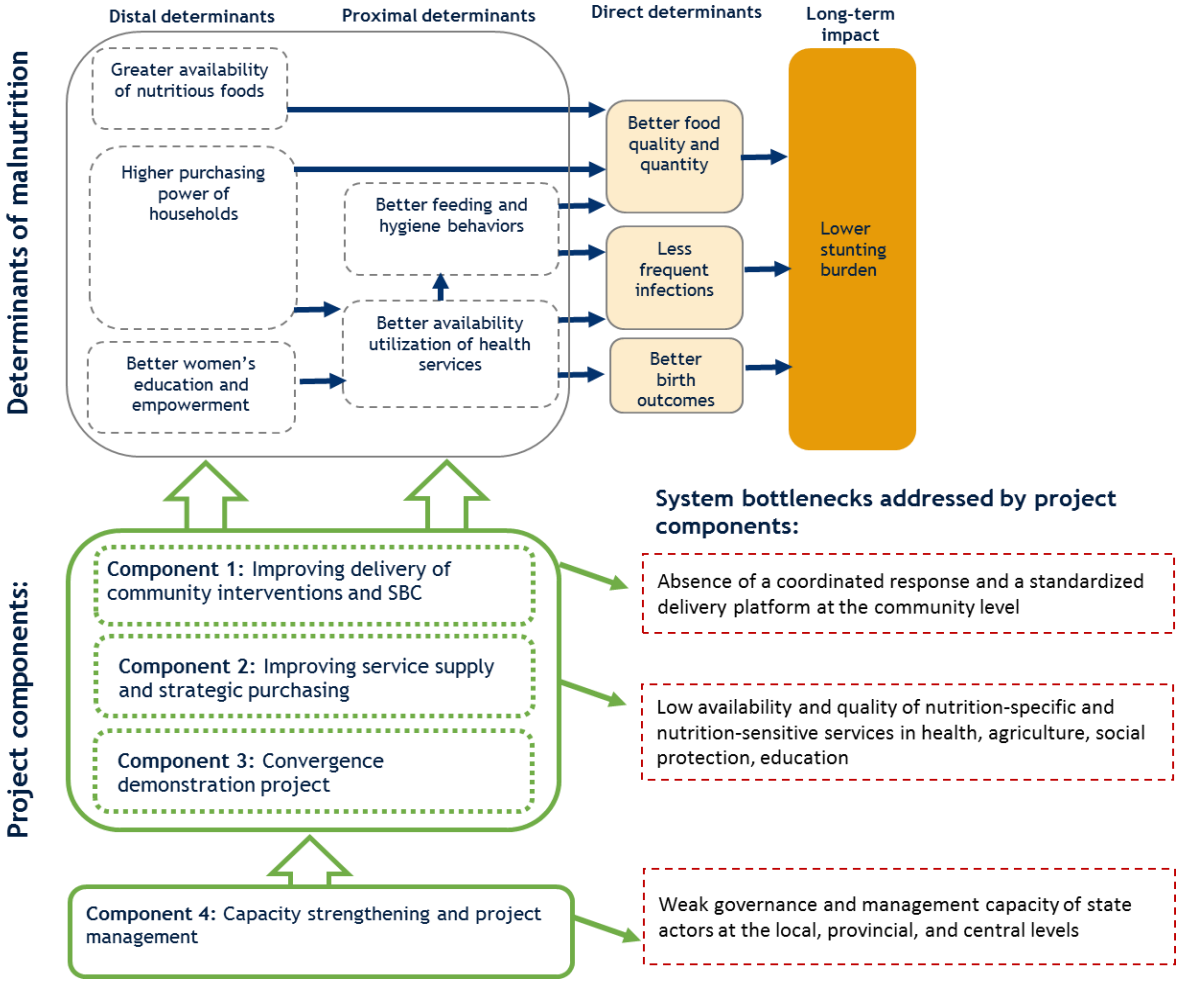
71. The demonstration pilot implemented under Component 3 will cover two HZs that will be identified based on proximity to INERA centers that will provide base inputs for household food production inputs and biofortified crops.[11] Overall, about 20,000 pregnant women and mothers of malnourished children 0-23 months of age will receive targeted cash transfers, and within that group, 18,000 households with production capacity will receive agriculture input kits. Finally, approximately 100,000 farmers will be producing biofortified crops by the end of the project.

D. Results Chain

72. Figure 5 (below) presents the project's theory of change. The project will help the Government overcome the key systemic bottlenecks outlined above. It will scale-up the NAC community platform to improve key nutrition behaviors and generate demand for nutrition-specific and nutrition-sensitive services. It will also increase the supply and quality of those services. The convergence demonstration project implemented under Component 3 will help test scalable solutions to improve access to high nutrition quality foods, increase purchasing power of vulnerable households, and improve nutrition of adolescent girls. Finally, the project will strengthen the capacity at the central and provincial levels to manage and coordinate. Together, those improvements will result in better quality and higher quantity of the foods consumed by children, less frequent and less severe illnesses, and better birth outcomes. Ultimately, they will contribute to the reduction of stunting prevalence in the project regions.

[11] Currently, there are no INERA stations or centers in the Kassai and the Kassai Central provinces. The convergence pilot could potentially be selected in an additional health zone in one of those provinces by a *CAPSA*. In the lead up to project effectiveness, a capacity assessment of the CAPSAs in Kassai and the Kassai Central will be undertaken. If the capacity is sufficient, an additional health zones in Kassai or Kassai Central may be added to the demonstration project.

Figure 5: Theory of Change of the Proposed Project



E. Rationale for World Bank Involvement and Role of Partners

73. The World Bank's HCP provides the key rationale for its involvement in this project. The HCP seeks to raise awareness and increase demand for interventions to build human capital and aims to accelerate better and more investments in people. DRC is one of the early adopters of the initiative. This project's development objective and design directly supports the HCP and directly targets all of the dimensions of the HCI (see Box 2).

74. Historically, the World Bank has had an extensive engagement in the human development sector in DRC. The current WBG's operational portfolio includes three projects supporting the health sector: PDSS, the Human Development System Strengthening (P145965), and the Regional Diseases Surveillence System Enhancement (REDISSE) Phase IV project (P167817). It includes projects supporting SP (the Productive Inclusive Project [P163962] and the Eastern Recovery Project [P145196]), projects supporting education and agriculture, as well as potentially complementary projects in other sectors (for example, the Roads Reopening and Maintenance Project ([P161877]). This breadth and depth of engagement allows the World Bank to mobilize the technical expertise necessary to successfully prepare and implement a truly multisectoral nutrition project (see Annex 6 for the geographic scope of the World Bank portfolio). It also

offers a unique opportunity to coordinate engagement across multiple investments to create synergies and maximize impact.

75. Currently, only a few large donors and development partners directly support the nutrition program in DRC. Most notably, UNICEF supports the implementation of the NAC model in 34 HZs. Other development partners have programs that focus either on acute malnutrition (for example, the United Kingdom Department for International Development (DFID), and the World Food Programme (WFP), especially in the humanitarian and emergency context, or on resiliency and food security (for example, the United States Agency for International Development (USAID), FAO, and HarvestPlus). The proposed project will be the first large-scale investment focused on stunting prevention in DRC. Coordination and collaboration with the key partners will be essential to achieve the project's objectives. Table 4 (below) presents the synergies with the key partners engaged in maternal and child nutrition in DRC.

Table 4: Synergies and Partnerships with Development Partners working in DRC

Partner	Areas of Collaboration
USAID	• Coordination with USAID's Breakthrough Action Project through the sharing of SBC knowledge, materials and products and coordinating the roll out of SBC workstreams between the World Bank Project and Breakthrough Action to ensure complementarity and efficiency of resources.
DFID	• Coordination with the DFID-funded acute malnutrition activities. • Geographic complementarity with the upcoming DFID investments (the 2020 "bridge financing") and the new 5-year country business case (ongoing discussions with DFID teams in DRC and the UK) and with DFID and the Government.
FAO	• Provision of agriculture inputs and small livestock kits for household with food production capacity. As the capacity of the Ministry of Agriculture grows in this area, they will take over this activity. • Support to project supervision related to the production and distribution of kits.
UNICEF	• Building on the experiences of UNICEF's support for the NAC. • Support in the community water, hygiene, and sanitation initiative *Villages et Ecoles Assainies;* • Support for the procurement of nutrition inputs, including ready-to-use therapeutic foods.
UNFPA	• Through PDSS, the United Nations Fund for Population (UNFPA) will support this new project through (i) provision of contraceptives and (ii) provision of TA to improve the supply chain for contraceptives to provide last-mile reproductive health services in the project's targeted areas. • Support for project supervision activities related to FP commodity procurement and supply chain.
Harvest Plus	• Support existing INERA and SENASEM activities to develop biofortified crop varieties and certify the crop varieties to be planted in project areas. • Support MOA and SNV to identify and contract local partners, NGOs, farmer associations, and cooperatives to grown biofortified crops. • Train MOA and SNV and partners to manage the dissemination of biofortified crops to farmers • Provide targeted TA to SENASEM, INERA and SNV. • Coordinate learning and capacity building through study tours, and so forth. • Support for project supervision activities related to biofortification.
European Union	• Complementing current EU strategic purchasing intervention in health facilities in in Kassai Central and Kassai.

76. The proposed project is fully compliant with World Bank procedures that are set out for IPF projects. The proposed operation is being processed in accordance with the condensed procedures outlined in Paragraph 12 of Section III of the World Bank IPF Policy, and Paragraph 56 of Section III of the IPF Directive: Exceptional Arrangements in Situations of Urgent Need of Assistance or Capacity Constraints. The safeguards requirements however, will not be deferred to implementation as outlined in Paragraph 12(a) of the IPF Policy. The use of this policy is justified because the DRC is deemed to: (a) have urgent needs of assistance; and (b) experiences capacity constraints. DRC is emerging from a period of protracted wars and political instability which has led to capacity constraints. The most recent examples of capacity constraint have been the pre- and post-election shut down of the Government, the fragile security situation, and the lack of access to the Internet by the government counterparts which led to a two-week hold on technical discussions on the project.

F. Lessons Learned and Reflected in the Project Design

77. The design of this project has incorporated lessons from ongoing operations, from international best practices, from thematic evaluations, and from other countries (Madagascar, Côte d'Ivoire, Burundi, Rwanda, and Nigeria) implementing similar projects. The following lessons have been considered:

78. **The NAC model can be successfully implemented in DRC**. Global experience demonstrates that in the context of chronic underinvestment in primary health care and significant accessibility challenges, provision of a basic package of nutrition and health services at the community level is vital. Experiences of the NAC pilot programs supported by UNICEF demonstrate the feasibility of the implementation of the NAC model. The experiences also demonstrate the need to: (a) engage local partners, such as NGOs, to provide support to CACs and the ReCos, especially in the initial period of implementation, and (b) address supply-side issues and expand access to primary health care services for pregnant and lactating women and children under-5 in communities where the NAC is implemented. The project incorporates this critical lesson by engaging NGOs to support the NAC and by expanding the PBF model in health facilities.

79. **PBF has been effective in increasing the utilization of key maternal and child services in DRC.** A recent analysis of the health management information system (HMIS) data comparing PBF and non-PBF facilities nationwide has demonstrated the utilization of some of the key maternal and child services, including assisted delivery, ANC, and immunization, that were increased over 12 months between 11 and 19 percent over and above the national secular trend. This data demonstrates that the expansion of PBF is a good strategy to increase the supply of services under this project. The cost of verification accounts for a substantial proportion of the overall PBF cost. This project will test innovative solutions, including machine learning for risk-based verification, to reduce those costs and to improve the efficiency of the program.

80. **Performance-based contracts have shown results in the DRC context.** The experience with contracting state and nonstate actors has led to substantial health, nutrition, and population (HNP) results in countries such as DRC, Afghanistan, Bangladesh, and Senegal. A number of lessons on how to manage performance-based contracts have been included in this project, notably the need for more than one contract per province to enable the transition out of nonperforming contracts should the need arise, the need to limit the number of performance-based indicators in the contracts, the need to engage extensively with stakeholders during the contract development process and to cultivate champions, and the need to build capacity within government on effective contract management.

81. **Effective leveraging of expertise from other development partners can enhance results.** The project was developed in close coordination with key development partners engaged in the support of nutrition and maternal and child health in DRC, including FAO, UNICEF, DFID, USAID, HarvestPlus, and others. The design of the project has capitalized on those experiences and will scale-up interventions that have been successfully implemented by those partners, although on a small scale (for example, UNICEF – NAC and cash transfers; FAO – household food production kits; HarvestPlus – biofortification; USAID – SBC formative research). Ongoing dialogue with partners will help ensure that their new investments will complement the nutrition and health service interventions of this proposed project.

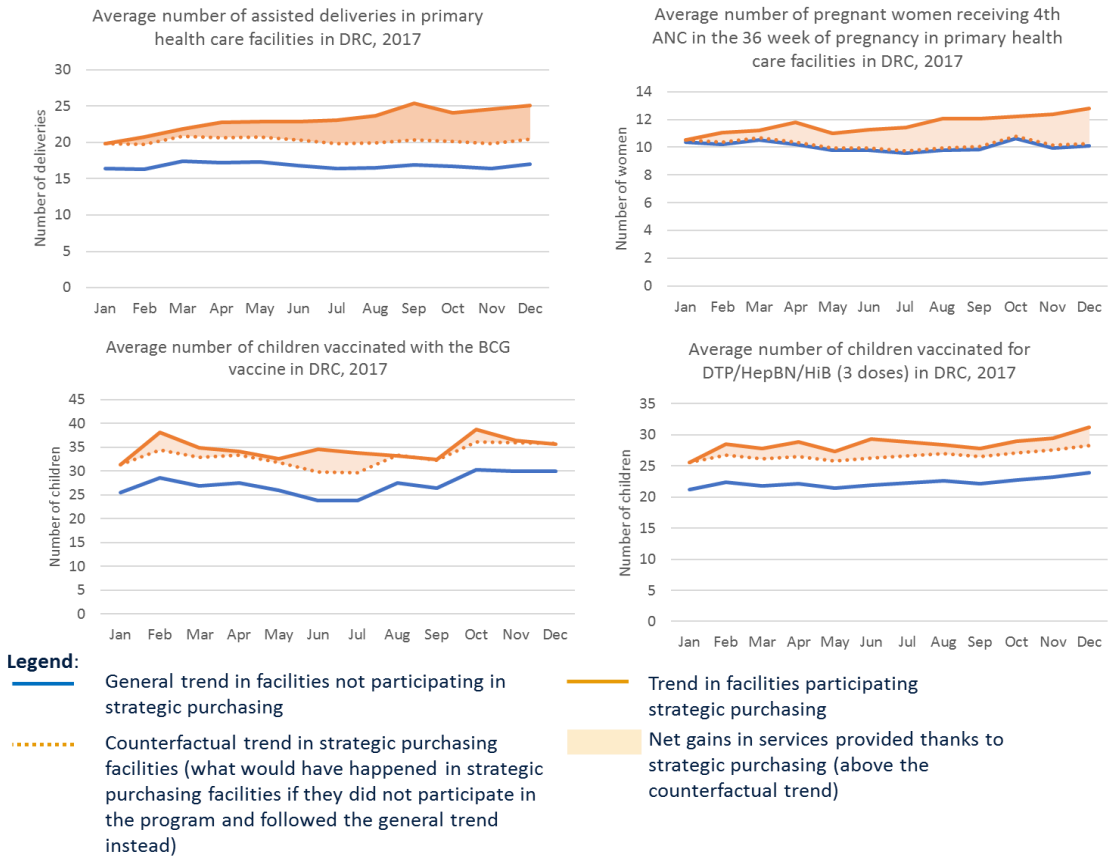
82. **Gender and Sexual and Gender-based Violence (SGBV).** Experience in preventing and responding to SGBV in DRC, including the World Bank's own investments, have tested mainstreaming of SGBV within other sectors, strengthening of capacities of NGOs and public institutions that work on SGBV mitigation and prevention in some of the geographic areas that will be covered by the proposed project. The proposed project will apply a mainstreaming approach of SGBV by drawing from past lessons learned from the responses in eastern DRC and aligning with gender-based violence (GBV) 2015 Inter-Agency Standing Committee (IASC) Guidelines.

83. **This project has taken into account the recommendations of the World Bank's DRC Demographic Dividend Advisory Services and Analytics (ASA) (2019).** These include: (a) scaling up FP/reproductive health services by piloting innovative approaches for reaching vulnerable women through community-based distribution of contraceptives and leveraging information and communication technology (ICT) for FP outreach; (b) supporting SBC communications at the community and national level and piloting alternative approaches to expanding access to youth-friendly FP and reproductive health services; and (c) strengthening the continuum of RMNCAH-N services to address under-5 and maternal mortality.

Box 4: The PDSS Project and the Utilization of Essential Maternal and Child Health Services in DRC

In January 2018, approximately 2,740 health facilities in the DRC were participating in the PBF program financed by PDSS. Analysis of the HMIS data shows that this investment has resulted in additional increases in the number of children and women receiving services, above and beyond the positive national trends. Over the 12 months of 2017, when compared with non-PBF facilities, each PBF facility added, on average, 16 more antenatal care consultations, 36 assisted deliveries, and 31 children vaccinated with the BCG vaccine and 32 with the third and final dose of the DTP/Hepatitis B/Hib pentavalent vaccine. Put differently, PBF on average has increased the levels of BCG vaccination by 11 percent, DTP/Hepatitis B/Hib vaccination by 13 percent, antenatal care consultations by 14 percent, and assisted delivery by 19 percent. At the national level, because of PBF, 8,500 more children were vaccinated with the BCG vaccine, 8,700 more children were vaccinated with the DTP/Hepatitis B/Hib vaccine, there were 10,000 more assisted deliveries, and approximately 4,000 more women received antenatal care consultation in December 2017 than in January of the same year.

Figure B1. Provision of Key Maternal and Child Health Services in the 14 Targeted Provinces, Showing Averages for Participating vs. Nonparticipating Facilities, DRC, 2017



III. IMPLEMENTATION ARRANGEMENTS

84. Reducing malnutrition requires strong coordination mechanisms, multisectoral and integrated solutions, and participation and engagement of multiple stakeholders. At the same time, experience has shown that getting multiple implementing agencies involved may undermine coordination of integrated service delivery as well as increase challenges and delays in project implementation, particularly in a context of weak institutional capacity and limited experience in the implementation of World Bank projects. Therefore, the proposed institutional arrangements will be kept simple by having a single sectoral ministry within which the project will be anchored and a single PCT responsible for the day-to-day management of project activities.

85. **Sectoral anchoring:** The MoH has been identified by the Government as the ministry within which the project will be anchored. Through the Project Technical Committee (see below) Ministries of Education, Social Affairs, Agriculture, and Fisheries and Livestock will provide support to the MoH in overseeing and providing technical inputs for specific activities and interventions implemented as part of the project that fall within their sectoral purview.

86. **National Steering Committee and Provincial Steering Committees:** To ensure coordination with the overall health system development strategy and the implementation of the PNDS, the project will be anchored in existing central and provincial level governance structures of the health sector: the National Health System Steering Committee (*Comité National de Pilotage du Secteur Santé*, CNP-SS) and the Provincial Health System Steering Committees (*Comités Provinciaux de Pilotage du Secteur Santé*, CPP-SS). The CNP-SS, chaired by the Secretary General of the MoH, will review and validate the annual work plan of the project during one of its regular meeting sessions. The CPP-SS in each of the four provinces where the project will be implemented, will ensure the coordination of the project activities with other activities of the health sector.

87. **Project Technical Committee:** Project implementation and oversight will be incorporated into the existing nutrition governance structures, more specifically, the national Scaling-up Nutrition (SUN) platform. PRONANUT serves as the SUN platform's executive secretariat and is responsible for the coordination and monitoring of the implementation of the National Multisectoral Nutrition Strategy. In this function, PRONANUT is mandated to hold regular meetings with sectoral ministries, development partners, and NGOs. Within this framework, PRONANUT will lead a small multisectoral technical committee that will provide technical guidance to the PCT, review annual work plans and semi-annual and annual monitoring reports, and facilitate dialogue with the participating sectors in order to deal with bottlenecks as they arise. In addition to PRONANUT, the committee will include representatives from four additional key directorates within the MoH (Community Health, Family and Reproductive Health, Studies and Planning, and Hygiene), as well as representatives from the MoSA, Ministry of Education, Ministry of Agriculture (from DEP, SNV, SENASEM), Ministry of Fisheries and Livestock, and Ministry of Research (from INERA).

88. **Project Coordination Team:** To capitalize on the existing expertise and enable quick and efficient implementation, the proposed project will use the existing Health System Strengthening Project PCT. This PCT is already implementing a PBF program, and the proposed project will use the existing institutional

arrangements and processes (for example PBF manual, purchasing agencies, verification processes, and agencies) to implement the PBF subcomponent (Subcomponent 2.1).

89. The PCT team will be expanded to allow for efficient and effective implementation. A separate team will be created within the PCT that will focus on the management of the proposed project. In addition to the overall PCT coordinator, who is already in place, the additional PCT staff hired will include at minimum: (a) project manager/focal point; (b) an FM specialist; (c) an accountant; (d) a procurement specialist; (e) an M&E specialist. In addition, a social safeguards specialist and an environmental safeguards specialist will be recruited by the PCT. Those two staff members will work on the proposed project and on other projects managed by the PCT. Finally, the PCT will also hire a nutrition/FP specialist, an SP specialist, an agriculture specialist, and an administrative assistant. The project will finance additional PCT staff and their training, as well as basic equipment and other necessary inputs.

90. **NGOs – Roles and Responsibilities:** Because of the public sector's severe capacity constraints, NGO will support the implementation of the NAC. NGOs will support the identification, training, supervision, and monitoring of the ReCos. Several large NGOs are present in the provinces supported by the project (for example, Catholic Relief Services (CRS), IMA World Health (IMA), the Adventist Development and Relief Agency (ADRA), and others). Some have worked with PRONANUT and UNICEF on the implementation of NAC in other provinces (for example, ADRA); others have experience with programs targeting acute malnutrition (for example, IMA). NGOs will be contracted directly by the PCT using performance-based contracts. It is envisioned that one or two NGOs will be contracted in each province (a total of four to eight NGOs). Additional NGOs will be contracted to support the provision of FP services.

91. **Technical Assistance Partners – Roles and Responsibilities:** To support the implementation of cash transfers, household food production kits, and biofortification, the PCT, with technical inputs from the sectoral ministries, will sign and manage contracts or TA agreements with TA providers. For biofortification activities, the PCT will contract directly with HarvestPlus, who will provide TA to INERA, SENASEM, and SNV. For the agriculture kits, the PCT will contract directly with the FAO who will produce and distribute the kits and provide TA to the appropriate government agencies.[12] For cash transfers, to the extent possible, the project will use the institutional arrangements used by the PIP project (that is, the PIP project implementation unit; PIU). To implement this component, the PDSS PCT will contract with the PIP PIU. If that is not possible, an alternative TA provider with experience in cash transfer programs in DRC will be identified during the first year of project implementation.

92. **Verification and Counter-verification Agencies – Roles and Responsibilities:** Following the PDSS model, the PCT will contract with *EUP* to provide payments for PBF facilities and NGOs and to conduct the verification of their performance. A counter-verification agency – Credes, will be contracted to carry out counter-verification.

93. Further details on the institutional arrangements, including an organizational chart, can be found in Annex 1.

[12] Through the Project Technical Committee, the sectoral ministries will help PIU monitor the technical aspects of the technical assistance, including the validation of the results achieved.

B. Results Monitoring and Evaluation Arrangements

94. The PCT will be responsible for monitoring and reporting progress and results on a routine basis throughout the life of the project. The general principle underlying the M&E approach is the alignment of the M&E process developed for the project with the M&E framework of the National Multisectoral Nutrition Strategy and with the PNDS. This alignment will increase the efficiency of the project investment. Furthermore, it will allow the project to benefit from and build upon the M&E capacity strengthening delivered through previous WBG investments in DRC (for example, the HMIS strengthening under the PDSS). Biannual reports will be provided to the World Bank that will include a narrative on the implementation progress and data on the Results Framework (RF) indicators. In addition, quarterly results matrices will be prepared that will contain brief updates on the results indicators, as well as key issues related to the social and environmental safeguards.

95. **Routine data:** Data on several RF indicators will be obtained from the HMIS. Over the past years, the World Bank and other partners including the Global Fund have made substantial investments in the strengthening of the HMIS and its migration towards the District Health Information System 2 (DHIS2). Currently, data from a vast majority of health facilities are available in electronic format in the cloud-based DHIS2 and are updated on a monthly basis. This data will be compiled by the PCT and reported every quarter. To further strengthen the HMIS, the project will contribute to the financing of the expansion of the Health Map (*Carte Sanitaire)* – an initiative to geocode all health facilities within DRC.

96. In addition to the HMIS, the PBF program will also collect data on a number of quality indicators. Together with the quantitative data on the number of services provided, the quality data will be reported on a quarterly basis and will be subject to verification and counter-verification. The project will finance the expansion of the PBF portal to include the new facilities in Sud Kivu, Kassai, and Kassai Central. The online interface of the portal is publicly available and will serve not only for data reporting, but also as an accountability tool.

97. At the community level, the project will finance the development of an information system to monitor the services provided by the ReCos. Given the capacity constraints, emphasis will be put on a lean set of key indicators and using the data not only for monitoring but first of all for the management, supervision, and quality assurance of the ReCos to improve service provision. Routine monthly and quarterly data will be aggregated for the project's quarterly and annual indicators. The ICT solutions tested under Component 4 of the project (that is, a system of job aids for ReCos) will provide additional data and supervision tools.

98. **Surveys:** In addition to routine data, the progress of the project will also be monitored using population-based surveys. A national Multi-Indicator Cluster Survey is currently being finalized (with a tentative publication date in the second half of 2019). It will provide updated baseline for some of the indicators included in the results framework. In addition, the project will finance two waves of national Standardized Monitoring and Assessment of Relief and Transitions (SMART) surveys in the third and fifth years, and two waves of provincial-level SMART surveys in the four provinces covered by the project. These will allow for regular monitoring of the key behavioral outcomes included in the RF. They will be customized to provide an added layer of verification for the availability of the nutrition, maternal, and child health services at the health and community levels to assess the performance of the PBF health facilities, the NGOs supporting the NAC, and the non-state actors (NSA) supporting FP.

99. **Performance monitoring:** Health facilities financed through PBF will produce quarterly reports with quantitative and qualitative performance indicators. These reports will form the basis of the PBF payments. The list of the key indicators emphasizing nutrition and FP services has already been developed by the Government. Similarly, NGOs contracted to provide support for the NAC and FP services will provide quarterly performance reports. The reporting grid and key performance indicators will be identified shortly after project approval. Verification agencies (EUP) will be used to verify the data submitted by the health facilities and the NGOs. The EUP will produce a quarterly report on the performance of the facilities and community service delivery with a focus on the key bottlenecks identified and on areas for improvement. In addition, Credes, a counter verification agency which currently provides counter-verification for the PDSS, will be contacted to conduct counter-verification in a sample of facilities and a sample of NGOs. The counter-verification mechanism will include a community survey as a means of citizen engagement and feedback. The questionnaires will be tailored to capture the key domains of satisfaction and perceived quality of facility-based and community-based services, with a focus on identifying key bottlenecks for prompt course correction. Large TA providers contracted using project financing, including FAO and HarvestPlus, will also prepare quarterly reports detailing the progress of the activities they are supporting and outlining key areas of note.

100. **Information and communication technologies for project monitoring:** The project will collaborate with the World Bank's Geo-enabling Monitoring and Support (GEMS) initiative. GEMS will provide support for establishing an online platform consisting of a cloud-based data base, a web portal, and mobile data collection applications based on Kodo ToolBox - an open-source software which enables the collection and reporting of real-time data to facilitate project monitoring and supervision. GEMS platforms have been successfully deployed in other FCV settings (for example, Niger), and an effort to establish a system for monitoring the overall WBG portfolio in DRC is under way. The project team has engaged the GEMS team and has begun discussing the initial training for the PCT staff. This training will be conducted in the period leading up to effectiveness. It will be carried out as a training of trainers (ToT) activity. Once the PCT staff are trained, they will be able to train others in the use of this system. It is envisaged that, in addition to the PCT staff, the system will be used by the EUP (the verification agencies for the PBF) and by the NGOs contracted to support the community service delivery. The data collected will feed directly in real time into the project database. The project will finance the acquisition of hand-held devices (tablets, smartphones) and the cost of training. Given the scale of the project and the amount of the data collected, the project may also finance additional server capacity.

C. Sustainability

101. First, the project will build the capacity of local communities to undertake basic actions aimed at improving nutritional status of women and children. By financing contracts with NGOs to support local governance structures, including the CAC and the community health development committees, the project will sensitize them regarding the fundamental importance of nutrition for the development of children and for the communities. Collaboration with NGOs will provide local communities with knowledge, skills, and tools that will remain once the project financing ends. Similarly, it is envisioned that income-generating activities launched under the project will continue after the project ends, as will household food production which was launched under the convergence project. Finally, the objective of the biofortification element of the pilot is to increase the utilization of biofortified crops to the extent that they could be sustained or even could displace nonbiofortified varieties.

102. Second, it is envisioned that the links created by the project between the communities and the formal health sector will remain even after the project ends. While initially those links will be supported by NGOs and NSA's, development of skill and knowledge transfer plans will be included in their contracts to ensure capacity building and sustainability. It is envisioned that by the end of the project, the communities will be able to continue implementing the NAC strategy with only the support of PRONANUT and the HZ staff.

103. Third, the project will finance the development of innovative tools and capacity strengthening to plan, implement, and manage multisectoral nutrition activities at the community, provincial, and central levels. Once developed, the skills and capacity should be sustainable without a need for future substantial investments.

104. Fourth, the project will build the capacity of the key actors at the provincial and central levels. One of the key obstacles to improving the nutritional status of women and children in DRC is the insufficient level of skills among the health system staff, especially at the provincial and local levels, related to the management and monitoring of programs. The project will invest in this critical capacity gap. Ultimately, the interventions implemented under the project will over time reduce the overall number of cases of stunting in the country to a level that will make it much less expensive and labor-intensive to manage.

IV. PROJECT APPRAISAL SUMMARY

A. Technical, Economic and Financial Analysis (if applicable)

Technical Appraisal

105. The technical design of this project is guided by global evidence showing that a package of high-impact interventions, delivered at scale, and focused on the critical period of 1,000 days from conception through a child's second birthday, can significantly reduce the burden of stunting. It also draws on global experience from initiatives such as Alive and Thrive that demonstrate that comprehensive and contextualized social and behavioral-change communication campaigns, including mass media, community mobilization, and inter-personal communication, can rapidly improve not only knowledge but also key child nutrition and health practices, including child feeding, hygiene, and FP. These experiences are reflected in the central role the delivery of services at the primacy health care and community levels, as well as in the critical role that social and behavioral change communication play in the proposed project.

106. Multisectoral actions that combine interventions in education, SP, and agriculture have been identified in the 2013 Lancet Series on Maternal and Child Nutrition, and in many subsequent key publications, as holding enormous potential to enhance the impact of nutrition-specific interventions delivered through the health sector. This multisectoral synergy is reflected in the convergence project that aims at scaling-up, in a coordinated fashion, the key evidence-based nutrition-sensitive interventions in agriculture, SP, and education in a subset of the targeted HZs.

107. The Government of DRC has benefited from the PPA of US$7.7 million to conduct a number of activities to support project preparation and ensure implementation readiness. The PPA is managed by

the PCT, which will also implement the project once it becomes effective, thus ensuring a seamless transition from the utilization of the advance funds to the funds of the project proper. Among other activities, the PPA is being used to recruit key additional personnel to support project implementation and to develop the project implementation manual.

Economic and Financial Analysis

108. A benefit-cost analysis was carried out to estimate the potential return on investment in terms of increases in economic productivity and incomes and to assess the overall economic impact of the project. The detailed methodology used in this analysis is presented in Annex 3. The estimation of the benefits was based on the scale-up of nutrition-specific and maternal and child health interventions, for which impact on health and nutrition status and, consequently, economic benefits, could be estimated. The economic benefits were calculated based on reduced child and maternal mortality and morbidity, on averted cognitive losses due to reductions in stunting prevalence, and on prevented productivity losses due to reduced prevalence of anemia. The cost and benefits were discounted at 3 percent (and varied from 0 percent and 5 percent in sensitivity analyses). The analysis showed that in the base-case scenario, the project investment would generate economic benefits with a net present value of US$1.6 billion and an internal rate of return of 7 percent. The investment would have an attractive 4.3 benefit-cost ratio, indicating that each dollar invested has the potential of generating more than 4 times as much in economic benefits over the productive lives of women and children who will benefit from the project. The analysis confirms the findings of the large body of literature regarding substantial economic benefits resulting from investments in child health, nutrition, and early child development, and suggests that the project will have a positive economic impact for beneficiaries and the country's economy as a whole.

109. **Rationale for public financing:** In general terms, public investment in health and nutrition focusing on women, infants, and young children can be rationalized based on their merit good nature (a good whose availability should not be dependent on the ability to pay). In addition, public financing, regulation, and even provision are justifiable due to widely recognized market failures in health and nutrition resulting from information asymmetries, presence of supplier-driven demand, complex and opaque production functions, and other market imperfections. Because of this, in DRC, like in most countries in the region, basic health and nutrition services including those whose provisions will be supported by the proposed project are already financed and provided primarily through the public sector. Public financing and provision are necessary to improve the efficiency and equity of service delivery.

110. The public sector plays a critical role in service delivery in other sectors as well. Those include provision of education through public schools, agriculture extension services provided by the Ministry of Agriculture and others. Furthermore, the engagement of local public governance structures, including community action committees (CAC) and health development committees, will be critical for the expansion of the community-based nutrition activities – the key component of the project.

111. **Value added of the World Bank's support:** The World Bank has been engaged with the Government of DRC in informal nutrition policy dialogue since 2014. The World Bank provided critical contributions to the development of key nutrition policy documents. Analytic work conducted by the World Bank in 2014-2015 on the health and economic impact of investing in nutrition has fed directly into the development of the National Multisectoral Strategic Nutrition Plan. The proposed project builds

on this, as well as, on a broader long-standing partnership between the World Bank Group and the government to improve health and human development outcomes and investment in nutrition-sensitive sectors. Finally, the World Bank is uniquely placed as a development assistance convener for nutrition in DRC. The World Bank has been a vital member of the DRC Global Financing Facility in Support of Every Woman and Every Child platform and a key partner in the implementation of the reproductive maternal, neonatal, child health and nutrition (RMNCH-N) investment case. Closely aligned with the investment case, the proposed operation, would also be the largest new investment directly supporting the implementation of the National Multisectoral Strategic Nutrition Plan. This engagement, combined with the global experience in supporting nutrition and maternal and child health, positions the World Bank very well to accompany the Government of DRC to strengthen and expand? essential nutrition services.

B. Fiduciary

(i) Financial Management

112. In accordance with the World Bank Directive, (Financial Management Manual For World Bank IPF Operations), and the World Bank Guidance, (Reference material - Financial Management in World Bank IPF Operations), the FM arrangements of the PDSSP PCT have been assessed to determine if the entity has acceptable FM arrangements in place that satisfy the World Bank's requirements. The World Bank team determined that FM arrangements at the PDSS PCT could be deemed adequate to implement the project, subject to meeting the following requirements: (a) opening the designated account (DA) in a financial institution acceptable to the World Bank; (b) drafting of a manual of procedures in order to take into account the new project and grant specificities; (c) acquiring of a multisite and multiproject version of the management accounting software TOM2PRO to accommodate the decentralized and multiagency nature of the Multisectoral Child Nutrition and Health Project, record project transactions and to prepare Quarterly Interim Unaudited Financial Reports, but not longer than three months after project effectiveness; (d) recruiting of a FM Specialist to assist the FM team that will be dedicated to the project; (e) recruiting an accountant to do the same; (f) recruiting an internal audit consultant who will contribute to strengthening the project's internal control environment and internal audit unit; and (g) agreeing to the ToRs for the recruitment of an independent external auditor, acceptable to IDA, based on acceptable ToR.

113. Implementation arrangements of the ongoing PDSS project will be maintained under the proposed project. The proposed project will use the existing FM arrangements currently in place at the PCT for the purposes of the PDSS.

114. The overall FM risk at preparation is considered High. The proposed FM arrangements, including the mitigation measures for this project, are considered adequate to comply with the provisions of the World Bank Directive: Financial Management Manual for World Bank IPF Operations, and the World Bank Guidance: Reference material - Financial Management in World Bank IPF Operations. Additional details on the FM assessment are found in Annex 5.

(ii) Procurement

115. Project procurement activities will be carried out in accordance with the World Bank's procedures specified in the World Bank Procurement Regulations for IPF Borrowers: Procurement in IPF Goods, Works,

Non-Consulting and Consulting Services (dated July 2016 and revised November 2017 and August 2018), and any other provisions stipulated in the Legal Agreement. In addition, the implementation of procurement will be in accordance with the "Guidelines on preventing and combating Fraud and Corruption" stipulated in 2.2a of Annex IV of the Procurement Regulations.

116. All goods works and non-consulting services will be procured in accordance with the requirements set forth or referred to in Section VI. Approved Selection Methods: Goods, Works, and Non-Consulting Services of the Procurement Regulations. In addition, the consulting services will be procured in accordance with the requirements set forth or referred to in Section VII. Approved Selection Methods: Consulting Services of the Procurement Regulations, the Project Procurement Strategy for Development (PPSD), and in the Procurement Plan approved by the World Bank.

117. A PPSD has been prepared with World Bank support and aims to ensure that procurement activities are packaged and prepared in such a way that they expedite implementation considering (a) the market analysis and the related procurement trends, and (b) the procurement risk analysis. The PPSD provides the basis and justification for procurement decisions, including the recommended procurement approaches for the project that have been reflected in the approved procurement plan covering the first 18 months of the project implementation. Table A4.1 in Annex 4 summarizes the various procurement methods to be used for the main activities financed by the proposed IDA credit/grant and the GFF grant.

C. Legal Operational Policies

	Triggered?
Projects on International Waterways OP 7.50	No
Projects in Disputed Areas OP 7.60	No

D. Environmental and Social

Field visits were conducted during project identification, and relevant safeguard instruments have been prepared. Environmental and social risks and impacts are deemed to be moderate and can be managed during project implementation. Security issues in some provinces may pose challenges for supervision at some sites. The ESF is new, so the Borrower will need support and capacity building from the Bank to enable the Borrower to gain experience operating under the new Bank standards.

118. This project is being prepared under the new Environmental and Social Framework. Field visits were conducted during project identification, and relevant safeguard instruments have been prepared.

119. Environmental and social risks and impacts are deemed to be Moderate and can be managed during project implementation. Apart from security issues that may pose challenges for supervision at a few sites in some provinces, biosafety risks and biological waste are among environmental risks to be closely managed, considering WBG Environmental, Health and Safety guidelines (EHSGs), as well as International Good Practices. The project does not involve significant or irreversible social impacts. Anticipated impacts, (including possible acquisition/restriction of land use, labor and working conditions, and potential impacts to community health and safety) can be managed or mitigated. An initial assessment of the project's potential

risks of gender-based violence using the World Bank's GBV Risk Assessment Tool determined the potential risk as Low. This risk rating will be reassessed once potential subproject sites and specific project activities have been identified and once their propensity for GBV risks can be determined.

120. Eight of the ten environmental and social standards have been screened relevant for this project: ESS 9 (Financial Intermediaries) is not relevant for the project since no activity will involve financial Intermediaries. The project will also not affect or involve risks to cultural heritage and the ESS 8 (Cultural Heritage) is not relevant. However, a Chance Finds protocol will be prepared for the project and included in the ESMF, within three months after project effectiveness. It will be applied as needed once specific subproject sites are identified.

121. The project has prepared, consulted upon, and disclosed all required instruments: Environmental and Social Management Framework (ESMF), Biomedical Waste Management Plan (BWMP), Pest Management Plan (PMP), Resettlement Policy Framework (RPF), Indigenous Peoples Planning Framework (IPPF), Stakeholder Engagement Plan (SEP), and Labor Management Procedures (LMP).

122. The World Bank and Borrower have jointly prepared an Environmental and Social Commitment Plan (ESCP), which includes measures for the preparation and implementation of the other environmental and social plans or instruments during project implementation. The ESCP is a negotiated document which is itself legally binding. The key applicable environmental and social standards in the project are listed below.

123. ESS 1 (Assessment and Management of Environmental and Social Risks and Impacts) - The Borrower prepared an ESMF for the screening, assessment, and management of the project's environmental and social risks and impacts which were determined to be site specific and mostly occurring during health facilities rehabilitation. These risks and impacts will be managed in accordance with the ESMF through preparation of site-specific instruments such as Environmental and Social Management Plans (ESMPs). The document was disclosed on March 19, 2019.

124. ESS 2 (Labor and Working Conditions) – The Borrower has prepared Labor Management Procedures (LMP) which define how project workers will be managed in accordance with the requirements of national law and ESS2. These include terms and conditions of employment, nondiscrimination and equal opportunity, and the establishment of workers' organizations. The LMP will include a grievance redress mechanism for workers and the roles and responsibilities for monitoring such workers. Measures to prevent and mitigate potential SGBV risks involving project workers will be included in contractor and worker contracts and codes of conduct. Measures relating to occupational health and safety are addressed in the ESMF and will be incorporated into the subproject safeguard instruments. The document was disclosed on March 19, 2019.

125. ESS 3 (Resource Efficiency and Pollution Prevention and Management) – A Biomedical Waste Management Plan (BWMP) includes measures for contracted health care facilities to manage biomedical waste consistent with the WBG EHS Guidelines for Health Care Facilities. The document was disclosed on March 19, 2019. An existing Pesticide Management Plan (PMP) prepared under the Kasai emergency program will be used to address potential use of pesticides for seed production.

126. ESS 4 (Community Health and Safety) – Labor influx is not expected since there will be very few public works. An initial GBV risk assessment has been carried out. The project has an overall low risk of GBV related to major civil works, as rated using the GBV Risk Assessment Tool. A GBV Action Plan will be completed by

the Borrower within three months after project effectiveness, and will include a number of GBV risk sensitization, prevention, and mitigations measures.

127. ESS 5 (Land Acquisition, Restrictions on Land Use and Involuntary Resettlement) –The project may undertake land acquisition leading to physical displacement. As potential sites are not yet known, the project has prepared a resettlement policy Framework (RPF). The document was disclosed on March 19, 2019. If needed, site-specific resettlement action plans (RAPs) will be prepared, consulted upon, disclosed, and implemented before any project works are to begin.

128. ESS 6 (Biodiversity Conservation and Sustainable Management of Living Natural Resources) – The ESMF provides guidance on screening and mitigation measures to ensure that project activities do not alter or cause destruction of any critical or sensitive natural habitats. Project activities may include the production and distribution of small animal livestock. An Animal Health and Welfare Plan will be prepared in a way consistent with the IFC Good Practice Note on Improving Animal Welfare in Livestock Operations.

129. ESS 7 (Indigenous Peoples/Sub-Saharan African Historically Underserved Traditional Local Communities) – There is a presence of Indigenous Communities in Kasai, Kasai Central, and Sud Kivu Provinces. The project has prepared a draft IPPF which provides guidance on meaningful consultation (in a culturally appropriate manner) in order to ensure inclusion of the Batwa/Pygmy populations in the Provinces. The IPPF also addresses harm, and based on initial consultations, identifies mitigation measures in the case of any adverse impacts and contains proposals for culturally appropriate benefits. The document was disclosed on March 19, 2019.

130. ESS 10 (Stakeholder Engagement and Information Disclosure) – A stakeholder engagement plan (SEP) was prepared prior to appraisal and disclosed on March 19, 2019. It will be updated during implementation as subproject sites are identified, and as communications and stakeholder engagement and communications needs evolve. The Borrower will engage in consultations with all stakeholders throughout the project life cycle, paying particular attention to inclusion of vulnerable and disadvantaged groups, to provide stakeholders with timely, relevant, understandable, and accessible information.

Climate Screening and Climate Co-benefits

131. This project has been screened for climate change and a number of vulnerabilities, described below, were identified through the process. The overall assessment of potential risks in the Summary Climate and Disaster Risk Screening Report is assessed as “moderate” due to extreme temperature. This exposure risk is assessed at this level for both the current and future timescales. This is likely to impact target beneficiaries in the project’s locations during implementation. In DRC, increases in temperature extremes by about 0.25°C per decade since the 1960s have been observed. An increased frequency of intense rainfall events has also been observed, along with increases in the temperatures of deep waters in Lake Tanganyika by 0.2–0.7°C in the same period. In the future, temperatures are predicted to increase by 1–2.5°C by 2050 and by 3°C by 2100. It is expected that the increased frequency of intense rainfall events and prolonged dry spells which have already been observed will continue.

132. The predicted climatic changes are expected to affect this project in two key ways: (i) through direct nutrition impacts; and (ii) indirectly through increasing vector-borne disease risk. First, higher

temperatures can affect crop yields, while some crops show reductions in protein and certain nutrients such as zinc, calcium and iron in the presence of higher carbon dioxide levels, contributing to undernutrition and stunting. Also, more intense and frequent rainfall can increase the risk of flooding in rivers, streams, and drainage ditches, periodically contaminating water sources. This would likely impact the spread of waterborne diseases and emerging infectious diseases with direct nutrition implications. Secondly, the predicted climatic changes may increase the range and prevalence of infectious disease vectors, in particular malaria, which is already a leading cause of morbidity and mortality in DRC. Malaria exerts an important health burden on the population. By 2030 an additional 65,000–80,000 people in DRC are predicted to be at risk from endemic malaria. There is evidence linking malaria parasitemia with increased risk of stunting and wasting. Hence, measures to reduce malaria risk will in turn reduce the burden of malnutrition.

133. The project intends to address these vulnerabilities through a number of mitigation and adaptation measures. The predicted increases in extreme temperature and intense rainfall events could present a significant challenge to achievement of the nutrition goals of the program. This project will implement mitigation solutions to the climate challenge by promoting sustainable transport modalities (walking and cycling by ReCos) where possible for the home visits under Component 1. Under Component 2, further mitigation benefits will be realized through the investments in basic equipment, ensuring they are low-energy appliances, as well as through the contribution to the MoH data collection and reporting methods which promise to reduce the need for transport to gather the data. For the health facilities, the project will finance solar refrigerators, solar panels to generate electricity, and LED lighting. In addition, the project will also procure solar chargers for tablets and mobile phones used by the health systems staff, NGOs, and ReCos using mobile-phone based job aids.

134. The project will achieve adaption measures through four key approaches: (i) by reducing standing water and mosquito proofing facilities to reduce the future predicted increase in malaria risk; (ii) by treating for diarrheal diseases in the health centers and the community; (iii) by creating heat-proofing facilities by planting native shading vegetation near these facilities, which should also have a mitigation benefit as outlined above; and (iv) by selecting new crop varieties selected under Component 3, which in addition to higher yield will have higher climate resilience than the traditional crops.

I. GRIEVANCE REDRESS SERVICES

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

Information on how to submit complaints to the World Bank Inspection Panel is available at www.inspectionpanel.org.

136. To ensure access to redress mechanisms, the project will set up grievance redress mechanism (GRM) committees at the CAC level in the communities included in the project. CAC members who are not ReCos and who are not involved in project implementation will be trained in recording the grievances and transmitting them to the PCT through the project grievance redress system. GMR will also be available through additional means including email, phone, or SMS, to allow citizens to ask questions, or express problems or concerns, thus allowing for the same complaint to be submitted through multiple channels. The PCT will address each of these in turn and monitor the response rate and quality. The percentage of grievances addressed within the specified amount of time will be tracked as an indicator in the project's results framework.

137. In addition, a separate GRM will be used for the reporting and redress of sexual and gender-based violence (SGBV) to address the needs of SGBV survivors. The mechanism will build upon the system established under the Gender-Based Violence Prevention and Response Project (P166763) in partnership with UNFPA. The system already exists in Sud Kivu and the proposed project will finance its expansion to the Kwily, Kassai, and Kassai Centrale provinces. When the GRM receives a complaint on SGBV, it will record information on at least two factors: (i) the nature of complaint (what the complainant says in his or her own words); and (ii) if, to the best of their knowledge, the SGBV survivor believes the perpetrator was associated with the project. The GRM will refer the survivor to NGO(s)/UNFPA to ensure the adequate provision of case management (while always maintaining the survivor's confidentiality). The NGO(s)/UNFPA will ensure that SGBV incidents are recorded safely and ethically, in line with best practices for documenting SBGV. It will also ensure that victims receive assistance based on each individual's needs and wishes and upon obtaining his/her informed consent, through direct support and/or referral to other SGBV services, including to medical, psychosocial, legal, safety and protection services, and livelihood support. NGO(s)/UNFPA will also sensitize and educate all local actors (communities, schools, health centers, and daily workers) on SGBV and the project standards of conduct, including the provisions prohibiting SGBV, raise public awareness about the different entry points to place complaints with the GRM, train stakeholders (project contractors, communities, PCT), assist and refer survivors to appropriate service providers, and monitor implementation of the SGBV prevention and response measures (that is that Codes of Conduct for contractors, workers, and supervisors are in place and signed, and that the GRM are maintaining case confidentiality and acting in conformance with the response protocol). NGOs will also be responsible for regularly engaging communities to gain understanding and trust of their needs, satisfaction, and level of knowledge of the mechanism, as well as to gain critical appreciation of the effectiveness of the GRM both for prevention and for response to instances of violence. The aggregated information so gathered will be monitored and reported by the PCT to the World Bank, the Government, and other stakeholders.

II. KEY RISKS

138. The overall risk of the proposed operation is "Substantial". The key risks and proposed mitigation measures are described below.

139. **The political and governance risks are rated High.** They include unforeseen changes in government, in particular within the context of the recent presidential election in December 2018. The proposed operation and the longer-term World Bank engagement to address stunting in DRC are driven by a very strong political commitment at the highest levels of government. It is possible that, following the election, personnel changes and changes in strategic direction at the central level could impact delivery of health and nutrition interventions at the community level and throughout the public sector. The project will mitigate this risk by engaging a broad range of stakeholders at the provincial and local levels to support project implementation.

140. **Macro-economic risk is rated Substantial.** Macro-economic risk is substantial mainly because of the high inflation and depreciation of the local currency. This risk could be mitigated by incurring substantial portions of project expenditures in U.S. dollars (for example TA agreements with UN agencies and other TA providers).

141. **Sector Strategies and Policies risk is rated Substantial.** Although in other parts of the DRC these freestanding activities are being implemented with good results, given the multisectoral nature of the proposed project and the security situation in three of the four target provinces, project implementation could prove challenging. This risk is being mitigated by building on what already exists with development partners and implementing agencies that already have a presence and capacity in the project areas.

142. The **risk related to the technical design of the project is Substantial**. Activities similar to those proposed by the project have already been implemented in other areas of DRC with support from other partners. To the greatest possible extent, the proposed project will use the delivery and implementation modalities that have already been tested and have been proven to be effective in the DRC and in other similar contexts. The risk related to the technical design will be mitigated by the setting up a project technical committee with members from each of the ministries involved. This will help with the coordination and information sharing among the ministries.

143. The risks in terms of **institutional capacity for implementation and sustainability are rated Substantial** because of the general limited capacity of the government, in particular the PRONANUT as well as the national sectoral ministries and provincial governments. To mitigate this risk, the project design will prioritize the strengthening of the operational and technical coordination at the local, provincial, and central levels.

144. **Fiduciary risks are rated High.** Fiduciary risks have a high probability of impacting the PDO in an adverse way. Overall the fiduciary environment of the country is weak. Despite making progress during the last decade, the DRC's governance ratings are among the lowest in the world and significantly below the Sub-Saharan African average. The World Bank's principal concern is to ensure that project funds are used economically and efficiently for their intended purpose. Fiduciary risks include: (a) since the PDSS PCT will implement the project in collaboration with several external stakeholders, there will be an inherent risk of lack of coordination and consolidation of actions and information; (b) poor governance and slow pace of implementation of Public Financial Management (PFM) reforms that might hamper the overall PFM environment; (c) the possibility of a lack of coordination since several stakeholders will be involved in implementation and they may not be familiar with the new implementation modalities of the project; and (d) weak FM capacity at different stakeholder levels and the corresponding risk of fraud and corruption. Mitigation measures include: (a) the PDSS PCT will ensure the coordination of the project with

the collaboration of other stakeholders; (b) the development of a project implementation manual (PIM) which will clarify the roles and responsibilities of the various stakeholders and provide clear definitions of implementation procedures in line with the World Bank's fiduciary requirements; (c) from inception, the necessity for seamless coordination will be integrated into the protocols/agreements between the PDSS PCT and other external stakeholders respectively; (d) regular internal audit missions (technical and financial audit) will be conducted during the project period with a focus on fraud and corruption risk in the implementation of project operations; (e) the FM staff will help stakeholders in preparing realistic budgets consistent with the work program; and (f) the project will acquire management accounting software and customize it to generate the financial reports for the project.

145. **Safeguard risks are rated Moderate.** The environmental and social risk classification for the project is moderate under the World Bank Environmental and Social Framework (ESF). No significant or irreversible risks or impacts are expected. Project risks are mainly related to security issues in some of the provinces that can have an impact on the project's supervision, and the need to strengthen stakeholders' capacity to comply with the new ESF requirements, especially at the provincial level. These risks will be mitigated by engaging in capacity-building activities, by preparing required environmental and social instruments, and by hiring environmental and social specialists to support the PCT in the implementation of environmental and social measures.

146. **Stakeholders' risks are rated Substantial.** Given the multisectoral nature of this project, many partners are involved, including government ministries, different levels of actors (central, provincial, district, and community) and external partners (UN Agencies, Development Partners, and local implementing partners). These risks will be mitigated through the formation of a Project Technical Committee and regular progress meetings with implementing partners.

III. RESULTS FRAMEWORK AND MONITORING

Results Framework
COUNTRY: Congo, Democratic Republic of
DRC Multisectoral Nutrition and Health Project

Project Development Objectives(s)

The development objective of this project is to increase the utilization of nutrition-specific and nutrition-sensitive interventions targeting children 0-23 months of age and pregnant and lactating women in the project regions and to respond to an eligible crisis or emergency.

Project Development Objective Indicators

Indicator Name	DLI	Baseline	End Target
Increase utilization of nutrition-specific/sensitive interventions targeting project beneficiaries			
People who have received essential health, nutrition, and population (HNP) services (CRI, Number)		0.00	4,000,000.00
Number of women who received essential nutrition services (Number)		0.00	1,500,000.00
Number of children aged 0-23 months who received essential nutrition services (Number)		0.00	2,500,000.00
Number of children who received post-natal consultations (Number)		613,684.00	816,200.00
Number of women who received post-partum family planning services (Number)		134,806.00	138,850.00
Number of pregnant women who received iron and folic acid supplementation (Number)		42,798.00	59,917.00
Number of households that received food production kits		0.00	18,000.00

Indicator Name	DLI	Baseline	End Target
(Number)			
Number of beneficiaries who received cash transfers (Number)		0.00	20,000.00

Intermediate Results Indicators by Components

Indicator Name	DLI	Baseline	End Target
C1: Improving the Delivery of Community Interventions and Social and Behavioral Change			
Number of villages/neighborhoods with a NAC (Nutritoin a Assis Communautaire) (Number)		0.00	1,030.00
Percentage of children 6-23 months of age who benefit from an acceptable diet (Percentage)		9.00	15.00
C2: Improving the Service Supply and Strategic Purchasing			
Average quality of care score at health centers supported by performance-based financing (Percentage)		25.00	65.00
Percentage of children who received treatment and recovered from Severe Acute Malnutrition (SAM) in target health zones (Percentage)		45.00	70.00
Number of first-time users of modern contraception (Number)		536,001.00	577,425.00
Number of women using family planning services in targeted health zones (Number)		323,154.00	348,129.00
Number of women aged 15−49 years who received antenatal care, four times or more (Number)		216,987.00	373,760.00
C3: Convergence Demonstration Pilot			
Number of adolescent girls who receive iron and folic acid supplements in school (Number)		0.00	18,000.00

Indicator Name	DLI	Baseline	End Target
Number of multipliers who produce biofortified crops in project zones (Number)		0.00	100,000.00
C4: Capacity Strengthening and Project Management			
Number of Community Health Development Committees (CoDeSa) who submitted quarterly activity reports (Number)		0.00	1,030.00
Average community health development committee (CoDeSa) functionality score (Percentage)		0.00	50.00
Percentage of complaints addressed within the period specified in the Project Operations Manual (Percentage)		0.00	100.00
Execution rate of the Provincial Health Directorate's approved work plan (Percentage)		52.00	75.00

Monitoring & Evaluation Plan: PDO Indicators

Indicator Name	Definition/Description	Frequency	Datasource	Methodology for Data Collection	Responsibility for Data Collection
People who have received essential health, nutrition, and population (HNP) services		Bi-annually	DSNIS database	Routine data collection by PRONANUT	MSP/DSNIS
Number of women who received essential nutrition services	Sum of women who received essential nutrition services through project support during the semester	Bi-annually	DSNIS database	Routine data collection by PRONANUT	MSP/DSNIS
Number of children aged 0-23 months who received essential nutrition services	Sum of children aged 0-23 months who received essential nutrition services	Bi-annually	DSNIS database	Routine data collection by PRONANUT	MSP/DSNIS

	through project support during the semester				
Number of children who received post-natal consultations	Sum of children who received post-natal consultation during the semester	Bi-annually	DNSIS database	Routine data collection through health facility monthly activity reports	MSP/DSNIS
Number of women who received post-partum family planning services	Sum of women who received family planning services after they gave birth during the semester	Bi-annually	DSNIS database	Routine data collection through health facility monthly activity reports supplemented by NGO/NSA reports	MSP/DSNIS
Number of pregnant women who received iron and folic acid supplementation	Sum of pregnant women who received iron and folic acid supplements during the past semester	Bi-annually	DSNIS database	Routine data collection through health facility monthly activity reports	MSP/DSNIS
Number of households that received food production kits	Sum of households who received household food production kits during the quarter through project support	Quarterly	Project records	FAO routine monitoring system	DEP/Minagri
Number of beneficiaries who received cash transfers	Sum of people who received cash transfers during the quarter	Quarterly	Reports of UGP PIP	Routine data collected by the PIP PIU	Ministry of social affairs

Monitoring & Evaluation Plan: Intermediate Results Indicators					
Indicator Name	**Definition/Description**	**Frequency**	**Datasource**	**Methodology for Data Collection**	**Responsibility for Data Collection**
Number of villages/neighborhoods with a NAC (Nutritoin a Assis Communautaire)	Annual sum of villages and neighborhoods with a NAC	Annual	PRONANUT data	Routine data collection by PRONANUT	MSP/Pronanut/DSNIS
Percentage of children 6-23 months of age who benefit from an acceptable diet		Annually	Survey data	Annual surveys financed/cofinanced by the project	MSP/Pronaut
Average quality of care score at health centers supported by performance-based financing	Numerator: sum of quality of care scores at all health centers supported by performance-based financing during the semester Denominator: total number of health centers supported by performance-based financing during the semester	Bi-Annually	PBF Database	PBF PDSS quality scoring used for PBF payments	EUP FBP/CT-FBR
Percentage of children who received treatment and recovered from Severe Acute Malnutrition (SAM) in target health zones	Numerator: Number of children who had Severe Acute Malnutrition, defined as very low weight for height (below -3z scores of the median WHO growth standards) or by the presence of nutritional oedema, received treatment	Bi-annually	PBF database	Routine data reported by the healthy facility monthly activity reports	MSP/Pronanut/DSNIS

	and recovered during the semester. Denominator: Number of children who had Severe Acute Malnutrition				
Number of first-time users of modern contraception	Sum of people in target health zone who accept for the first time in their lives any modern family planning method provided by the project during the semester. "Modern" family planning methods refer to: pill, intrauterine device, implant, injectable, condom (male and female), spermicide, diaphragm, patch, vaginal ring, sponge, and sterilization (tubal ligation and vasectomy).	Bi-annually	PBF database	Routine data reported by the healthy facility monthly activity reports supplemented by NGO/NSA data	MSP/PNSR/CT FBR
Number of women using family planning services in targeted health zones	Sum of women using family planning services in targeted health zones during the semester. Family planning services may include: pill, IUD, implant, injection, condom (male and female), spermicides/foam/jelly, diaphragm, tubal ligation, sterilization (male and female), vaginal ring, patch,	Bi-annually	PBF database	Routine data reported by the healthy facility monthly activity reports supplemented by the NGO/NDA data	MSP/PNSR/CT FBR

	sponge, and lactational amenorrhea method (LAM)				
Number of women aged 15−49 years who received antenatal care, four times or more	Number of women aged 15−49 years in target health zones who received antenatal care four or more times during the semester.	Bi-annually	Performance Based Financing database	Routine data reported by the healthy facility monthly activity reports	MSP/PNSR/CT FBR
Number of adolescent girls who receive iron and folic acid supplements in school	Sum of students in target schools who received iron and folic acid supplements during the quarter	Quarterly	School registers	Data collected by the School Health Program	Ministry of Health, School Health Program
Number of multipliers who produce biofortified crops in project zones	Sum of multipliers who produce fortified crops in project zones during semester	Bi-Annually	National Service of Agricultural Statistics	Data collected by HarvestPlus	DEP/Minagri
Number of Community Health Development Committees (CoDeSa) who submitted quarterly activity reports	Sum of CoDeSa who submitted their quarterly activity reports during the quarter	Quarterly	Project reports	Routine data collected by the project	Project management
Average community health development committee (CoDeSa) functionality score	Measurement of functioning to be determined	Quarterly	TBD	Routine data collected by the project	TBD
Percentage of complaints addressed within the period specified in the Project Operations Manual	Numerator: number of complaints addressed within specified number of weeks during the quarter, as determined by the Project Operations Manual	Quarterly	Project reports	Routine data collected by the project	Project management

	Denominator: number of complaints received during the quarter				
Execution rate of the Provincial Health Directorate's approved work plan	Numerator: sum of expenditures from start of the year to current reporting period Denominator: annual budget amount approved in Provincial Health Directorate's work plan	Quarterly	Project reports	Routine data reported by the Provincial Directorates of Health	Project management

ANNEX 1: Implementation Arrangements and Support Plan

1. Reducing malnutrition requires strong coordination mechanisms, multisectoral and integrated solutions, and participation and engagement of multiple stakeholders. At the same time, experience has shown that involving multiple implementing agencies may undermine coordination of integrated service delivery as well as increase challenges and delays in project implementation, particularly in a context of weak institutional capacity and limited experience in the implementation of World Bank projects. Therefore, the proposed institutional arrangements would be kept simple by having a single sectoral ministry within which the project will be anchored and a single PCT responsible for the day-to-day management of project activities.

2. **Sectoral anchoring:** The MoH has been identified by the Government as the ministry within which the project will be anchored. Through the Project Technical Committee (see below), Ministries of Education, Social Affairs, Agriculture, and Fisheries and Livestock will provide support to the MoH in overseeing specific activities and interventions implemented as part of the project that fall within their sectoral purview.

3. The five ministries were intimately involved in the preparation of the project. Representative from the ministries identified and delegated by the respective Secretaries General were part of the Project Preparation Committee (PPC), led by PRONANUT. It is expected that several members of the PPC will continue their engagement as members of the Project Technical Committee (see below). The membership of the PTC will be determined by the Government in the lead-up to the effectiveness.

4. **National Steering Committee and Provincial Planning Committees:** To ensure coordination with the overall health system development strategy and the implementation of the PNDS, the project will be anchored in existing central and provincial level governance structures of the health sector: the CNP-SS and the CPP-SS. The CNP-SS, chaired by the Secretary General of the MoH, will review and validate the annual work plan of the project during one of its regular meeting sessions. The CPP-SS in each of the four provinces where the project will be implemented, will ensure the coordination of the project activities with other activities of the health sector.

5. **Project Technical Committee:** PRONANUT serves as the SUN platform's executive secretariat and is responsible for the coordination and monitoring of the implementation of the plan. In this function, PRONANUT is mandated to hold regular meetings with sectoral ministries, development partners, and NGOs. Within this framework, PRONANUT will lead a small multisectoral technical committee that will provide technical guidance and monitoring of the implementation of the project. The committee will be established based on a ministerial decree. In addition to PRONANUT, it will include representatives from key directorates within the MoH (Community Health, Family and Reproductive Health, Studies and Planning, and Hygiene), as well as representatives from the MoSA, Ministry of Education, Ministry of Agriculture, and Ministry of Animal Husbandry. The technical committee will validate the annual work plan prepared by the PCT and review and validate the periodic progress reports. It will provide technical direction to the PCT, monitor progress towards project objectives, and facilitate dialogue with the participating sectors in order to deal with bottlenecks as they arise.

6. **Project Coordination Team:** To capitalize on the existing expertise and to enable quick and efficient implementation, the proposed project will use the existing Health System Strengthening Project PCT. The PCT team will be expanded to allow for efficient and effective implementation. A separate team will be created within the PCT that will focus on the management of the proposed project. The PCT team will be

expanded to allow for efficient and effective implementation. A separate team will be created within the PCT that will focus on the management of the proposed project. In addition to the overall PCT coordinator, who is already in place, the additional PCT staff hired will include at minimum: (a) project manager/focal point; (b) an FM specialist; (c) an accountant; (d) a procurement specialist; (e) an M&E specialist. In addition, a social safeguards specialist and an environmental safeguards specialist will be recruited by the PCT. Those two staff members will work on the proposed project and on other projects managed by the PCT. Finally, the PCT will also hire a nutrition/FP specialist, an SP specialist, an agriculture specialist, and an administrative assistant. The project will finance additional PCT staff and their training, as well as basic equipment and other necessary inputs.

4. The PCT is already implementing a PBF program, and the proposed project will use the existing institutional arrangements and processes (for example, the PBF manual, purchasing agencies, verification processes, and agencies) to implement the PBF subcomponent (Subcomponent 2.1).

5. **Verification and Counter-verification Agencies – Roles and Responsibilities:** Following the PDSS model, PCT will contract with the *EUP* to provide payments for PBF facilities and NGOs and verify their performance. A counter-verification agency, Credes, will be contracted to carry out counter-verification.

6. **NGOs – Roles and Responsibilities:** Because of the public sector's severe capacity constraints, NGOs will support the implementation of the NAC. NGOs will support the identification, training, supervision, and monitoring of the ReCos. Several large NGOs are present in the provinces supported by the project (for example, CRS, IMA, ADRA, and others). Some of them have worked with PRONANUT and UNICEF on the implementation of NAC in other provinces (for example, ADRA). Others have experience with programs targeting acute malnutrition (e.g. IMA).

7. NGOs will be contracted directly by the PCT. It is envisioned that one or two NGOs will be contracted in each province (a total of four to eight NGOs). Additional NGOs will be contracted to provide FP services. NGOs contacts will be performance-based and will use verification and counter-verification mechanisms also used for PBF. Administrative data produced by the NGOs will be reported and verified with a sample of clients who will receive household visits and surveys to counter-verify data.

8. **Technical Assistance Partners – Roles and Responsibilities:** To support the implementation of SBC, cash transfers, household food production kits, and biofortification, the PCT will sign and manage contracts or TA agreements with TA providers. For biofortification activities, the PCT will contract directly with HarvestPlus, who will provide technical support.

9. The PCT will contract an international SBC provider or a consortium of international and local providers. The contract will be competitively bid. This implementer will: test and design mass media campaigns; develop and execute a strategy of nurturing champions for nutrition and FP, including religious leaders; and develop messaging through IPC to be executed through a number of actors (school based, community based ReCos, facility based). The consortium may include implementing partners who will cover each of the provinces, while also managing national level multimedia approaches. The consortium will also need to have capacity to perform costing of SBC interventions and cost-effectiveness analysis. Coordination of SBC activities among the various development partners will ideally be led by the MoH through a steering committee or other mechanism.

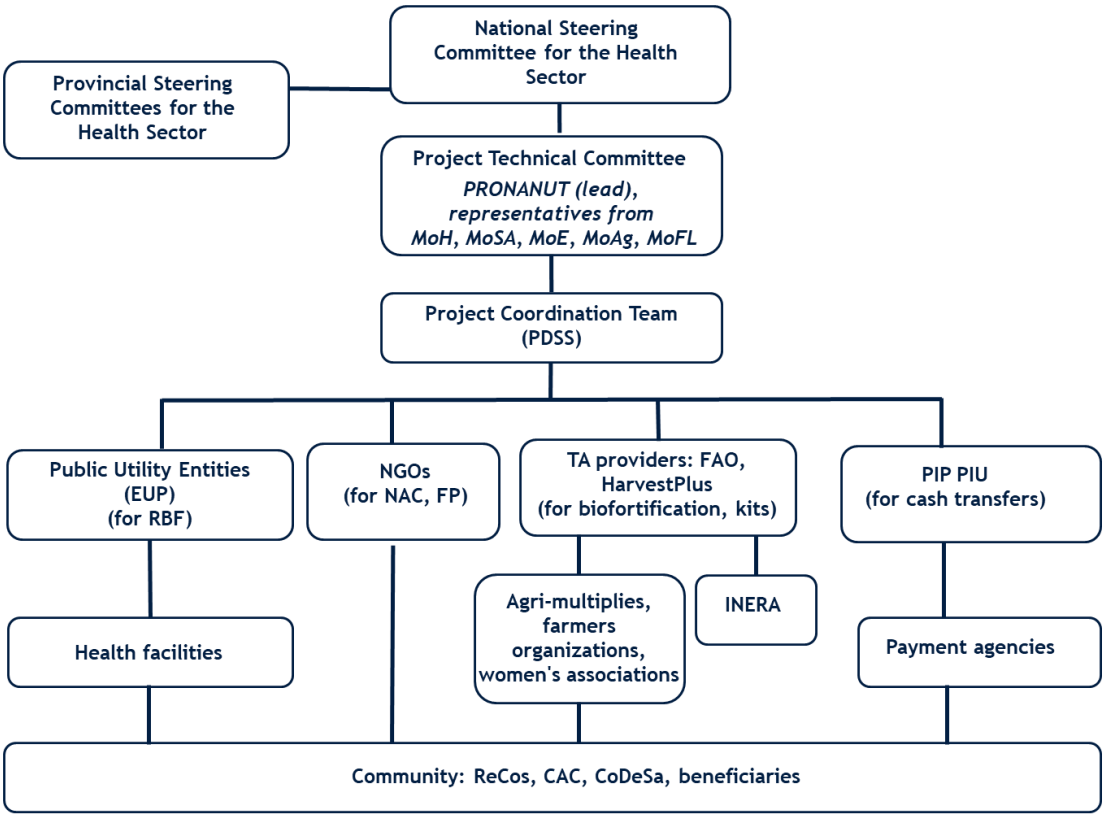
10. Through PDSS, the Government will enter into performance-based contracts with NSAs to expand FP and reproductive health coverage and access at the community level. The contractors will be selected from a transparent competitive procurement process that will be led by the MoH. The existing PCT of PDSS will manage the contracts – anticipated to be one per province. The verification agencies established for the PBF subcomponent will conduct the counter-verification of reported activities by the contractors on a quarterly basis as is done currently for the facilities. Administrative data produced by the NSAs will be reported and verified, with a sample of clients that will receive household visits and surveys.

11. To implement the cash transfer component the proposed project will use, to the extent possible, the institutional arrangements of the Productive Inclusion Project (See chart in Figure A1.1). PIP includes a cash transfer component targeting HZs with high levels of poverty and focuses on similar target groups (pregnant women and children under 2 years of age). PIP will be implemented by a PIU under the MoSA, which in turn will be contracting with payment agencies. The PCT of the proposed project will contract with the PIP PIU to deliver cash transfers in the HZs selected by the pilot. This arrangement will allow the project to capitalize on the existing arrangements and ensure consistency with the overall World Bank SP strategy in DRC. It will also help ensure that the cash transfers financed by the project are coordinated with the other pilot activities and with the community interventions implemented under Component 1 and with PBF implemented under Component 2. It is envisioned that to deliver the transfers, the PIP PIU will contract with a large national provider (for example, a large national NGO or a UN agency) who in turn will contract with accredited payment agencies at the local level. These may include money transfer companies, microfinance institutions, telephone companies, and/or NGOs. These local implementation agencies, which have experience in the delivery of cash and in-kind transfers, will deliver small, regular transfers to the beneficiaries to help stabilize consumption. A similar implementation modality is already used by other World Bank investments (for example, the Eastern Recovery Project) and by other development partners. If subcontracting with the PIP PIU is not possible, an alternative TA provider with experience in cash transfer programs in DRC will be identified during the first year of project implementation.

12. For the food production kits, the PCT will contract directly with the FAO to produce and distribute the kits and provide TA to the appropriate government agencies. FAO will contract with INERA to produce with CAPSA the initial stock of breeder seeds and inputs for further multiplication. Once the initial stock is ready, FAO will contract agrimultipiers' associations in the selected HZs to multiply the initial stock of inputs for the kits for further reproduction by farmers' organizations (FOs) and women's association (WAs). The FAO will then contract with farmers' organizations and women's associations in the selected HZs to produce the inputs needed for the kits. The FAO will purchase three quarters of the material produced by the FOs and the WAs. FAO will contract with local NGOs to assemble and distribute the kits and train the beneficiaries in their use.

13. A similar implementation arrangement will be used for the scale-up of biofortified crops. The PCT will contract with HarvestPlus to provide TA to the Government and to coordinate biofortification activities. HarvestPlus will contract with INERA and SENASEM to produce the initial stock for breeder seeds for crops including biofortified cassava, maize, and beans. Once the breeder stock is produced and certified, HarvestPlus will contract with local agrimultipiers. HarvestPlus has extensive experience in building these partnerships with NGOs, farmer associations, and small seed companies in DRC and other countries. It currently works with 10 NGOs, 23 farmer associations, and 3 seed company partners to fortify maize and beans. HarvestPlus will contract with local partners (for example NGOs) to disseminate the biofortified crops among farmers in the targeted HZs and conduct farmer training.

Figure A1.1: Institutional Arrangements



Implementation support plan

14. To support project implementation, the World Bank team will conduct six implementation support missions a year. It is envisaged that the missions will be more frequent in the first two years of project implementation (for example, six missions a year), to ensure operational readiness and provide close support in the initial period of implementation. The frequency of the missions may be reduced during later stages of implementation (for example, four missions a year). These missions will serve to: (a) review the progress towards the achievement of the PDO and the RF indicators; (b) provide support for any implementation issues that may arise; (c) provide technical support and capacity building for the government team; and (d) monitor the implementation of safeguards mechanisms and facilitate appropriate mitigation measures. All missions conducted will include field visits.

15. The World Bank team supporting project implementation will consist of specialists in the key technical areas of the project, including nutrition, maternal and child health, FP and reproductive health, SP, education, and agriculture (see chart in Table A1.1 below). It will also include specialists in FM, procurement, social and environmental safeguards, law and legal matters, and administration. In additional to the team members based in Washington, the project will be supported by country-based staff, including a SP specialist, a health specialist, a social development specialist, an environment specialist, a FM specialist, a procurement

specialist, and an administrative support/project assistant. Additional technical expertise, both international and national in scope, may be mobilized for specific tasks as needed during project implementation.

16. The HZs where the project is to be implemented have been selected based on, among other criteria, the ease of access to ensure that the implementation of the project can be properly monitored and supervised. However, given the FCV status of the DRC and the overall challenges related to accessibility and security, it may not be possible to provide direct supervision and implementation support to all HZs financed by the project. Therefore, additional implementation support mechanisms will be used.

17. Geo-Enabling Monitoring and Support. The project will collaborate with the World Bank's GEMS. It will provide support for establishing an online platform consisting of an online data base, a portal, and mobile data collection applications based on an open-source software (Kobo Toolbox) that enables the collection and reporting of real-time data to facilitate project monitoring and supervision. GEMS platforms have been successfully deployed in FCV settings (for example, Niger), and an effort to establish a system for monitoring of the overall WBG portfolio in DRC is under way. The project team has engaged the GEMS team and has begun discussing the initial training for the PCT staff. This training will be conducted in the period leading up to the effective date as a ToTs activity. Once the PCT staff are trained, they will be able to train others in the use of the system. It is envisaged that, in addition to the PCT staff, the system will be used by the EUP (the verification agencies for the PBF) and by the NGOs contracted to support the community service delivery. The data collected will feed directly and in real time into the project database. The project will finance the acquisition of hand-held devices (tablets, smartphones) and the cost of training. Given the scale of the project and the amount of the data collected, the project may also, if needed, finance additional server capacity. The cost of ToT will be covered by the World Bank budget (BB).

18. Partner Systems: The project will finance TA from the FAO, HarvestPlus and other partners with an extensive presence on the ground. Collaboration with those agencies will enable the project to benefit from their existing monitoring and supervision mechanisms. In addition, their contractual arrangement with the project will include detailed reporting requirements.

Table A1.1: Project Implementation Support Skills and Mission Matrix

Skills Needed	Number of staff weeks	Number of trips	Comments
Team leadership - technical and operational	20	6 per year	HQ-based
Technical team members	8	at least 2 trips per year per staff member	2 HQ-based staff
Technical team members	12	at least 6 trips per year per staff member	2 Country-based staff
Procurement expertise	4	As needed	Country-based
FM expertise	4	As needed	Country-based
Environment expertise	4	at least 2 trips per year	Country-based
Social development expertise	4	at least 2 trips per year	Country-based
M&E expertise	6	at least 1 trip per year	HQ-based
Operations support	6	at least 1 trip per year	HQ-based

Legal expertise	1	As needed	HQ-based

19. To support the number of trips presented above, a variable cost budget of US$147,000 per year will be needed. An additional US$20,000 during the first year will be needed to develop the GEMS system and to conduct the ToTs. The cost of hand-held devices for the staff or the PCT, EUP, and NGOs will be covered by the project.

ANNEX 2 Detailed Component Description

Component 1. Improving the Delivery of Community Interventions and Social and Behavioral Change (US$177.8 million equivalent: US$170.0 million from IDA; US$7.8 million from the GFF)

Subcomponent 1.1: Improving the Delivery of Community Nutrition Interventions (US$170.0 million equivalent from IDA)

1. The proposed project will finance the standardization and scale-up in the project provinces of the community nutrition platform, based on the policy and institutional framework developed to date by the Government, the NAC model. The model uses *relais communautaires* (ReCos) – a cadre of community nutrition agents -- to provide a basic package of nutrition services targeting pregnant and lactating women, children under the age of 5, and adolescent girls. The ReCos will also work as a key interface between the community and public service providers, making referrals as needed.

2. The ReCos will carry out a community census to identify all pregnant women, children under the age of 5, and adolescent girls. They will conduct home visits and carry out community sensitization and information sessions (*causeries*) to deliver IYCF counseling/messages to all pregnant and lactating women and mothers of children under the age of 5. Based on the parental education curriculum and materials developed in DRC with support of the World Bank,[13] the ReCos will also deliver messages to parents about correct infant and young child care and early stimulation practices. They will screen children for acute malnutrition and other illnesses, and provide referrals and linkages to health facilities for pregnant and lactating women to promote utilization of prenatal and post-natal care services and FP. Additionally, the ReCos will provide support to health facility staff during campaigns to provide vitamin A supplementation, deworming, and vaccination.

3. To address the impact of adolescent pregnancy and short-birth spacing as determinants of stunting, the ReCos will work to create demand and to facilitate access to reproductive health and FP services. The ReCos will provide counseling and behavior change communication related to reproductive health and gender issues. They will also counsel pregnant women and mothers of children under-5 on FP and reproductive health. Finally, they will provide referrals to public and nonpublic FP providers to increase the utilization of modern FP methods. ReCos will be trained specifically on GBV from a rights-based approach in order to work with women and girls in a gender-sensitive manner.

4. The ReCo guidelines published in 2017 indicate that the local PRONANUT agents (*animateurs communautaires*), in partnership with local community organizations (CAC), should be responsible for the identification and supervision of the ReCo. However, recognizing the capacity constraints of PRONANUT, and of

[13] The health and the education Global Practices are currently implementing a geographical convergence approach to foster cross-sectoral collaboration by leveraging the comparative advantage of each sector (health, nutrition, and education) while delivering an integrated package of high-impact interventions focused on early childhood development (ECD; Education Quality Improvement Project (EQUIP)- P157922, the Additional Financing Grant for the Health System Strengthening Project for Better Maternal and Child Health Services (PDSS AF I- P157864), and a grant from the TF072402 - Early Learning Partnership Multi Donor Trust Fund. This joint initiative was designed to lead to the development of quality standards for ECD in health centers and community-based structures. By the end of Fiscal 2019, an integrated ECD model adapted to the DRC context of fragility will be available and expandable to various convergence points for safe childcare, early learning, play, and stimulation that prepares children for school. Lessons learned, including associated costs, will contribute to the development of an integrated model of early years' activities and coordination across sectors at both national and decentralized levels. The model is being jointly implemented by the Ministry of Primary and Secondary Education, the Ministry of Health, and the Ministry of Social Affairs, under the leadership of PRONANUT. The model and the institutional arrangements established will be used by different projects, including the DRC Child nutrition Project, aiming at providing young children, especially those living in rural areas, with an environment that is conducive to life-long learning as a foundation for human development.

the health system more broadly, the guidelines stipulate that over the next several years, the identification, training, and supervision of the ReCo should be done through NGOs. The PCT will conduct a prequalification exercise to identify a short list of eligible nonstate actors who may bid for this scope of work of identifying, training, and supervising ReCos and providing community-based FP services (described below). The PCT will then announce a competitive bidding process where applications from offerors will be first evaluated on the quality of the technical proposal, and then on a cost basis. The project PCT will contract with the successful NGOs. The contracts with the NGOs will be performance-based and the payments will depend, among other factors, on the numbers of ReCos recruited and trained, the numbers of supervision meetings convened, and the number of supportive supervision visits carried out.

5. Each ReCo will be assigned to a specific health facility and included in the HZ supervision structure. During the proposed project, supervision will be delivered jointly by the NGOs and the staff from the HZ. Once a month, the ReCos will meet with the supervision team (HZ, *animateur communautaire*, and NGO animator) to provide monthly reports, discuss the challenges they face and identify solutions. In addition, every month, the supervision team will travel to one *aire de santé* to provide supervision, coaching, and support to the ReCos who work there. The NGOs will be encouraged to propose innovative methods of supervision that are cost effective in the challenging field settings where the ReCos are deployed (for example, GIS tagging of home visits). The NGOs will develop skill-transfer plans; it is envisioned that in later phases of the SoP, the identification, training, and supervision responsibilities will be transferred to the appropriate health system agencies.

6. Academic literature and global experience of community health and nutrition programs shows that providing financial incentives increases the availability and the quality of services and improves community workers' retention. It also shows that providing financial incentives is feasible and sustainable even in low-resource settings (for example, Mali, Niger, and Madagascar). Initial discussions with the MoH indicate that they recognize this evidence base and are considering the best and most sustainable ways of providing financial motivation to ReCos. Therefore, the proposed project will be consistent with the national policies and practices to be set forth and will provide financial motivation to ReCos. The project will test incentives targeting the communities, more specifically the *Cellule d 'animation communautaire*, in a form of support for income generating activities. Those incentives will be provided through the contracted NGOs. Alternative modalities of providing incentives may also be considered and tested.

7. Activities financed by the project will include performance-based contracts with NGOs to conduct a number of activities, including: identifying and training of the ReCos; developing, testing and scaling-up of a system of output-based financial incentives for the ReCos; developing service standards, and an accountability framework for the ReCos; and providing necessary equipment. The NGOs will be supported by the appropriate state actors.

Subcomponent 1.2 Social and Behavioral Change (US$7.8 million from the GFF)

8. Social and behavior change will be a critical subcomponent of this project because it will underpin and support most of the main interventions. A comprehensive SBC strategy with broad consensus among a range of stakeholders, including the Government, key donors, development partners, and implementers, will be necessary to tackle intractable impediments to behavior change and to advance the multisectoral actions needed to improve stunting. It is envisioned that SBC will be utilized at every level of the system, including: national mass media campaigns; provincial and HZ campaigns with more local language messaging; facility- and school-based counseling; and IPC at the community and household levels.

9. The content, modalities, and specific messages of the SBC strategy will be informed through formative research on nutrition and FP that will be executed during the lead-up to the effective date of the project. The

formative research will seek to determine: (a) a limited set of key messages that should be promoted; (b) the potential to implement integrated SBC in view of the fact that the same target groups are implicated in the project for nutrition, FP, and SP; and (c) innovative modalities, technologies, and platforms to conduct SBC. This formative research will also provide the basis for the IPC materials for the ReCos in nutrition and FP. The formative research will be competitively bid-out using the PPA. During implementation, the SBC subcomponent of the project will host embedded implementation research to enable rapid identification of bottlenecks and roll-out impediments, as well as to accomplish quick wins that can be scaled-up. Above all, the SBC strategy is to be creative, targeted, and evidence-based in order to effect sustained behaviorial change across the population.

10. Because several partners are already promoting SBC in DRC on similar topics, coordination will be important to ensure complementarity and efficiencies of investments. Coordination may be accomplished through a government-convened steering committee on SBC, or through extensive consultation. The World Bank has engaged in discussions with USAID, which is making a large SBC effort through its Breakthrough Program which it will be implementing in some of the priority provinces.

11. The implementation arrangements for the SBC component of the project will be carried out through an agreement or a contract with an international SBC provider, or a consortium of providers, to bring innovative ideas and global expertise to bear on the challenge of sustainable behavior change. This provider will: test and design mass media campaigns; develop and execute a strategy of nurturing champions for nutrition and FP, including religious leaders; and develop messaging through IPC to be executed through a number of actors (school based, community-based ReCos, and facility based). It is envisaged that the contract(s) with the SBC nonstate actors will be managed by the PCT. The provider may have implementing partners who will cover each of the provinces, while also managing national level multimedia approaches.

Component 2. Improving Service Supply and Strategic Purchasing (US$247.0 million equivalent from IDA)

Subcomponent 2.1: Performance-based Financing of Health Services (US$185.0 million equivalent from IDA)

12. This subcomponent will focus on improving the supply (quantity and quality) of key nutrition-specific and nutrition-sensitive interventions delivered through health care facilities. It will finance the expansion of the existing performance -based financing scheme implemented under the PDSS project (P147555) to the proposed project regions. The scheme will provide health facilities with financial incentives in the form of discretionary spending based on the quantity and quality of their service output. The project will expand the current PBF program in terms of scale and scope. First, PBF will be implemented in the regions that are not currently covered by the PDSS program, in parallel and in coordination with activities under Component 1. Second, the PBF incentive scheme will emphasize key nutrition-specific and nutrition sensitive services. PBF incentives will target the following services for pregnant and lactating women, children 0-5 years, and adolescent girls: ANC (including iron/folic acid supplementation and IPTp); routine child health visits for children 0-59 months of age (consultations *prescolaire*); FP; assisted deliveries; immunization; management of acute malnutrition; and integrated management of child illnesses. In addition to providing financial incentives, the project will also finance key inputs and equipment. The project will finance the procurement of FP commodities for PDSS facilities in the target provinces to reduce the incidence of stockouts. Family planning services will also be strengthened by putting special emphasis on improving the quality of post-partum services for all women, and especially among adolescent girls, through the use of vignettes, and by the measurement of patient-reported quality of

counseling using interviews of FP clients.[14] In cholera endemic areas the project may also finance inputs for setting up cholera treatment points in primary health facilities. This subcomponent will complement the Health System Strengthening Project (P147555) and use its existing implementation arrangements.

13. Under the umbrella approach of strategic purchasing that is articulated in the PNDS 2019-2021, access to FP will be expanded through facility-based and community-based delivery platforms. The provision of FP in health facilities will be strengthened primarily through the expansion of the PDSS' PBF approach, with special emphasis on improving the quality of post-partum services for all women, and especially among adolescent girls and first-time mothers. Facility utilization rates for delivery are high (more than 80 percent), for both all women and for adolescents, providing an opportunity to counsel post-partum girls and women on FP choices, as well as to emphasize post-partum FP over the course of ANC visits. Moreover, the experience in the pilot project of introducing post-abortion care (PAC) in the Kinshasa PDSS facilities can be used to inform scale-up through this project, thereby further expanding FP uptake.

14. Quality of counseling will be improved through two primary means. First, vignettes to reinforce FP counseling skills will be used in the PBF facilities by the HZ supervisory team at the facility level as part of the quality scoring and pay-for-knowledge scheme. In addition, client-reported quality will be measured by administering a small set of FP consultation-related questions to respective clients through an existing community survey. These questions will cover four domains of quality related to respectful care, method selection, effective use of method selected, and continuity of use, which have been shown to influence continuation of uses of contraceptive methods.

15. The expansion of the PDSS will also ensure that all selected facilities will be supplied with a full range of FP commodities. The project will finance the procurement of these commodities for PDSS facilities in the target provinces to reduce the incidence of stockouts. While the emphasis will be on promoting long-acting reversible contraceptive (LARC) methods which tend to be more reliable, the facilities will maintain full choice of all methods for clients. The PDSS facilities will also ensure privacy and confidentiality for reproductive health and FP consultations. The project may test different methods to strengthen coverage and quality of post-partum FP provision within the PBF platform.

Subcomponent 2.2: Performance-based Contracts with Nonstate Providers of Family Planning (US$62.0 million equivalent from IDA):

16. Currently 34 percent of women using contraception receive services from public providers (DHS 2013-2014). During project preparation, supporting nonpublic providers of FP services (for example, NGOs) and strengthening of linkages between health facilities and nonpublic providers has been discussed with the MoH. Nonstate actors may provide services through mobile and static facilities and would be responsible for ensuring reliable procurement of the full range of quality contraceptive commodities. The nonstate actors would operate under performance-based contracts with the PCT. Depending on their capacity, it is expected that one nonstate actor would cover one province, unless it has been demonstrated that an actor has established coverage in more than one province.

[14] A 10-question measurement tool is being validated in a number of countries, including DRC, to be able to measure and track the quality of FP services as reported by the client. It is envisioned that his system can be piloted in this new project and factored into the quality payment calculation.

17. The NSAs will also be contracted to provide TA to PDSS facilities to improve the quality of FP services in ensuring sustainability of activities. Similar to how the international NGO Jhpiego is now supporting PDSS with the rollout of a low-dose, high frequency training approach, NSAs may be contracted to provide FP-specific support to facilities. Moreover, the NSAs can assist the DPS and HZ supervisory teams in strengthening capacity in FP monitoring. An effective referral system will be developed for ReCos to refer interested clients to the NSAs and public facilities.

Component 3: Convergence Demonstration Project (US$47.0 million equivalent from IDA)

18. This component is intended to demonstrate the added value of the multisectoral convergence to improve nutrition outcomes. To do this, in a subset of the HZs targeted by Components 1 and 2, the project will finance complementary activities in SP (targeted cash transfers), agriculture (biofortification and targeted distribution of household food production kits), and education (supplementation in schools). The actions selected for the pilot have shown effectiveness in improving nutrition outcomes and have been successfully implemented in DRC, albeit at through a small scale and short duration programs. Once the added value of the convergence approach is demonstrated, specific interventions (for example, cash transfers, biofortification, and so forth), could be expanded in a coordinated fashion through sector-specific World Bank investments and through broader initiatives and programs. For example, nutrition-sensitive cash transfers could be scaled up through future social safety-net programs, biofortification could be expanded through future agriculture investments, and so forth.

19. ***Targeted cash transfers for vulnerable children and pregnant and lactating women:*** The project will in the pilot project use the ReCos to connect vulnerable pregnant and lactating women and mothers of vulnerable children with social safety net services to improve access to adequate quantity and quality of foods. Targeted cash transfers are a strategy recommended in the most recent DRC SCD (2018) to improve social safety nets. While conducting the community census, the ReCos will identify vulnerable women and children and refer them to a targeted cash transfer program.

20. Each household will receive a basic transfer of US$15 per qualified child per month, the total amount of money to be paid to each child being US$360 over 24 months. It is presumed, however, that within a household that is of concern to the project, the likelihood of having a second child in need of assistance is very high. The basis for this assumption is that the average family size in the context is seven children per household. For this reason, the cash transfer subcomponent will target up to two children per household, making it a total amount of US$30 for each selected household and US$720 in total over 24 months.

21. Payments will be made on a quarterly basis for two years using accredited payment agencies. Given the five-year lifetime for the subcomponent, there will be two cohorts with 10,000 selected beneficiaries each, making the total number of beneficiaries 20,000 households. The first cohort will enter during the second year of the Project.

22. The identification and enrollment of beneficiaries will be a four-stage targeting approach, namely: (i) geographical targeting to select communities in a HZ; (ii) community-based targeting whereby a welfare assistance committee identifies all households that in their opinion could qualify for the cash transfer; (iii) a category-based approach where beneficiaries with some specifications are included (pregnant and breast-feeding women, malnourished children in their first 23 months); and (iv) a Proxy-Means Test-based poverty score. This fourth approach is critical because the households who score below the eligibility cut-off score are validated by the entire community with the objective of excluding those who are considered as not extremely poor or not being resident

of the HZs under consideration. In addition to the targeting approaches above, the registration process of beneficiaries will also be informed by the data from the HMIS, more specifically, from patient registers (such as the RMNCAH register [pregnant women register] and the Integrated Management of Childhood Illness (IMCI) [child health] register). The elaboration of the registry of beneficiaries will require expertise from the MoSA and the National Institute of Statistics. NGOs will be consulted when circumstances warrant this. The MoSA will manage the registry, follow-up on payments, and settle disputes that may arise.[15]

23. To implement the cash transfer component, the proposed project will use, to the extent possible, the institutional arrangements of the PIP. PIP includes a US$20 million cash transfer component targeting HZs with high levels of poverty, with a focus on similar target groups (pregnant women and children under 2 years of age). PIP will be implemented by a PIU under the MoSA, which in turn will be contracting with payment agencies.[16] The PCT of the proposed project (see below) could contract with the PIP PIU to deliver cash transfers. This arrangement would allow the project to capitalize on existing arrangements and ensure consistency with the overall World Bank SP strategy in DRC. At the same time, it would also help ensure that the cash transfers financed by the project would be coordinated with other project activities.[17]

24. The beneficiary targeting procedures and cash delivery mechanisms under PIP are still being finalized, and the proposed project will rely on those mechanisms to the greatest possible extent, while at the same time ensuring that the transfers are nutrition-sensitive (for example, participation in nutrition sessions carried out by the ReCo would be used as accompanying measures/soft conditionalities). It is envisioned that to deliver the transfers the PIP PIU will contract with a large national provider (for example, a large national NGO or a UN agency) who in turn will contract with accredited payment agencies at the local level. These may include money transfer companies, microfinance institutions, telephone companies, and/or NGOs. These local implementation agencies with experience in delivery of cash and in-kind transfers will deliver small, regular transfers to the beneficiaries to help stabilize consumption. A similar implementation modality is already used by other World Bank investments (for example, the Eastern Recovery Project) and other development partners. Cash will be distributed at regular intervals at health facilities to create incentives and an opportunity for the women and children who receive cash to at the same time use health services. The project will finance the transfers and cover the cost of identifying and hiring the national and local implementation agencies. If this nutrition-sensitive cash transfer pilot proves to be effective and scalable, it is envisioned that it could then be taken over and scaled-up by an existing World Bank SP project (for example, through additional financing) or it can be the basis of a new World Bank SP operation.

25. **Household food production kits for vulnerable children and pregnant and lactating women:** To restore the productive capacity of the households of vulnerable women and children and prevent their relapses into food insecurity and malnutrition, the demonstration project will complement the cash transfers with agriculture inputs and small livestock kits for households with food production capacity. The PCT will sign a TA agreement with FAO, which has a track record of delivering agricultural inputs and support in the country. To ensure the sectoral ownership and accountability, the contract with the FAO may be countersigned, if appropriate, by the appropriate representatives of the Ministry of Agriculture and the Ministry of Fisheries and Livestock. The Directorates of Studies and Planning within each Ministries will be responsible for the technical oversight of the activities implemented under the contract and the technical aspects of contract monitoring that falls within their purview.

[15] During the first year of the project, the emphasis will be put on developing the beneficiary register and the development of the delivery platform. The distribution of the cash will start in year three of the project.
[16] The beneficiary targeting mechanisms cash delivery modalities under PIP are still being finalized.
[17] Alternative arrangements using the Social Fund rather than the PIP PIU will also be explored during project preparation.

FAO will initially lead this activity, but through joint design of a pilot intervention and on-the-job training, it will gradually build the capacity of the government (Ministry of Agriculture, and Ministry of Fisheries and Livestock) to eventually take over the implementation of this activity.

26. Since 1998, FAO has been supporting farmers and vulnerable populations in DRC in the context of agricultural recovery and food security. By providing agricultural inputs, fisheries, and small livestock, FAO has helped boost agricultural production of more than 2 million households. The distribution of inputs in the form of kits (that include tools) is accompanied with technical training that is implemented in coordination with the sector ministries. A recent operation of this kind took place in North Katanga. In 2014, FAO, with its partners, distributed 12,000 tools (watering cans, hoes, machetes, and rakes); 130 kg of vegetable seeds such as amaranth, eggplant, okra and leeks; and approximately 3 million sweet-potato cuttings, as well as improved cassava strains. Some 3,000 households (1,648 women and 1,352 men) benefited from these inputs, including 2,545 internally displaced persons of the country, 455 families hosting refugees, and 24 groups for seed multiplication. The distribution of inputs went hand-in-hand with capacity building through the Farmer Field Schools, which also served as forums to address social issues.[18]

27. The project will first finance the production of the key inputs that will constitute the kits. For seeds and cuttings, FAO and the sector ministry will take the lead, at first in partnership with INERA, CAPSA (*Centre d'Adaptation et de Production des Semences Améliorées*) and agribusiness associations, and then in partnership with producers' organizations and WA in collaboration with SENASEM for seed certification and the production of basic and commercial seeds, respectively. At the community level, FAO will contract on a competitive basis with NGOs who along with SNV will take the lead in the distribution of kits to beneficiaries, and their training. For small livestock, FAO and the sector ministry, in collaboration with WAs, SNV, and NGOs, will establish small animal production/breeding units in villages that will serve as a source of inputs for local communities. Through targeting conducted jointly with the cash transfer activity, FAO, the sector ministries and NGOs will identify vulnerable women who will receive training to set up food production units at their homes. At the end of the training, women beneficiaries will receive a food production kit that will include items such as small animals (protein kits), nutrient-rich seeds and cuttings, and farming tools to replicate activities at home. In order to ensure availability of seeds and small animals, the project will train and work through women's associations and other existing community structures within the communities, hosting the production units in order to multiply the seeds and the small animals, as well as to build the capacity of SNVs to support this production. An assessment study will be conducted to determine the actual composition of kits, including whether fisheries can be part of them.

28. As with the cash transfer pilot, if the household food production kit pilot proves to be effective and scalable, it could then be taken over and scaled-up by existing or planned World Bank SP projects (for example, productive safety nets) or agriculture projects.

29. **Biofortification:** To improve micronutrient status of women and young children, the demonstration project will also finance the scale-up of locally-developed biofortified varieties of key crops, including vitamin A maize and cassava, and iron-rich beans. Since 2011, SENASEM, and INERA, with the help of HarvestPlus, the IITA, and CIAT, have been adaptively breeding and testing biofortified varieties of vitamin A cassava and maize and high iron beans, which also have higher levels of zinc. Over the past decade, HarvestPlus has also helped build the capacity of INERA, as well as breeders in public universities, to adaptively breed biofortified crop varieties achieving both agronomic and nutrition traits (breeder seeds). Given that the consumption of tubers account for

[18] *http://www.fao.org/documents/card/en/c/2c71f3c1-639b-4fc0-8022-15efb378e67a/*

over 40 percent of the total calories consumed by rural households, (Adoho et al. 2018) popularization of biofortified cassava and orange-flesh sweet potatoes in particular has the potential to substantially reduce vitamin A, iron, and zinc deficiencies and to improve related health and nutrition outcomes, including diarrhea incidence and stunting.

30. The expansion of biofortification will be implemented through a contract between the PCT and HarvestPlus to support INERA and SENASEM and CAPSA that falls under the Ministry of Agriculture. To ensure the sectoral ownership and accountability, the contract will be with HarvestPlus, may be countersigned, if appropriate, by the appropriate representative of the Ministry of Agriculture. The Directorate of Studies and Planning with support from other technical units within the Ministry, as appropriate, will be responsible for the technical oversight of the activities implemented under the contract, and the technical aspects of contract monitoring.

31. To a very limited extent, biofortified varieties of cassava and beans have been introduced in Kwilu, and biofortified beans, maize, and orange fleshed sweet potatoes have been introduced in Sud Kivu. The demonstration project will aim at expanding this activity in the pilot heath zones to replace the currently grown varieties of popular crops, including maize, beans, and cassava with biofortified ones. Specifically, HarvestPlus and INERA, backstopped by the Consultative Group for International Research on Agriculture (CGIAR) centers responsible for initial biofortified crop variety development, will select a number of suitable varieties of each biofortified crop, and then contracted multiplication partners will multiply them (seed replication stage). HarvestPlus will then work with SENASEM to certify the multiplied varieties that can be planted in project areas. Once sufficient quantities of biofortified planting materials (seeds and cuttings) are available for the project areas, HarvestPlus will work with the Ministry of Agriculture and SNV to identify and contract local partners, including NGOs, farmer associations, and cooperatives working in the target areas, to grow the biofortified crops. Once sufficient quality seeds and vines are available, HarvestPlus will train the Ministry, SNV, and partners to manage the dissemination of biofortified crops to farmers. Dissemination can happen in different ways, such as through establishing demonstration plots, building farmer capacity through farmer field schools and training days, and/or using the NAC. HarvestPlus and its partners also use Participatory Varietal Selection (PVS) by farmers, enabling farmers to pick the varieties most suitable for their own needs, and techniques like “pay it forward” whereby farmers who receive biofortified varieties are expected to give some of their production to other farmers in the following season. Some or all of these will be used in the project depending on local conditions.

32. The project will make a special effort to reach women farmers, who often have less mobility and availability for farmer training days due to their multiple roles. Gender bias training will be included by HarvestPlus in the training and capacity building of Ministry of Agriculture and partner extension agents, including recognition of the multiple roles of women that may condition how extension services are delivered to them. Recognizing that cassava and beans are primary crops for women, dissemination may be done in conjunction with the new community nutrition platforms once these are established. This method has been successfully used in Uganda using nutrition meetings at community health centers to disseminate orange flesh sweet potatoes. HarvestPlus will provide messaging in conjunction with PRONANUT for the training of the ReCos in demonstration pilot areas concerning the nutritional advantages of the biofortified varieties, as well as ways to incorporate these varieties in local diets, including recipe development and basic processing.

33. HarvestPlus will also provide targeted TA to SENASEM, INERA, CAPSA, and the SNV. The project will support study tours and training (for example, showing how other countries are building seed systems), as well as

lessons from the private sector. The TA will also focus on best practices for aflatoxin control for maize, including engagement with Partnership for Aflatoxin Control in Africa at the AU.

34. **Iron and folic acid supplementation for adolescent girls:** In addition to targeting adolescent girls through community-based services, the education system can be used as a platform to reach these girls. This subcomponent will pilot interventions aimed at improving girls' nutritional status through interventions to reduce anemia prevalence. Under this subcomponent, the project will pilot deworming for school-aged children, intermittent micronutrient supplementation for adolescent girls, and capacity strengthening for teachers to deliver these interventions with the support of the ReCos. The activity will be supported by performance-based contracts with NGOs. In the areas where the demonstration project will be implemented, the NGOs that have been contracted to identify and monitor the ReCos and support their supervision (see Component 1) will also provide the training for the teachers, procure and deliver commodities, and monitor the distribution. The project will finance the inputs (vitamin A, multiple micronutrients, and albendazole/mebendazole for deworming), as well as training for teachers.

Component 4. Capacity Strengthening and Project Management (US$30.2 million equivalent; US$28.0 million from IDA; US$2.2 million from GFF)

35. This component will serve two objectives: (i) to build the capacity at the central, regional, and local levels to ensure sustainable strengthening of country systems and to ensure that activities financed under Components 1, 2, and 3 are implemented successfully; and (ii) to provide the Government and the World Bank with evidence-based analysis on various aspects of service delivery in the nutrition sector which can lead to sound recommendations for improvement.

Subcomponent 4.1 Capacity Strengthening (US$16.7million equivalent from IDA)

36. Under this subcomponent, the project will finance capacity strengthening of PRONANUT and other relevant programs within the MoH and other relevant line ministries to effectively plan, manage, and monitor programs. Capacity strengthening will include investments in basic equipment, information technology infrastructure, consultants, skills training, coaching, and supervision. The project will finance a contract with one or more entities (for example, a UN agency or a large international NGO) who will provide TA and deliver training, coaching, and supervision for national staff and develop time-bound skill-transfer plans. The TA will include strengthening of the government's core public sector management systems for human resource management, logistics and supply chain management, FM, procurement, and integrity arrangements at different levels of the nutrition service delivery chain, in addition to project-specific fiduciary oversight. This component will also cover the cost of strengthening the monitoring capacity of the subnational and national institutions involved in the management and implementation of nutrition activities.

37. The project will also contribute to the implementation of the MoH's strategy for the reform of the health information system. This will involve reinforcing data collection and reporting, piloting innovative data collection and reporting methods (for example, using mobile technology for data collection and reporting at the community and heath facility level) and expanding analytic capacity within national M&E units in the relevant ministries. Capacity building will emphasize regular and rigorous monitoring of the implementation of the current project to allow for timely detection of implementation bottlenecks and appropriate course corrections. The project will explore options for community-based monitoring and collecting feedback from beneficiaries on access and quality of services, which can feed into the community-level information system.

38. The project will also use PBF schemes at the provincial level to provide discretionary financing in exchange for achieving certain performance metrics. It will expand the Single Contract, which provides incentives to the DPS with respect to their execution of certain agreed elements of their quarterly work plans. The incentives will focus on the joint planning and review of maternal and child health and nutrition activities, (for example, payments made against the joint annual nutrition reviews led by the DPS). The contracts will be signed between the DPS and the provincial health inspectorates and PCT. Their execution will be monitored and verified by the EUP.

Subcomponent 4.2 Disruptive Technologies, Innovation, and Learning (US$8.4 million: US$6.2 million equivalent from IDA; US$2.2 million from the GFF)

39. Under this subcomponent the project will finance a robust learning and innovation agenda. First, the program will include rigorous implementation research related to the demonstration project. This will determine whether multisectoral convergence is effective and scalable, and, if so, what delivery modalities should be used in the subsequent projects in the SoP and in other WBG investments and projects that will take those pilots to scale. Second, the project will finance learning related to the use of technology-based innovations to improve service delivery. Those innovations will include machine learning (for example, risk-based verification to reduce the cost of PBF[19]), novel methods for child anthropometry, electronic job-aids for facility-based and community-based providers, and other types of innovations. The key elements of the learning agenda, as well as key partners to support it, will be identified during project preparation. The emphasis will be put on learning by doing, on scaling-up the pilot projects and innovations identified as effective and cost-effective, on in-time course-correction, and on building domestic research capacity in DRC.

40. Third, the project will support a series of studies which will improve the collective understanding of the key challenges in the nutrition sector and will contribute to informing policy dialogue and future interventions. The first study will focus on analyzing the institutional and governance obstacles to improved delivery of nutrition services in DRC, given that weak governance is identified as one of the three systemic bottlenecks to reducing the burden of stunting. The second study will focus on assessing the specific capacity-building needs of the key actors at central, regional, and local levels. This will ensure that the capacity-strengthening activities are well targeted and designed according to the needs of the different beneficiaries, taking into account the context of each participating province. Findings from the analysis of institutional and governance obstacles to improved delivery of nutrition services in DRC will also inform the design of functional reviews of key institutions with a view to optimizing their mandates, organizational structure, human resources, and performance management for improved service delivery. The fourth piece of analysis will be a public expenditure review of the nutrition sector with the goal of identifying and addressing potential fiscal, allocative, and operational inefficiencies. The study will analyze the following aspects: (a) overall fiscal planning, budget allocation, budget execution, and comparative analysis between authorized budget provision, funded budget, and budget execution; (b) comparative analysis between allocated budget, its expenditure, and health outcomes/performance by program and geographic location; (c) budget allocation and expenditure by economic classification, including the level of detailed recurrent expenditure, in particular the wage bill, and capital expenditure with a comparative analysis with other countries; and (d) financial flows and their management at the central, regional, and local levels, including involvement of local structures.

[19] Periodic verification of the reports submitted by health facilities accounts for a substantial proportion of the overall cost of RBF. Risk-based verification is a process in which a computer algorithm is used to analyze the data submitted by health facilities and identify those where the risk of irregularities is the highest. Intensive verification is then focused on those facilities while less frequent verification is used for all other facilities.

Subcomponent 4.3 Project Management (US$5.1 million equivalent from IDA)

41. This component will finance the costs associated with the day-to-day project management, including the costs of running the Project Implementation Unit.

Component 5: Contingent Emergency Response Component (CERC) – (US$0.00)

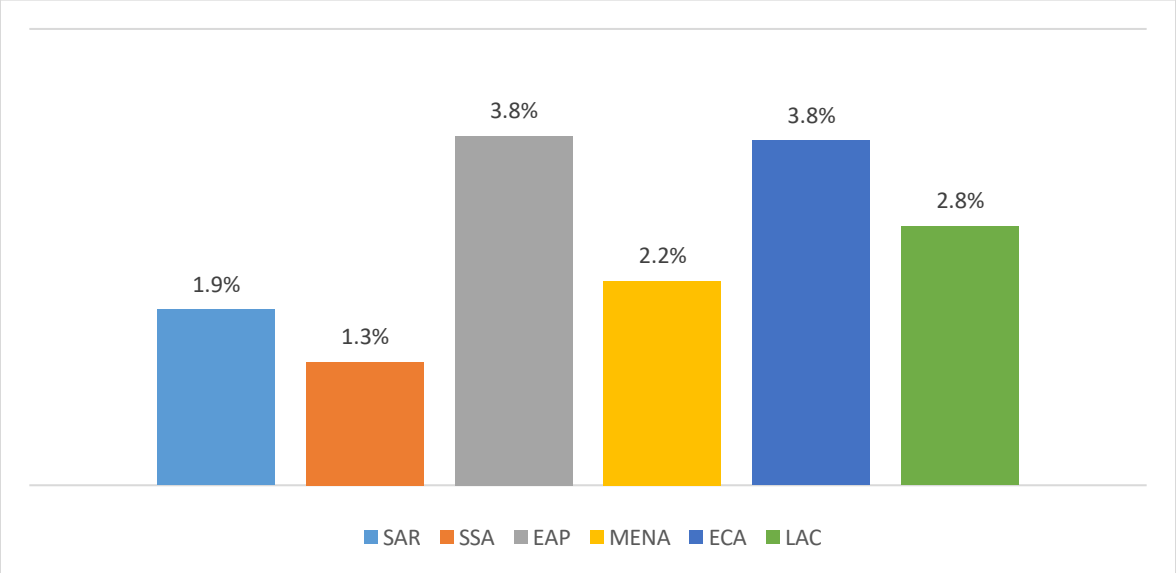
42. A no-cost CERC will be included under the proposed project in accordance with World Bank Policy IPF: paragraphs 12 and 13, for projects in Situations of Urgent Need of Assistance or Capacity Constraints. This will allow for rapid reallocation of project proceeds in the event of a natural or man-made disaster or crisis that has caused, or is likely to imminently cause, a major adverse economic and/or social impact.

ANNEX 3: Economic and Financial Analysis

1. Although intrinsic development objectives in their own right, nutrition outcomes are also instrumental in stimulating economic growth. Poor nutrition in early childhood can result in decreased cognitive ability, lower educational attainment, lost earnings, and losses to national economic productivity. The most damaging effect of malnutrition occurs during pregnancy and in the first two years of life, and the effects of this early damage on health, brain development, intelligence, ability to learn, and productivity are largely irreversible. Improving child health and nutrition, especially in the first 1,000 days, is critical for addressing the WBG's twin goals of reducing poverty and boosting shared prosperity. At the individual level, chronic malnutrition in children is estimated to reduce a person's potential lifetime earnings by at least 10 percent. Studies have shown that a 1 percent loss in adult height results in a 2 to 2.4 percent loss in productivity. The economic costs of undernutrition have the greatest effect on the most vulnerable in the developing world. A recent analysis estimates these losses to be 4 to 11 percent of GDP in Africa and Asia each year, which is equivalent to about US$149 billion of productivity losses each year. Most of those losses are due to cognitive deficits. As developing countries move from manual labor-based economies to economies that are based on skilled labor requiring high mental capacity, the impact of child malnutrition and stunting on incomes and economies will likely increase further.

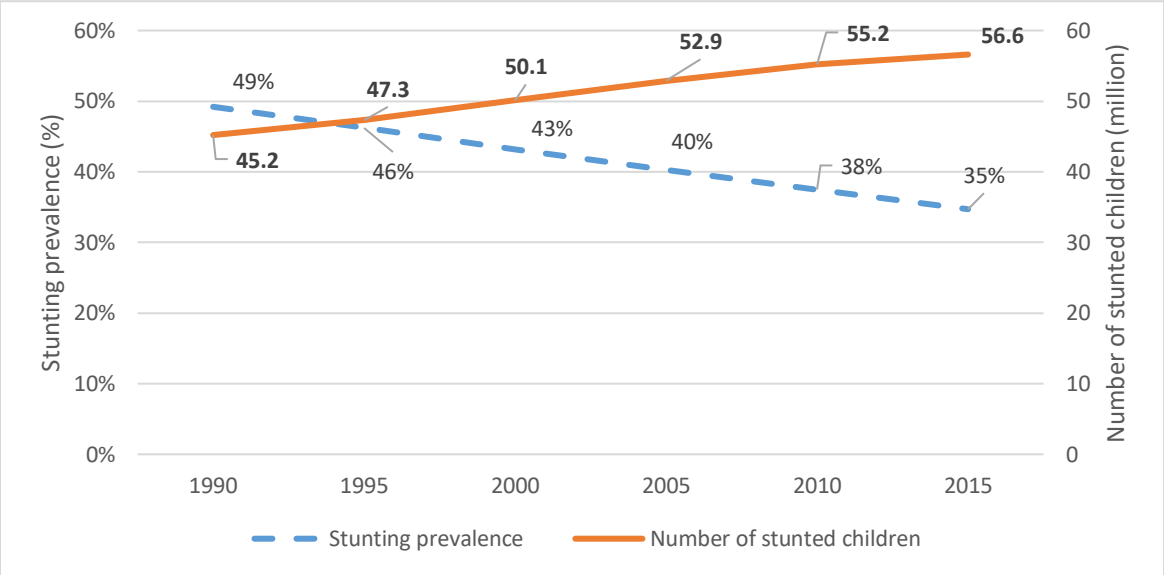
2. Since 1995, progress in reducing chronic malnutrition and its principal manifestation, stunting, has been slower in Africa than in other regions. Over the past two decades, among all World Bank regions, the Africa region has seen the lowest average annual decline in stunting prevalence (see Figure A3.1).

Figure A3.1: Average Annual Rate of Reduction in Stunting Prevalence between 1990 and 2015, by World Bank Region



3. Consequently, although both the Europe and Central Asia regions and the East Asia and the Pacific regions have managed to reduce stunting prevalence by almost two-thirds, Africa achieved a reduction of only one-quarter during the same period. Furthermore, because of high fertility and population growth, the number of stunted children on the continent within that time frame actually increased by about 12 million (see Figure A3.2).

Figure A3.2: Stunting Prevalence and the Number of Stunted Children in Sub-Saharan Africa, 1990-2015



4. Household data consistently shows that although stunting prevalence tends to be higher in lower-income quintiles, it is very high even among the richest households, often exceeding 20 percent. Recent analyses show that the association between economic growth and reduction in stunting prevalence is weaker in Africa, where a 1 percent increase in per capita gross national income (GNI) is associated with a 0.2 percent reduction in stunting prevalence, than it is in other regions, where the same increase in GNI is associated with a 0.6 percent decrease in the prevalence of stunting (Eozenou, Mehta, and Kakietek 2017). In fact, based on these estimates, economic growth in Africa over the next decade would not be enough to offset the impact of rapid population growth, and despite increasing the purchasing power of households, the absolute number of stunted children on the continent would continue to rise (see Figure A3.2).

5. The weak elasticity of stunting prevalence with respect to income is likely due to the ubiquity of risk factors, such as high fertility, food insecurity, lack of access to clean water and improved sanitation, the low socioeconomic status of women, and political instability, among others, all of which attenuate the impact of higher incomes. At the same time, some countries with relatively low levels of income, such as Senegal, have been able to achieve dramatic reductions in stunting prevalence, while relatively rich countries, such as Nigeria, have seen only small declines. In sum, the evidence from within-country and cross-country analyses demonstrates that economic growth alone will not be sufficient to substantially reduce stunting in African countries, and that direct action and specific interventions are needed.

6. In DRC, the prevalence of stunting remains alarmingly high. According to the most recent data, about 42.6 percent or about 5.6 million children under the age of 5 are stunted (DRC DHS 2014). In fact, DRC has the third largest population of stunted children in Sub-Saharan Africa (after Nigeria and Ethiopia). While the prevalence of stunting has been declining on the African continent over past decades, in the DRC it has remained stagnant (44.4 percent in 2001, 45.8 percent in 2007, 43.5 percent in 2010, and 42.6 percent in 2013), with an annual average decline rate of 0.15 percentage points. Moreover, due to high fertility and population growth, the number of stunted children in DRC in 2014 was about 45 percent (1.7 million) higher than in 1995.

7. Stunting presents a challenge in virtually all regions of the country. In 21 out of 26 provinces of DRC, stunting prevalence exceeds 40 percent -- the World Health Organization's "very high public health significance" threshold. In Nord-Kivu, Sud-Kivu, Tanganyika, Lomami, Sankuru, and Kasai, more than half of all children under the age of 5 are stunted.[20]

8. Cross-country comparisons show that chronic malnutrition is affecting DRC more than other countries with similar income levels. Only three low-income counties have stunting prevalence higher than that in DRC - Burundi, Madagascar, and Mozambique (see in the main text Figure 3, Panel 1). In a number of countries with very similar per capita GDP, stunting prevalence is substantially lower (Central African Republic, Malawi, Liberia, Sierra Leone, and Uganda,). The pace of stunting reduction is slower in DRC than what could be expected based on its income level. In virtually all low-income countries, stunting prevalence has been declining faster than in the DRC (see in the main text Figure 3, Panel 2). This includes other FCV countries such as Somalia, the Central African Republic, and Afghanistan. The comparisons with other low-income countries presented above suggests that substantial reductions in stunting prevalence in DRC can be achieved if chronic malnutrition is prioritized at the policy and programmatic level.

9. Interventions aimed at improving nutrition have been identified as some of the most cost-effective development actions. According to the global investment framework for RMNCH, one dollar invested in the essential package of maternal and child health interventions is estimated to yield about nine dollars in economic benefits. This benefit-to-cost ratio is even higher for evidence-based high-impact nutrition interventions that target stunting and micronutrient deficiencies.

Economic Impact of the Project:

10. The proposed project is intended to improve both underlying determinants and direct causes of malnutrition. In the short term, it can lead to improvements in nutrition status and physical and cognitive development in children who benefit from it. In the long term, it can lead to increases in productivity when children grow up, higher wages and incomes for individuals and households, and faster economic growth at the national level.

Methods:

11. This analysis uses standard methods to estimate the economic benefits that can be generated by the proposed project to assess whether the investment is justified on economic grounds. To this end, the impact of the intervention financed through the project on health and nutrition status of women and children is estimated. This impact is then translated into economic benefits based as net present value. Finally, the project costs are compared to the benefits, and the internal rate of return and benefit cost ratio are calculated. This section presents the methods used to conduct the analysis.

[20] In addition to stunting, the prevalence of other dimensions of malnutrition remains alarmingly high. Nearly 8 percent of all children under the age of 5 suffer from acute malnutrition (DHS 2013) and 60 percent suffer from anemia. The prevalence of anemia is higher (76 percent) in younger children (6-8 months of age), which suggests inadequate accumulation of iron before birth. This is related to the high prevalence of anemia among women of reproductive age and pregnant women which reaches 38 percent and 43 percent, respectively (DHS 2013).

12. The impact of the project in terms of the number of lives saved, the number of cases of childhood stunting averted, and the number of anemia cases in pregnant women prevented were calculated using the Lives Saved Tool (LiST). This tool translates changes in the coverage of interventions into estimates of morbidity and mortality reduction and changes in the prevalence of stunting and anemia. LiST was used to model the impact of expanding the coverage of the following nutrition-specific interventions provided through the health system or through the community-based NAC platform: promotion of good infant and young child nutrition, including breastfeeding and complementary feeding; iron and folic acid supplementation for pregnant women; vitamin A supplementation for children 6-59 months of age; zinc supplementation for the treatment of diarrhea; management of moderate acute malnutrition; treatment of severe acute malnutrition; and provision of complementary foods (or cash to buy food) for children 6-24 months of age living in food insecurity. Finally, the model was also used to model the impact of expanding the coverage of ANC.

13. Economic benefits were calculated based on the health and nutrition impact estimates. In the base-case scenario, one life saved at age 5 was valuated as one times GDP per capita. One case of stunting averted was valuated at 21 percent of GDP per capita based on estimates of the impact of childhood stunting on adult wages (Hoddinott et al. 2013) and further adjusted to account for the proportion of income from wages and valuated at 52 percent (based on Lubker 2007). One case of anemia prevented was valuated as 5 percent of per capita GDP for women who engaged in light physical labor, 17 percent for women engaged in heavy physical labor, and 4 percent for women engaged in nonphysical labor. In the base case scenario, it was assumed that 1 percent of women engaged in light physical labor, 60 percent engaged in heavy physical labor, and 30 percent engaged in nonphysical labor. The following equation summarizes the approach to the valuation of health outcomes and calculation of monetary benefits:

$$B = LS*(1-P)*GDPpc+LS*P * GDPpc*(1-S)*L + CS * GDPpc * S * L + IS * GDPpc * ALi*Li*l + GDPpc*AH*H*L + GDPpc*AO*O*L$$

where:

B = monetary benefits
LS = unique lives saved
CS = unique cases of stunting prevented
IS = additional children who benefited from salt iodization
P = prevalence of stunting
GDPpc = GDP per capita
S = percent of wage income gained as a result of the child not being stunted
ALi = percent of wage income gained as a result of anemia prevented in women engaged in light physical labor
Li=percent of women engaged in light physical labor
AH = percent of wage income gained as a result of anemia prevented in women engaged in heavy physical labor
H=percent of women engaged in heavy physical labor
AO = percent of wage income gained as a result of anemia prevented in women engaged in other (nonphysical) labor
O=percent of women engaged in other (nonphysical) labor
L = proportion of income from labor

14. The benefits were calculated over the lifetime of children benefitting from the interventions, because once accrued, the developmental and cognitive benefits resulting from good nutrition persist for life. Conservatively, it was assumed that the children would start earning wages at the age of 18 and earn until the age of 59.6 (the life expectancy at birth in DRC). For pregnant women, the benefits were calculated only during the implementation of the project, because if iron/folic acid supplementation is stopped, women can again develop anemia.

15. LiST is a cohort model that produces annual estimates of prevalence and mortality in a cohort of children 0–59 months of age. Over five years, the same child would contribute to stunting prevalence and mortality averted five times as he or she ages through the cohort (once at 0–11 months, then again at 12–23 months, and so forth). Consequently, the same child could be saved from being stunted or from dying multiple times during that time period (for example, a child could be at risk of dying from diarrhea at age 1, then again at age 2, then again at age 3, and so forth).

16. To avoid counting and assigning a monetary value multiple times to stunting or mortality averted in the same child, based on the LiST output, estimates were made of unique lives saved and unique cases of stunting averted. More specifically, every year, the number of cases of stunting averted and lives saved in children 48–59 months old who would be aging out of the LiST cohort in that year were estimated. Consistent with the extant literature, it was assumed that after children reach 5 years of age, their stunting status is irreversible and that children who are not stunted at age 5 would remain not stunted and vice versa.

17. Net present value was calculated using the following formula:

$$NPV = \sum_{t=0}^{n} \frac{(Benefits - Costs)_t}{(1+r)^t}$$

where:

r = discount rate
t = year
n = analytic horizon (in years)

Beneficiaries:

18. The project will cover 103 HZs in four priority provinces: Kwilu, Kassai, Kassai Central, and Sud Kivu. In total, it is projected that about 1.5 million pregnant women and 2.5 million children 0-23 months of age will benefit from the project over the five years. Table A3.1 presents the projected number of beneficiaries covered by the package of community maternal and child services each year. This projection is done under the conservative assumption that during the first year, the project will focus mostly on preparatory activities, policy development, and capacity strengthening and that the service scale-up in that year will be very limited. The projections presented here likely underestimate the number of beneficiaries reached.

Table A3.1: Projected Number of Pregnant Women and Children 0-23 Months of Age Benefiting from the Package of Community Nutrition Services by Year

Beneficiaries	Year 1	Year 2	Year 3	Year 4	Year 5
Children 0-23mo	0	282,900	565,800	848,800	848,800
Pregnant women	0	170,300	340,600	510,900	510,900

23. The demonstration pilot implemented under Component 3 would cover two HZs. The HZs were identified based on proximity to INERA centers/stations that will provide base inputs for household food production inputs and biofortified crops. Overall, about 36,000 households will receive agriculture input kits, and within this group, about 20,000 pregnant women and mothers of malnourished children 0-23 months of age will receive targeted cash transfers. Finally, about 100,000 famers will be producing biofortified crops by the end of the project.

Results:

24. Impact modelling using LiST, along with additional estimates of the impact of improvements in food availability and diversity, showed that, over five years, the project investment would prevent over 35,000 malnutrition-related deaths in children under the age of 5, and over 192,000 cases of anemia in pregnant women (Table A3.2). Finally, over the life of the project, over 226,000 children in the target regions would reach the age of 3 stunting-free with optimal physical and cognitive development.

Table A3.2: Projected Impact of the Project

Impact indicators:	2020	2021	2022	2023	2024
Deaths prevented	3,138	5,065	8,847	9,190	9,434
Cases of stunting prevented	10,612	28,408	52,382	66,734	68,046
Cases of anemia prevented	17,224	29,114	47,488	48,579	49,682

25. The impact of the project on the health and nutrition status of women and children would translate into substantial economic benefits. The base-case scenario assumed a 3 percent discount rate of costs and benefits. It also assumes a 4.00 percent annual GDP growth rate – the average annual growth rate for the past 20 years (WDI 2018). Finally, it was also assumed that about 75 percent of income in DRC comes from labor and is, therefore, directly responsive to changes in productivity resulting from improved cognitive development, nutrition, and health status.

26. Under this set of assumptions, the project investment of US$502 million would generate economic benefits with a net present value of US$1.6 billion and an internal rate of return of 7 percent. The investment would have a very attractive 4.3 benefit-cost ratio, indicating that each dollar invested has the potential of generating more than four dollars in economic benefits over the productive lives of women and children who will benefit from the project. The analysis confirms the findings of the large body of literature regarding substantial economic benefits resulting from investments in child health, nutrition, and early development, and suggest that the project will have a positive economic impact for beneficiaries and the country's economy.

27. The values of the key parameters were varied in sensitivity analysis. Table A3.3 (below) presents the benefit-cost ratio, the net present value of economic benefits, and the internal rate of return under different sets

of assumptions. Overall, the sensitivity analysis demonstrated that varying the values of key parameters does not alter the overall conclusion. Even under a high discount rate (5 percent), and a lower percentage of income coming from labor (52 percent), the net present value of the economic benefits is substantial, with benefit-cost ratios exceeding 1 (1.4 and 3.5, respectively).

Table A3.3: Sensitivity Analysis

Assumptions:	**Benefit-cost ratio**	**Net benefits (US$ billion)**
Discount rate		
0%	18.6	US$7.5
3%	4.3	US$1.6
5%	1.4	US$0.4
GDP growth		
10-year average (2006-2016) 4.00%)	4.3	US$1.6
5-year average (2011-2016) (6.12%)	10.4	US$3.9
% of income from labor		
% of income from labor (52%)	3.5	US$1.3
% of income from labor (75%)	4.3	US$1.6

ANNEX 4: Procurement

Applicable Procurement Regulations

1. Project procurement activities will be carried out in accordance with the World Bank's procedures specified in the World Bank Procurement Regulations for IPF Borrowers: Procurement in IPF Goods, Works, Non-Consulting and Consulting Services dated July 2016 and revised November 2017 and August 2018, and any other provisions stipulated in the Legal Agreement. In addition, the implementation of procurement will be in accordance with the "Guidelines on preventing and combating Fraud and Corruption" stipulated in section 2.2a of Annex IV of the Procurement Regulations.

2. All goods, works and non-consulting services will be procured in accordance with the requirements set forth in or referred to in Section VI - Approved Selection Methods: Goods, Works, and Non-Consulting Services of the Procurement Regulations. The consulting services will be procured in accordance with the requirements set forth or referred to in Section VII. - Approved Selection Methods: Consulting Services of the Procurement Regulations, the PPSD, and the Procurement Plan approved by the World Bank.

3. A PPSD has been prepared with World Bank support and aims to ensure that procurement activities are packaged and prepared in such a way that they expedite implementation considering both (i) the market analysis and the related procurement trends; and (ii) the procurement risk analysis. The PPSD provides the basis and justification for procurement decisions, including the recommended procurement approaches for the project that have been reflected in the approved Procurement Plan covering the first 18 months of the project implementation. Table A4.1 below summarizes the various procurement methods to be used for the main activities financed by the proposed IDA Credit.

Table A4.1: Procurement Methods

Type of Procurement	Selection Methods
Goods	Request for Proposals, Request for Bids, Request for Quotations, and Direct Selection
Works	Request for Proposals, Request for Bids, Request for Quotations, and Direct Selection
Non-consulting Services	Request for Proposals, Request for Bids, Request for Quotations, and Direct Selection
Consulting Services	Quality Cost Based Selection, Fixed Budget Based Selection, Least Cost Based Selection, Quality Based Selection, Consultant's Qualification Based Selection, Direct Selection, and Selection of Individual Consultants.

Procurement Plan

4. The Procurement Plan, including its updates, shall include for each contract: (a) a brief description of the activities/contracts; (b) the selection methods to be applied; (c) the cost estimates; (d) the time schedules; (e) the World Bank's review requirements; and (f) any other relevant procurement information. The Procurement Plan covering the first 18 months of the project implementation was prepared and approved, together with the PPSD, during the negotiations of the proposed project. Any updates of the Procurement Plan shall be submitted for World Bank approval. The Recipient shall use the World Bank's online procurement planning and tracking tools (STEP) to prepare, clear, and update the procurement plans and manage all procurement transactions and related

documentation.

Institutional arrangements for procurement.

5. The PCT established under the MoH for the implementation of the PDSS will be responsible for ensuring that the fiduciary aspects of the project are managed appropriately. The procurement unit within the PCT will be staffed with well-qualified and experienced staff who will be fully responsible for carrying out all the procurement activities of the project. All staff will be recruited on a competitive basis.

Assessment of the Ministry's capacity to implement procurement.

6. A procurement capacity assessment of PCT, was conducted. It noted that the PCT has extensive experience with the World Bank procurement guidelines and that the coordination of the project will need to be fully reinforced by the new staff who will be recruited to implement the project.

Guiding principles of the implementation of procurement.

7. The Government has decided to mainstream the implementation of the project into the existing entities and structures and that it will be framed by the following principles: (a) line ministry to be made more responsible and accountable in project implementation with a focus on strengthening country systems; (b) equity; and (c) performance-based agreements which make providers accountable for delivering specific results. All the procurement activities of the project will be carried out by the procurement unit within the PCT to be set up and staffed with at least two qualified and experienced staffs.

Procurement risk assessment.

8. Given the (a) country context and associated risk; (b) low procurement capacity in implementing under NPF; and (c) the fact that this project will be implemented under the World Bank's New Procurement Framework, the procurement risk is rated **High**.

9. The prevailing risk can be improved to Substantial if the corrective measures identified in Table A4.2 below are implemented.

Table A4.2: Procurement Action Plan Corrective Measures

Ref	Tasks	Responsibility	Due Date
1	Recruit a well-qualified and experienced staff for the procurement unit within the PCT.	PDSS	Three months after effectiveness
2	Train all the procurement staff on the World Bank's New Procurement Framework (online courses and face-to-face courses) and on the use of Systematic Tracking of Exchanges in Procurement (STEP) tools, which will be used to manage all procurement transactions and related documentation.	PCT Word Bank	Three months after effectiveness
3	Update the project implementation manual of PDSS including the new project implementation that will describe procurement procedures and arrangements for the project	PCT	By effectiveness

	along with the standard and sample documents to be used.		
4	Organize a launch workshop involving all stakeholders.	PCT	Three months after effectiveness
5	Develop a contract management system to ensure that all contracts under the project are effectively and efficiently managed.	PCT	Continuously

Procurement Reviews and Thresholds

Table A4.3: Thresholds for Procurement of Goods and Works and Nonconsulting Services Based on Risk

	Procurement Type	Prior Review Threshold (US$)	Comments
1	Goods	Above 1,500,000	All
2	Nonconsultant Services	Above 1,500,000	All
3	Works	Above 5,000,000	All
4	Consulting Services firm	Above 500,000	All
5	Individual Consultant	Above 200,000	All

Frequency of Procurement Supervision

10. In addition to the prior review to be carried out by the World Bank, at least two implementation support missions will be carried out annually, including field visits to be carried out for post-review of procurement actions. As agreed with the Government, contracts will be published on the Web through STEP. Annual compliance verification monitoring will also be carried out by an independent consultant and will aim to: (a) verify that the procurement and contracting procedures and processes followed for the project were in accordance with the Financing Agreement; (b) verify technical compliance, physical completion, and price competitiveness of each contract in the selected representative sample; (c) review and comment on contract administration and management issues as dealt with by the PCT; (d) review the capacity of the PCT in handling procurement efficiently; and (e) identify improvements in the procurement process in light of any identified deficiencies.

Summary of PPSD to Support the Preparation of the PAD

11 Key risks within the procurement process have been identified and corresponding mitigations are proposed (see the Risks section above and the Risks section of the PPDS). The project implementation manual will be updated to ensure that the proposed mitigation measures are reflected. Procurement arrangements for high- or substantial-risk contracts within the project in Table A4.4 below.

Table A4.4: Procurement Arrangements for High or Substantial Risk Contracts

Contract Name, Description and Category	Estimated cost in US $	Bank Review	Approche de Passation des Marchés/ Concurrence, Appel d'Offres : • National • International • Open • Limited • Direct Selection Single source • QCBS, QBS, etc. • Negotiations • BAFO	Evaluation Method • Noted criteria (VfM) • Lowest evaluated cost
Recruitment of International NGOs in charge of Implementation of the NAC approach	150,000,000	Prior	International Open/QBS	Criteria noted Publication of ROI
Recruitment of International NGOs in charge of support of FP	52,000,000	Prior	International Open/QBS	Criteria noted Publication of ROI
Selection of a money transfer company for allocations	20,000,000	Prior	Single source with SOFICOM	Not applicable, but cost negotiation
Contract with a specialized organization in agriculture	14,000000	Prior	Single source with FAO	Not applicable, but cost negotiation
Contract with Accredited Research Institutes for production of fortified organic seeds	12,000, 000	Prior	Single source with HARVEST PLUS	Not applicable, but cost negotiation
Contract with a firm in charge to develop and implement change of the behavior and social change	7,000,000	Prior	International Open/QBS	Criteria noted Publication of ROI
Contract for PRONANUT building capacity	5, 000,000	Prior	International Open/QBS	Criteria noted Publication of ROI
Contract with a specialized organization for technical and logistical support	4,000,000	Prior	International Open/QBS	Criteria noted Publication of ROI
Contract with a firm in charge to develop and implement an electronic job aid system	1,200,000	Prior	International Open/QBS	Criteria noted Publication of ROI
Contract with a firm in charge to develop and test a risk-based verification system	900,000	Prior	International Open/QBS	Criteria noted Publication of ROI
Supply of furniture, hardware, and information technology equipment	750,000	Post	National Bid Request	Lowest evaluated cost

Recruitment firm for targeting vulnerable households' recipients of financial allocations	350,000	Post	National Open/CBS	Criteria noted (VfM) Publication for ROI
Recruitment of a firm for an inventory of health facilities in the five targeted provinces	350,000	Post	National Open/CBS	Criteria noted (VfM) Publication of ROI
Supply and installation of Internet connection equipment (VSAT and related)	200,000	Post	Limited/Request for Quotations	Lowest evaluated cost
Supply of five 4x4 vehicles for project coordination	250,000	Post	Limited/Request for Quotations	Lowest evaluated cost
Construction and/or rehabilitation of sanitary facilities	280,000	Post	Limited/Request for Quotations	Lowest evaluated cost
Contract with Accredited National Research Institutes INERA and SENASEM for production of fortified organic seeds	100,000	Post	Single source with SENASEM,	Protocol
Recruitment of an individual consultant for feasibility studies and design of water infrastructure hygiene and sanitation	50,000	Post	National Open/SIC	Publication of ROI
Contract with a mobile operator in charge of the dissemination of alert messages in national languages for the benefit of targeted households	50,000	Post	National Open/CBS	Criteria noted (VfM) Publication of ROI

NB: Whatever the method of selection, the ToR must be submitted to IDA before any processing of consultants' selections (firms or individuals).

ANNEX 5: Financial Management

Financial Management and Disbursement Arrangements

1. In accordance with World Bank Directive: Financial Management Manual For World Bank IPF Operations, and World Bank Guidance: Reference material - Financial Management in World Bank IPF Operations, the FM arrangements of the PDSS Project (P147555) PCT have been assessed to determine if the entity has acceptable FM arrangements in place that satisfy the World Bank's requirements. These arrangements would ensure that the implementing entity: (a) use project funds only for the intended purposes in an efficient and economical way; (b) prepare accurate and reliable accounts as well as timely periodic financial reports; (c) safeguard assets of the project; and (d) have acceptable auditing arrangements.

2. The World Bank team determined that FM arrangements at the PDSS PCT could be deemed adequate to project implementation subject to meeting the following requirements: (a) opening the DA in a financial institution acceptable to the World Bank; (b) drafting of a manual of procedures in order to take into account the new project and grant specificities; (c) acquiring a multisite and multiproject version of the management accounting software TOM2PRO to accommodate the decentralized and multiagency nature of the Multisectoral Nutrition and Health Project, recording project transactions, and preparing Quarterly Interim Unaudited Financial Reports, not longer than three months after the project effectiveness; (d) recruiting a FM Specialist to assist the FM team that will be dedicated to the project; (e) recruiting an accountant to do the same; (f) recruiting an internal audit consultant who will contribute to strengthening the project's internal control environment and internal audit unit; and (g) agreeing to the ToRs for the recruitment of an independent external auditor acceptable to IDA, based on acceptable ToR.

3. The project Implementation entity will be the PDSS PCT. Implementation arrangements of the ongoing PDSS project will be maintained under the proposed project. The current arrangements provide for the PDSS PCT to be the main implementing unit for the Nutrition Project. To this end, the FM aspects of the PDSS have been reviewed. The proposed project will use the existing FM arrangements currently in place at PDSS.

4. The overall FM risk at preparation is considered High. Additional details on the FM assessment are found below.

Project Institutional and Implementation Arrangements

5. The proposed project will be implemented by the PCT which currently manages PDSS. The PDSS-PCT will implement all components of the project. The implementation of the cash transfer component will be subcontracted to the PIP PIU. Both entities have experience with World Bank projects and have fiduciary and safeguards capacities. The project will be governed by a Project Technical Committee consisting of PRONANUT as its chair, with permanent members from other pertinent directorates within the MoH, and from the MoSA, Ministry of Education, Ministry of Agriculture, and Ministry of Fisheries and Livestock. The full Committee will meet at least twice a year. Smaller working groups set up for specific project components will meet with more frequency to guide activities and coordination of the investments undertaken by the three entities.

Financial Management

Country PFM Situation and Use of Country Systems

6. The overall project fiduciary risk is considered High; fiduciary risks have a high probability of impacting the PDO in a highly adverse way. Overall the fiduciary environment of the country is weak, with the main reasons further detailed.

7. Despite making progress during the last decade, the DRC's governance ratings are among the lowest in the world and significantly below the sub-Saharan African average. Because of weak governance, improvements in the institutional performance of the DRC's economy and political participation systems have been stagnant. The national budget is insignificant given the size, population, and natural resource wealth of the country. The tax revenue base in the DRC is narrow and does not allow the Government to mobilize the revenues needed to finance its own operations and deliver public services. In addition, the structural deficit has reinforced systemic corruption. Budget execution suffers from: (a) redundant and lengthy steps in budget execution processes, including various political interventions in the approval of commitments and payments; (b) abuse in the use of exceptional or emergency procedures; and (c) excessive centralization of budget execution authority in the Ministry of Finance and the Ministry of the Budget. The 2017 Country Policy and Institutional Assessment (CPIA) by the African Development Bank Group for the DRC show overall below-average performance relative to IDA Borrower and sub-Saharan Africa countries, especially in the areas of economic management and public sector management and institutions. There is a number of reasons for this below-average performance. The weakness of formal institutions charged with the oversight of public finances has enabled the widespread use of discretionary power. Data controls in the FM system are weak. There have been some delays in financial reporting. Some internal control deficiencies have resulted in the default of compliance with core rules. Internal audits have not been systematically performed in keeping with generally accepted standards. While external audits have been adequate, there have been some delays in audit reports and follow up.

8. Assessments by the World Bank and other donors, notably the 2008 Public Expenditures Review, the 2012 Public Expenditure and Financial Accountability (PEFA), and the 2015 Public Expenditure Management and Financial Accountability Review, portray an unsatisfactory economic and financial control environment including weak budgeting preparation and control, financial reporting, and external audit procedures, and limited human resources. In-depth structural reforms are consequently required in the areas of economic governance, public expenditure management, financial sector expertise, and public enterprises to strengthen capacity in public administration. To this end, with the support of the donor community, the Government of DRC undertook a series of PFM reforms in budget preparation and execution, adhesion to treasury forecasts, preparation of regular budget execution reports, and simplification of the national budget classification system. The first critical step in these series of PFM reforms was the adoption in July 2011 of a new PFM Organic Law, preceded by the adoption of a new procurement code in December 2008. Additional decrees are being finalized to further clarify the Organic Law. The second PEFA, concluded at the end of 2012, took stock of the areas of progress and revised the existing PFM strategy plan accordingly. The new World Bank-financed project "Strengthening PFM and Accountability" (P145747), effective since May 2014, strengthens the PFM system both at the central level and at some provinces levels. The outcomes of the use of the country national PFM systems assessment report which had been undertaken in April 2013 will be gradually implemented for the World Bank-financed projects. Concerning internal and external audits, discussions will be engaged with the Government to organize the working environment of the General Finance Inspection (*Inspection Générale des Finances*) and the Chief Audit Office (*Cours des comptes*).

9. Most of these reforms are still ongoing, and it will admittedly take time for these reforms to yield substantial improvements in the management of public funds. As a result, the overall country fiduciary risk is still

considered High.

Risk Assessment and Mitigation Measures

10. The World Bank's principal concern is to ensure that project funds are used economically and efficiently for the intended purpose. Assessment of the risks that the project funds will not be so used is an important part of the FM assessment work. The risk features are determined over two elements: (i) the risk associated with the project (inherent risk); and (ii) the risk linked to a weak control environment of the project implementation (control risk). The content of these risks is described below, mainly focusing on the PDSS PCT.

Table A5.1: Risks, Risk Rating, and Risks Mitigating Measures.

Risk	Risk rating	Risk Mitigating Measures Incorporated into Project Design	Residual Risk after mitigation measures	Conditions for effectiveness (Y/N)
INHERENT RISK	**S**		**S**	
Country level Poor governance and slow pace of implementation of PFM reforms that might hamper the overall PFM environment.	H	Some PFM reform programs were implemented and concluded successfully, through IDA-financed projects, such as the Enhancing Governance Capacity (P104041), and the Establishing Capacity for Core Public Management (P117382). Currently ongoing is the Strengthening PFM and Accountability (P145747) projects approved on January 2014 by the World Bank's Board. These reforms will address the key new challenges the country is facing.	H	
Entity level - Lack of coordination due to several stakeholders being involved and to political interference of the ministry. - All stakeholders not familiar with the new implementation modalities of the project. - The PDSS will implement the project in association and in collaboration with several external stakeholders. There will be an inherent issue of coordination and consolidation of actions and information.	**H**	- The PDSS PCT will ensure the coordination of the project with the collaboration of other stakeholders. - Establish a manual of procedures which clarifies the roles and responsibilities of the various stakeholders. The PIM will define implementation procedures in line with adequate fiduciary requirements. Training sessions will also be provided. From inception, the necessity for seamless coordination will be integrated into the protocols/agreements between the PDSS PCT and other external stakeholders respectively.	**S** (During implementation)	
Project level - Weak capacity and	S	- Drafting and implementation of an Accounting, Financial and Administrative Procedures Manual,	**M** (Within three	

lack of availability of different stakeholders involved in other tasks within their usual duties. - Weak FM capacity at different stakeholder levels and risk of fraud and corruption.		coupled with the adoption of a PIM that includes adequate fiduciary procedures. - Regular internal audit missions (technical and financial audit) to be conducted during the project period with a focus on fraud and corruption risk in the implementation of project operations.	months after effectiveness) (Within three months after effectiveness)	
CONTROL RISK	**S**		**S**	
Budgeting The budget preparation process may be delayed given the number of stakeholders involved in the project implementation.	S	- The FM staff will help stakeholders in preparing realistic budgets consistent with the work program. Moreover, the manual of procedures will define the arrangements for budget formulation, budgetary control, and the requirements for budgeting revisions. - Annual detailed disbursement forecasts will be included in the budget. Quarterly IFR will provide information on budgetary control and analysis of variances between actual performance and budget estimates.	**S** (Prior to effectiveness)	Yes
Accounting Lack of reliable accounting system and low knowledge of the FM procedures of IDA.	**S**	- Acquisition of management accounting software and its customization to generate the financial reports of the project. - Implement appropriate training sessions based on agreed accounting procedures - Recruitment of a FM specialist and an accountant with proven experience in managing World Bank-financed projects to assist the FM team that will be dedicated to the project.	**M** (Within three months after effectiveness (Within three months after effectiveness (Within three months after effectiveness)	
Internal Controls and Internal Audit An internal control environment not suited to the World Bank's fiduciary management procedures.	**S**	- The drafting of a manual of procedures in order to take into account the new project and grant specificities. - Regular internal audit missions (technical and financial audit) to be conducted during the project implementation with a focus on fraud and corruption risk. - Recruitment of an internal audit consultant who will perform a risk assessment analysis of the project for the use of the government's internal audit institutions. In addition, the capacity of the internal audit institutions will be strengthened through training sessions.	**S** (Prior to effectiveness) (During implementation) (Within three months after effectiveness	Yes
Funds Flow (i) Risk of misappropriation of funds, allocated to the project activities,	**H**	Opening the DA in a financial institution acceptable to the World Bank. As relates to cash transfers, special attention will be paid to the following aspects of the cash transfers:	**H** (During preparation)	

used for non-eligible purposes; (ii) Weak capacity in the disbursement procedures of IDA which could affect the disbursement rate.		▪ Targeting and identification of beneficiaries ▪ Processing of applications (verification of eligibility and beneficiaries) ▪ Effecting actual payments (security and regularity of payment systems) ▪ Prospective of forecasting relevant disbursements ▪ Audit and control of process (ex-ante and ex post) ▪ Accounting and justification of expenditure) A specific section on the fiduciary management of cash transfers will need to be included in the manual of procedures to be drafted. Require of the future FM consultant to ensure compliance with disbursement letter stipulations, especially the monthly submission of withdrawal applications.	(During implementation)	
Financial Reporting Delay and difficulties in the submission of acceptable IFRs to IDA due to weak capacity of the FM team and to the number of stakeholders involved in the project.	**S**	(i) Acquisition of management accounting software and its customization to generate the financial reports of the project. (ii) Agreement of the format and content of the Interim Financial Report which will include the project specifics.	**M** (Within three (03) months after effectiveness) (During preparation)	
External Auditing External audit arrangements are not defined and lack of capacity of public institutions of control to assure the external audit of the project.	**S**	Recruit independent external auditor based on agreed ToR developed in line with International Accounting Standards (including fraud and corruption). ToRs will be subject to approval by IDA.	**M** (Within three months after effectiveness)	
Fraud and Corruption Possibility of circumventing the internal control system with colluding practices as bribes, abuse of administrative positions, mis-procurement is a critical issue.	**H**	The ToR of the external auditor will comprise a specific clause on the audit of corruption Organize frequent controls of each actor in order to help prevent and mitigate the risk of diversion of funds. Payment requests will be approved by the Coordinator and the Financial Manager prior to disbursement of funds. Internal audit ToR will include a periodic review of project transactions, both accounting and procurement.	**S** (Within three months after effectiveness)	
Overall FM risk	**H**		**H**	

Table A5.2: Key Issues and Action Plan to Reinforce the Control Environment.

No	Issue	Remedial action recommended	Responsible entity	Completion	Project Effectiveness conditions
1	Disbursement arrangements	Project Implementation must open a new DA in a financial institution acceptable to the World Bank.	DRC Government	Completed	N
2	Accounting Staffing	In contracts of prospective FM staff, including coordinator, the ToRs for essential staff will need to systematically include objective performance criteria: • Recruit a project FM specialist • Recruit a project accountant	PDSS PCT	Within three months after effectiveness	N
3	Information system accounting software	Acquisition of a multisite and multiproject version of the management accounting software TOM2PRO to accommodate the decentralized and multiagency nature of the Multisectoral Child Nutrition and Health Project, record project transactions, and prepare Quarterly Interim Unaudited Financial Report not longer than three months after effectiveness.	PDSS PCT	Within three months after effectiveness	N
4	Administrative, Accounting and Financial Manual of procedures	Draft a manual of procedures (i) to include the specificities of the new project; (ii) ensure adequate ownership by the new players; (iii) strengthen the anti-corruption aspects, and (iv) ensure the comprehensive coverage of all the components of necessary FM arrangements in IPF projects by beginning the planning and budgeting, accounting, internal control, funds flow, financial reporting, and auditing arrangements of the Borrower and entity responsible for project implementation; and (iv) include a specific section on the fiduciary management of cash transfers. At a minimum, as relates to cash transfers, special attention will be paid to the following aspects of the cash transfers: ▪ Targeting and identification of beneficiaries ▪ Processing of applications (verification of eligibility and beneficiaries) ▪ Effecting actual payments (security and regularity of payment systems) ▪ Prospective of forecasting relevant disbursements ▪ Audit and Control of process (ex ante and ex post) ▪ Accounting and justification of expenditure)	PDSS PCT	By effectiveness	Yes
5	Internal auditing	Recruitment of an internal audit consultant who will contribute to strengthening the project's internal control environment and internal audit unit.	PDSS PCT	Within three months after effectiveness	N
6	External financial auditing	Agree the ToRs for the recruitment of an external auditor acceptable to IDA.	PDSS PCT	Three months after effectiveness	N

Governance and anticorruption considerations

11. The country's political situation has weakened the governance and anticorruption environment. In the context of the project, the following governance and anticorruption measures will contribute to enhance transparency and accountability during project implementation: (a) an effective implementation of the fiduciary

mitigation measures should contribute to strengthen the control environment; (b) the ToRs of both the internal audit unit and external auditor will include a specific chapter on corruption auditing; (c) the FM manual of procedures will include anticorruption measures with a specific safety mechanism that will enable individual persons and NGOs to denounce abuses or irregularities; (d) measures to improve transparency such as providing information on project status to the public and to encourage participation of civil society and other stakeholders will be strengthened during project implementation; and (e) an anticorruption action plan will be prepared in addition to the robust FM arrangements designed to mitigate the fiduciary risks.

12. **Staffing and Training:** the PDSS PCT will maintain adequate staff resources for the level of project operations and activities. This will be sufficient to maintain accounting records of project-financed transactions and to prepare project financial reports. The FM arrangements will be implemented by the PDSS PCT. In order to compensate for the extra workload to be borne by the PDSS PCT FM staff, a qualified and experienced FM specialist will be recruited to support the PDSS PCT in the supervision of the overall FM activities of the project. An experienced accountant will also be hired to support the accounting division. The PDSS PCT will have overall responsibility for the FM project, including budgeting, accounting, reporting, disbursement, and internal control at both the central and decentralized level.

13. **Budgeting:** The PDSS PCT will prepare, an annual work plan and budget for the implementation of project activities, taking into account project objectives. The work plan and budgets will identify the activities to be undertaken and the role of the respective parties in the implementation. The annual work plans and budgets will be consolidated into a single document by PDSS PCT, with the support of the FM team, which will be submitted to the Technical Committee and the Steering Committee for approval, and then to IDA for a “no objection” review no later than November 30 of each year. The consolidation will be carried out after PDSS PCT has assured, through its technical departments, that the plan and the budget meet the objectives of the project. The budgeting arrangements will include an annual work plan and budget to be prepared for each year. The project FM Manual of Procedures will define the arrangements for budgeting, budgetary control, the requirements for budgeting revisions, and the adoption by the the Technical Committee and the Steering Committee of the budget. Annual detailed disbursement forecasts and budgets will be required – an emphasis will need to be placed on the prospective nature of such forecasts so that uses of funds are adequately covered. IFRs will provide information on budgetary control and analysis of variances between actual and budget. Deadlines, as mandated by the Finance Agreement, for budget preparation and approval will need to be complied with.

14. **Accounting Policies and Procedures:** The accounting systems and policies, administrative, and financial procedures will be documented in the project’s Administrative, Accounting and Financial Manual. It will be used by the project staff as a reference manual, by IDA to assess the acceptability of the project accounting, reporting, and control systems, and by the auditors to assess project accounting systems and controls and to design specific project audit procedures. Accounting management software that can handle multiple project, multiple sites, and multiple donor characteristics will be procured. At least two sets of financial reports will be prepared by PDSS PCT: the quarterly Interim Financial Reports, as required by the World Bank 45 days after the close of each quarter. The IFRs will be based on formats developed in the World Bank’s Guidelines on Financial Monitoring Reports, albeit with some adjustments. The manual of procedures will indicate provisions for quarterly and yearly financial reporting, including physical progress. The quarterly reports will include a table on budget execution. The format of this report will include: (a) a statement of sources and uses of funds; (b) a table summarizing the use (utilization) of funds by category, activities, and by components; (c) an updated procurement plan; (d) a report on the physical progress of activities; and, (e) the summary of missions of internal audit, as well as the implementation status of the recommendations of internal or external audit and supervision missions. Project accounts will be maintained

on an accrual basis, supported with appropriate records and procedures to track commitments and to safeguard assets.

15. **Internal Control and Internal Auditing:** The internal control will be organized in the PDSS PCT's Administrative, Accounting, and Financial Handbook which will be updated so as to provide a framework for project implementation which will be in compliance with IDA directives. It will highlight the management of the project and the appropriate separation of tasks and responsibilities. The internal audit functions will be performed by PDSS PCT's Internal Audit Division, whose professional capacity will be strengthened by recruiting an internal audit consultant who will contribute to strengthening the project's internal control environment and internal audit unit, as well as to improving PDSS PCT's internal governance framework, and provide a project risk map.

16. **Financial Reporting and Monitoring:** The manual of procedures will indicate provisions for quarterly and yearly financial reporting, including a report on physical progress. The quarterly reports include a table on budget execution. The format of this report will include: (a) the statements of sources and used funds, and utilization of funds per category; (b) the update of the procurement plan; (c) the physical progress; and (d) the summary of missions of internal audit as well as the implementation status of the recommendations of the internal or external audit and supervision missions.

17. **External Auditing:** The project financial statements and internal control system managed by the PDSS PCT will be subject to annual audits by an independent external auditor acceptable to the World Bank whose mandate will be renewed every two years.

18. The audit report should reflect all the activities of the FM program and be submitted to IDA within six months after the end of each fiscal year. The selection of an external auditor of project financial statements should be presented to IDA for nonobjection. Appropriate ToR for the external auditor will be provided to the project team.

19. The external auditor will give an opinion on the annual financial statements in accordance with auditing standards of the International Federation of Accountants. In addition to audit reports, the external auditor will also provide a management letter on the internal control procedures outlining recommendations for improving the control system, accounting, and financial procedures as a result of the audit as well as maintaining compliance with financial covenants under the financing agreement.

20. The project will be required to submit, not later than June 30 of each fiscal year, the annual audited financial statements. The audit reports that will be required to be submitted by the PCT and the due dates for submission are:

Table A5.2: Audit Reports and Due Dates.

Audit Report	***Due Date***
Institutional Financial statements, that is, annual audited financial statements (including Statements of Sources and Uses of Funds with appropriate notes and disclosures) and Management Letter.	Submitted within **six** months after the end of each fiscal year.

21. The project will be required to produce a final audit report no later than six months after the closing of

project.

22. In line with the new access to information policy, the project will comply with the disclosure policy of the Bank of audit reports (for instance making them available to the public without delay after receipt of all reports' final financial audit, including qualified audit reports) and place the information on its official website within one month after acceptance of the final report by IDA.

Implementation Support and Supervision Plan.

23. FM implementation support missions will be consistent with a risk-based approach and will involve a collaborative approach with the project team. A first implementation support mission will be performed six months after the project becomes effective. Afterwards, the missions will be scheduled by using the risk-based approach model and will include the following: (a) monitoring of the FM arrangements during the supervision process at intervals determined by the risk rating assigned to the overall FM Assessment at entry and subsequently during Implementation (ISR); (b) integrated fiduciary review on key contracts; (c) review of the IFRs; (d) review of the audit reports and management letters from the external auditors and follow-up on material accountability issues by engaging with the task team leader, client, and/or auditors; the quality of the audit (internal and external) also is to be monitored closely to ensure that it covers all relevant aspects and provides enough confidence on the appropriate use of funds by recipients; (e) physical supervision on the ground; and (f) assistance to build or maintain appropriate FM capacity.

24. Based on the outcome of the FM risk assessment, the following implementation support plan is proposed:

Table A5.3: FM Activities.

FM Activity	**Frequency**
Desk reviews	
Interim financial reports review	Quarterly
Audit report review of the program	Annually
Review of other relevant information such as interim internal control systems reports.	Continuous as they become available
On site visits	
Review of overall operation of the FM system	Annual (Implementation Support Mission
Monitoring of actions taken on issues highlighted in audit reports, auditors' management letters, internal audit and other reports	As needed
Transaction reviews (if needed)	As needed
Capacity building support	
FM training sessions	Before project starts and thereafter as needed

25. The objective of the above implementation support plan is to ensure that the project maintains a satisfactory FM system throughout the project's life.

Conclusion of the Assessment

26. The overall residual FM risk at preparation is considered High. The proposed FM arrangements for this

project are considered adequate to meet the World Bank's minimum fiduciary requirements under World Bank Directive: Financial Management Manual For World Bank IPF Operations, and Bank Guidance: Reference material - Financial Management in World Bank IPF Operations.

Disbursements

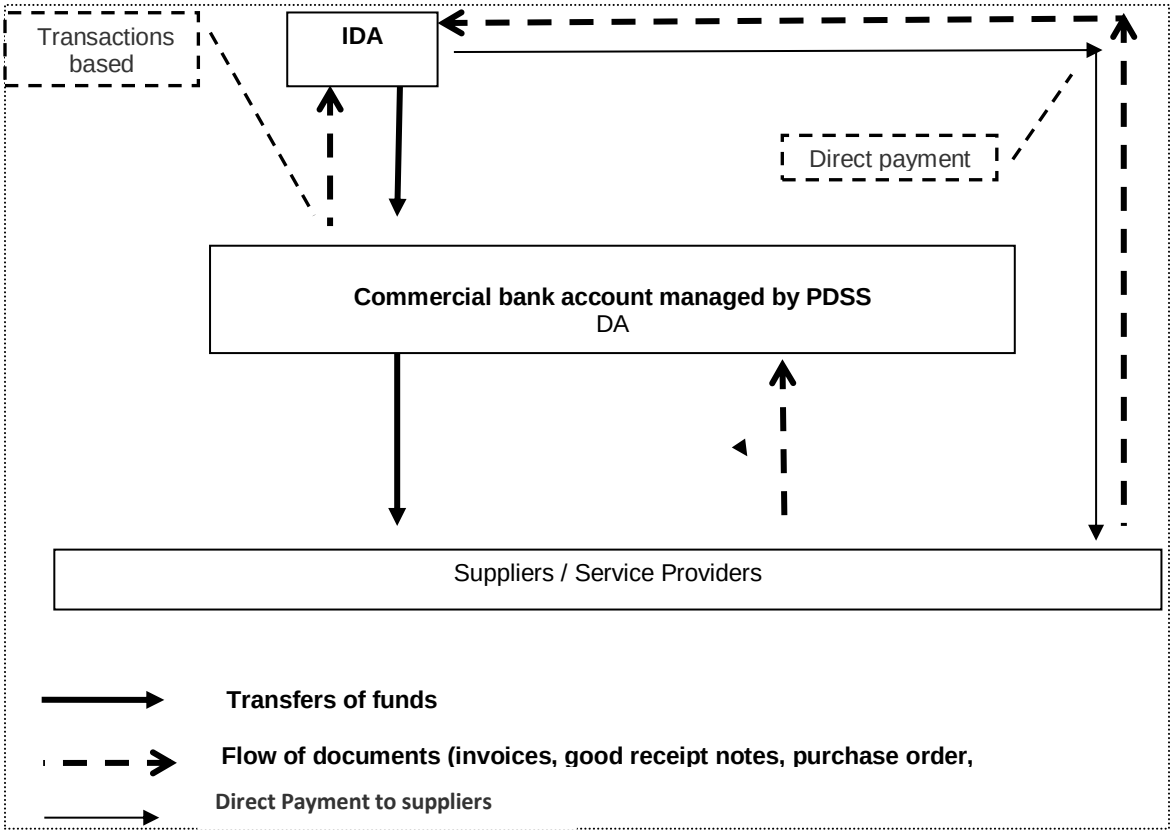
Designated Account

27. The PDSS PCT will have one DA that will be managed by a joint signature of both the PDSS PCT FM Specialist and the PDSS PCT Project Coordinator. It will be used to finance all eligible project expenditures under the different components. The DA will be opened in a reputable commercial bank on terms and conditions acceptable to IDA under the fiduciary responsibility of the PDSS PCT. This account will be held in U.S. dollars. The DAs will receive cash advances to pay project expenses eligible for IDA financing. Payments will be made in accordance with the provisions of the manual of procedures (that is, joint signatures by the Project Coordinator/ PDSS PCT Director and FM Specialist). The DA will be managed according to the disbursement procedures described in the Project Manual of Procedures and the Disbursement Letter.

Disbursement Methods

28. By the effectiveness date of the project, it will use the transaction-based disbursement procedures, that is, replenishment, direct payment, reimbursement, and special commitments. The transaction-based disbursement method will be applied for the DA, which has received an initial advance of US$7.7 million. The DA will be used for all payments less than twenty percent of the ceiling and replenishment will be submitted as often as possible. Funds flows for the DA are illustrated as follows:

Figure A5.1: Flow of Funds.



Funds Flow Arrangements

29. **Disbursement arrangements:** The transaction-based disbursement method will be applied. The DA will be used for all payments less than twenty percent of the ceiling and replenishment applications will be submitted at least once a month.

Monthly Replenishment Applications:

30. The DA will be replenished through the submission of withdrawal applications on a monthly basis by the PDSS PCT and will include reconciled bank statements and other documents as may be required until such time as the Recipient may choose to convert to report-based disbursement.

31. **Disbursements by category:** The table below sets out the expenditure categories to be financed by the loan. This table takes into account the prevailing Country Financing Parameter for the DRC in setting out the financing levels. In accordance with World Bank standard procurement requirements, contracts will continue to be approved “all taxes included” for local expenditures.

Table A5.4: Eligible Expenditure Table under IDA and GFF

Category	Amount of the Credit Allocated (expressed in SDR)	Amount of the Grant Allocated (expressed in SDR)	Percentage of Expenditures to be Financed (inclusive of Taxes)
(1) Goods, works, non-consulting services, and consulting services, Operating Costs, Training for the Project except for Part 1.2 and Part 4.2(ii)	30,000,000	30,000,000	100%
(2) BPNS Subgrants under Part 1 of the Project and 4) RH Subgrants under Part 2.2 of the Project	72,750,000	72,750,000	100% of amounts disbursed
(3) PBF Subgrants under Part 2.1 of the Project	66,650,000	66,650,000	100% of amounts disbursed
(4) Cash Transfers under Part 3 of the Project.	4,350,000	4,350,000	100% of amounts disbursed
(5) CERC	0	0	
(6) Refund of the Preparation Advance	7,500,000	7,500,000	Amount payable pursuant to Section 2.07 (a) of the General Conditions
(7) Refund of the Kassai Emergency Project Preparation Advance	2,800,000	2,800,000	Amount payable pursuant to Section 2.07 (a) of the General Conditions
TOTAL AMOUNT	177,300,000	177,300,000	

ANNEX 6: World Bank Portfolio Mapping

Figure A6.1: Overall World Bank Portfolio in DRC

Figure A6.2: Human Development Portfolio in DRC (active projects in HNP, SPJ, and ED)

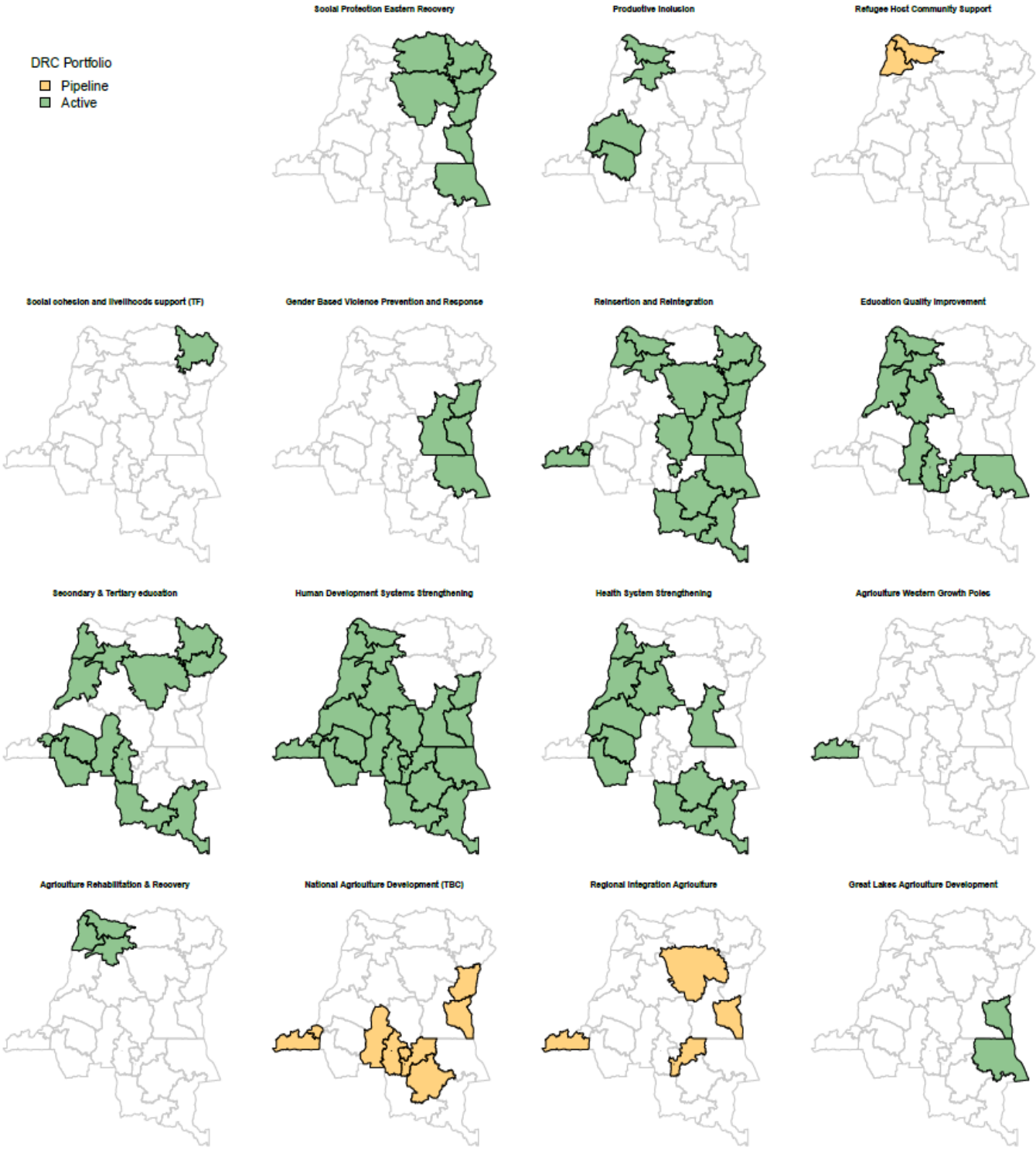


Table A6.1: Opportunities for Synergies and Collaboration with Human Development and Other Relevant Projects

Project	GP	Project Area*	PDO	Opportunities for Synergies and Collaboration
Eastern Recovery Project (STEP) (P145196)	SPJ	S. Kivu, Eturi, N. Kivu, Tanganyika	To improve access to livelihoods and socioeconomic infrastructures in vulnerable communities in the eastern provinces of DRC.	Subcomponent 2 of the STEP focuses on strengthening agriculture value chains. This support has the potential to improve market access and market penetration for the biofortified crops disseminated under Component 3 of the proposed project, as well as for any excess production of the household food production kits.
HD Systems Strengthening Project (HDSSP) (P145965)	HNP	N. Kivu, S. Kivu, Kasai, Kasai Centrale, Kwilu Tanganyika, Tshuapa, Maniema, N, Ubangi, S. Ubangi, Equateur, Mai-Ndobe, Haut Katanga, Haut Lomani, Lualaba, Kasia Orientale, Sankuni, Mongala, Kinshasa, Kongo Centrale, Kwango	To increase the availability of data for decision making for human development and to strengthen systems for essential medicines.	HDSSP has invested in the strengthening HMIS. The current project will complement the investments made under HDSS through a number of activities including expanding the Carte Sanitaire (geo-location of health facilities) in the project provinces and developing the community-level health and nutrition information system which will be integrated into the HMIS.
Regional Great Lakes Integrated Agriculture Project (RGLIAP) (P143307)	SPJ	S. Kivu and N. Kivu	To sustainably enhance the productivity of selected value chains in DRC and Burundi in targeted areas and to improve agricultural regional Integration.	Direct synergies: Subcomponent 1.1 of (RGLIAP) focuses on: strengthening the capacity of selected producer organizations or cooperatives, facilitates access to improved planting materials of cassava, facilitates dissemination of improved production techniques, and facilitates access to agricultural inputs production of selected value-chains in S. Kivu. Those activities will support the implementation agricultural activities under Component 3 of the proposed project and biofortification, and targeted distribution of household food production kits) to improve nutrition outcomes in four provinces. The proposed project will work with the RGLIAP to maximize the overlap between the producer organizations supported by RGLIAP and engaged to grow/multiply biofortified crops and inputs for the household production kits.

Gender Based Violence Prevention and Response Project (GBVPRP) (P166763)		S. Kivu, N. Kivu, Maniema, Tanganyika	To increase in targeted HZs: (i) the participation in Gender-Based Violence (GBV) prevention programs; (ii) the utilization of multi-sectoral response services for survivors of GBV	Direct Synergies: building on the experience of the GBVPRP, the MNP follow on project will link with the Village Savings and Loans Associations (VSLAs) and utilize this group for the agriculture component including for nutrition education, and household food production. The proposed project will complement the GBVPRP by ensuring the availability of postexposure services for SGBV survivors and by training ReCo on issues related to SGBV. The SGBV project currently supports PBF in health facilities in seven HZs in Sud Kivu. This support will be ending in July 2019. The proposed project will take over the financing of the PBF in those HZs to ensure the continued availability of services.
Health Systems Strengthening Project (PDSS) (P157864)	HNP	Equateur, Maniema, Haut Katanga, Kwilu, Kwango, Lualaba, S. Ubangi, Mai-Ndobe, Mongala, Tshuapa, Haut Lomani	To improve utilization and quality of MCH services in targeted areas. The primary focus of the project will be on MCH with improvements in MCH service delivery achieved though the scale-up and strengthening of PBF.	The proposed project will use the PBF platform supported by the PDSS project. In Kwilu. The proposed project will benefit from the presence of PBF financed by PDSS and complement it by implementing the community nutrition and health platform, SBC, and nonstate providers of FP. In Kassai, Kassai Central, and Sud Kivu, the project will expand PBF using the delivery and implementation modalities developed by PDSS. This project will also use the PDSS PCT to capitalize on the existing well-functioning PCT. The MNP will supplement the PCT with additional staff positions to support the implementation of MNP.
Productive Inclusion Project (PIP) (P163962)	SPJ	Kwilu, N. Unbangi, Mongala, Mai-Ndobe, Kwango	To improve the access of poor households to productive safety nets interventions and establish the core building blocks of a safety-net system.	The proposed project will work directly with PIP in the convergence demonstration project areas. It aims at using the PIP PIU (through a subcontract with the PCT) and the PIP's delivery mechanisms (for example, its cash transfer providers) to delivery of the unconditional cash transfers in the demonstration pilot HZs. The two projects will be aligned to develop joint beneficiary targeting criteria. The registries developed by both projects will serve as the basis for the national SP registry.
Education Quality Improvement Project (EQUIP) (P157922)	ED	N. Ubangi, S. Ubangi, Mongala, Tshuapa, Equatuer, Kasai, Kasai Centrale, Lomani, Tanganyika,	To: (a) improve pupils' learning achievements in primary education, and (b) strengthen sector	There are no direct synergies or opportunities for collaboration. However, the proposed project aims at improving preparedness for primary education among children by improving their health and nutrition status.

			governance	
Impact Evaluation on PSD Interventions in DRC (P143272)	AG	Kongo Central	To generate evidence on what works to improve women's economic outcomes and improve early childhood development.	The proposed project will collaborate closely on the priority learning outcomes of the impact evaluation so that intermediate and final results can be incorporated directly into the project, and potentially scaled-up if found to be cost-effective for outcomes of interest.
Quality and Relevance of Secondary and Tertiary Education Project (P149233)	EDU	Haut Uele, Eturi, S. Ubangi, Mongala, Equateur, Tshopo, Kongo Centrale, Kwongo, **Kasai**, Kasai Orientale, Lualaba, Haut Katanga	To: (i) improve the teaching and learning of Mathematics and Science in general secondary education, and (ii) enhance relevance of technical and vocational education and training in priority sectors at secondary and tertiary levels.	No direct opportunities for collaboration or synergies.
Reinsertion and Reintegration Project (P152903)	AG	Haut Uele, Eturi, N. Ubangi, S. Ubangi, N. Kivu, **S. Kivu**, Tanganyika, Maniema, Haut Katanga, Haut Lomani, Lualaba, Kasai Orientale, Sankuni, Tshopo, Mongala, Kinshasa, Kongo Centrale	To support the socio-economic reintegration of demobilized ex-combatants.	No direct opportunities for collaboration or synergies.

Note: * **bold underlined font** indicates the provinces of the geographic overlap with the proposed project's areas

ANNEX 7: References

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ANNEX 8: Map of the Democratic Republic of Congo